

The Lived Experience
of
Older Adults Participating
in a
Social Support Network Group

The Lived Experience of Older Adults Participating in a Social Support Network Group

Submitted by

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Statement of Authorisation

I, Regina Mary McDonald, declare that this thesis titled “The Lived Experience of Older Adults Participating in a Social Support Network Group”, to the best of my knowledge and belief, is my own work, except where acknowledged in the text.

Chapters 1, 2 and 3 were submitted for upgrade to Doctor of Philosophy from Masters of Philosophy in November 2005. These three chapters have since had additional material added as part of this thesis submission for PhD. This thesis has not been submitted for any academic award at this or any other tertiary or academic institution.

Findings from Study One have been published in a peer reviewed nursing journal: Contemporary Nurse (2008), Vol 29, Issue 2 pp. 184-194: titled - “Exploration of social support systems for older adults: A preliminary study”, and in the Proceedings of the 5th National Conference of Emerging Researchers in Ageing, November 2006, titled - “The Lived Experience of Older Adults Participating in a Social Support Network Group”. Some sections of the thesis on theory and method, along with Study One findings are contained in those publications.

Findings from Study Two have been prepared for submission and possible publication in a peer reviewed journal.

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Signed.....

Date

Abstract

Title:

“The lived experience of older adults participating in a social support network group”.

Introduction:

This thesis explored the experiences of older people participating in social support groups using a mixed method design of qualitative and quantitative paradigms with the qualitative design taking the primary data collection role.

Social support commonly refers to the availability, or actual provision of relationships, information and assistance. Instrumental support constitutes a range of services that may include domestic services, shopping, and transport. Alternatively, expressive support assists in maintaining a level of independent functioning and reduces social isolation by having contact with others. However, most support services often focus on physical functioning and disability only, and do not address emotional and psychological support (referred to as expressive support) so often required by the older adult to maintain physical and psychological well-being. Therefore, independent and functional older adults often find themselves feeling desperately lonely, socially isolated and in a state of despair as a consequence of the lack of support and contact with their peers which may result in the development of psychological problems including depression. There are limited community support services available to address these problems that reinforce the body as needing care and support but that the mind or psyche or emotions do not. This has been referred to in the philosophical literature as Cartesian dualism or mind-body split. Social support groups, where older adults engage with their peers, have the capacity to address this problem through social networking and social trust and reciprocity that facilitates social integration for mutual benefits, and in the process, builds social capital.

Aim:

The two studies reported in this thesis are independent. However, the findings were compared to see if differences in group participation emerged. The aim of this study was to better understand the benefits that older adults may receive from social engagement with peers and the impact this may have on their health and well-being.

Method

The study employed a mixed method research design using hermeneutic phenomenology as the qualitative foundation to obtain a better understanding of the lived experience of older adults, and quantitative methods to provide complementary information about the benefits received from participating in groups as a means of social support, and explored the relationship of this phenomenon to their health and well-being. Data from the latter were examined utilising descriptive and inferential statistical analyses.

Findings

Group membership and peer support appear to provide a platform for achieving and maintaining emotional health and well-being enhancing social capital. Being part of the group encouraged the development of enduring relationships that offered experiences of humanness, interconnectiveness and consolidation of their social world. The findings suggest that being part of a group raises self-esteem, promotes a sense of self-worth and increases feelings of self-confidence. This culminates in a feeling of well-being that may reduce psychological morbidity and mortality. Additionally, group membership provides a forum that supports the concept of health promotion and illness prevention among this cohort of older participants.

Acknowledgements

This thesis is dedicated to my husband Peter, son James and daughter Alexandra who have supported me in so many ways throughout this challenge. I love you all and am proud of all of your own individual achievements and successes. In this dedication I include my mother who died before this thesis was completed. She always supported my educational undertakings.

To achieve this thesis I acknowledge the assistance of my original supervisor Associate Professor Peter Brown for his support and help in study structure, data analysis and interpretation. I thank him most gratefully. I also acknowledge the contribution to data analysis made by Dr Kate Moore, Professor of Psychology, Charles Darwin University and later the committed support and direction provided by Professor Tracey McDonald (unrelated), Australian Catholic University, North Sydney. Without her dedicated guidance this work would not have been completed. I cannot offer her enough thanks.

Very special thanks go to all study participants who through their generosity of time and information made the project possible.

I thank the RSL Day Club Advisors and Coordinators, and the State Council of the Returned and Services League of Australia (NSW Branch), Department of Veterans' Affairs, NSW Office, for their support of the project and their assistance in allowing access to the majority of study participants. I also thank the volunteers, at the Day Club sites visited, who made me feel so welcome with their warm hospitality and good humour.

Lastly, I acknowledge my nursing colleagues for their encouragement and support along the journey toward my success. I especially thank all who supported me in the establishment of the groups at the hospitals, and to the volunteers for their ongoing support and facilitation of the groups that provide a social support network and a health promotion program for older person's mental health community clients. Thank you one and all.

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Ethics Approval from ACU National (Australian Catholic University) Higher Research Ethics Committee (HREC).

Appendix 2: Participants Information Letter

Participants Information Letter: Australian Catholic University.

Appendix 3: Consent Letter

Consent Letter for Participants: Australian Catholic University.

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Appendix 5: Study Presentations

Table of conference presentations related to the study and study findings.

Appendix 6: Study Publications

- 6.1 Proceedings of the 5th National Conference of Emerging Researchers in Ageing, November 2006, titled - "The Lived Experience of Older Adults Participating in a Social Support Network Group".
- 6.2 Contemporary Nurse (2008), Vol 29, Issue 2 pp. 184-194: titled- "Exploration of social support systems for older adults: A preliminary study".

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Development of the Thesis

Study One, a preliminary study, was undertaken prior to undertaking the main study, Study Two. The Introduction and Literature Review are provided in the first two chapters. Study One and qualitative methodology is described in Chapter Three with the preliminary findings of the qualitative thematic analysis reported in Chapter Four.

Following completion of Study One, the potential to recruit additional older adults participating in groups as a means of social support across the State of NSW was increased through the support of the Returned and Services League of Australia (RSL) NSW Branch (Department of Veterans' Affairs (DVA) NSW Office) with access to groups of older adults that they facilitate for the purpose of socialisation.

The second component of the research study incorporated both qualitative and quantitative data collection methods and consists of an additional four chapters. Chapter Five describes additional quantitative data, study methodology and methods, and reports on the outcomes of the descriptive and inferential analysis of the quantitative data. Chapter Six presents results of the qualitative analysis of additional narratives for Study Two. Chapter Seven offers an overall discussion of the study findings and a final reflection on the overall research. In the final chapter, Chapter Eight the concluding remarks are provided along with recommendations for further studies and importantly implications for nursing practice are expressed.

CHAPTER 1

INTRODUCTION

This chapter introduces the research study topic and presents background information that provided a rationale for the study and the study structure. A mixed method design using a primary qualitative paradigm with an embedded quantitative element was employed to explore the experiences of older adults participation in social support groups and the benefits they may receive from such engagement.

The problem statement, that there is little understanding of the experiences and meaning of group participation by older adults, provided direction for the research design, which is underpinned by Heideggerian phenomenology and philosophical hermeneutics. This paradigm focus is on understanding and interpreting the meaning of the human experience. The exploration of this phenomenon was complemented by the use of a quantitative paradigm using descriptive and inferential analysis.

The key aim, is to develop a rich and full description of older people's group experiences, and specific objectives, are to have a greater understanding of social support and social networks for older people.

1.1 Introduction

Older adults are at risk of experiencing adverse health outcomes and developing psychological distress as a result of severe physical illness, social isolation, loneliness and adverse life events (Neno, Aveyard, & Heath, 2007; Tomaka, Thompson, & Palacious, 2006; Kawachi & Berkman, 2001). In general, there is a well established link between social support and different aspects of health and well-being (Hansson, 2006; Helliwell & Putnam, 2004; Antonucci, 2001; Berkman, Glass, Brissette & Seeman, 2000). Social networks have been identified as a mediating factor in human behaviour in

terms of personal crisis and sustained happiness (Steptoe & Diez Roux, 2008; Tolsdorf, 1976, p. 407) because they link people together providing mutual social support (Putnam, 2000; Robertson, 1987). Therefore, the influences between the social context, the individual and their health are important to consider, in terms of the focus being on the social mechanisms that have an effect on social support and provide ongoing social relationships (Thorlindsson, 2011).

Researchers have shown that such forms of social support can function as a buffer on the impact of stressful life events (Beckley, 2006; Kawachi & Berkman, 2001; Cohen and Wills, 1985) such as widowhood (Cohen and Wills, 1985) increasing the connectedness and supportiveness of those involved by providing a network of relationships through which an individual shares common interests and concerns (Lyyra & Heikkinen, 2006).

Beckley (2006, p. 130) proposed that social support is a multifaceted concept. Group memberships are one form of a social network system that may fill a void in the support needs (Reblin & Uchino, 2008, p. 203) of older people and provide some of the multidimensional elements which contribute to social support. Groups, and in particular 'primary groups' (Robertson, 1987, p. 168), where social interaction occurs and peer support is reciprocated, have the capacity to offer empathy and understanding through the shared experiences of others in similar situations (Munn-Giddings & McVicar, 2006, p. 26), for example, where older people are experiencing emotional and psychological distress (Mead, Hilton & Curtis, 2001, p. 135).

Peer support occurs where people of similar age and social characteristics come together and reconstitutes lost social support and assist older people to cope with life crises (Kelly, 1999, p. 63). Participation in peer support groups is reported to provide "personal gains of empathy, emotional information, experiential knowledge and practical information, based on a core value of reciprocity" and that such groups "offer a valuable type of resource in the community that is not replicated in professional-client relationships" (Munn-Giddings & McVicar, 2006, p. 26).

At the core of this present study is the collection, interpretation, and sharing of personal knowledge of older adults' experiences associated with social support and group participation. This is referred to in the literature as 'experiential knowledge' which is knowledge gained from personal experiences of life and of living (Gerrish, 2010, p. 491).

Hermeneutic phenomenology underpins this study. The study combines two research approaches in a mixed method design that blends qualitative (interpretivist) and quantitative (positivist) paradigms within the one research study resulting in enhanced findings (Simons & Lathlean, 2010, p. 331) that may influence healthcare knowledge and health outcomes and provide greater understanding of the context and process of care for older people (p. 332) particularly related to their social world.

This thesis records the history of the development of a mixed method (qualitative and quantitative) study; the methodology and methods employed to explore the experiences of older adults participating in a 'group' as a means of peer support and a social network system; and the findings that feature the benefits they received from this participation. Although some research participants had experienced health problems (e.g. Study One participants had experienced mental health problems; Study Two participants a variety of health problems) the research, in general, does not focus on any specific group type (e.g. related to a particular illness or ethnic or religious affiliation). Rather it focused on the experience and meaning of group participation as a means of social support. Thus, the meaning of social support gained through group participation by older adults is conceptually defined and delineated as additional attributes to the groups which adds to social capital for the elderly.

1.2 Statement of the Problem

Little research has been published on the lived experiences and the impact of group participation by "well" older adults (as well as those who may have experienced psychological distress), living in the community. Moreover, group participation has not been strongly identified or argued as being a possible health promotion program for older adults. As well, little research has

been carried out in Australia, as noted by Howat, Duncan, & Horner (2004), to identify priorities for health promotion programs in relation to older adults (p. 50). Furthermore, research on the conceptuality of social support (Finfgeld-Connett, 2005; Williams, Barclay and Schmied, 2004) and social capital (Carlson & Chamberlain, 2003; McKenzie, Whitely & Weich, 2002) and the elderly is required and may have implications for policy development and the allocation of resources.

An in-depth study of the meaning, and of the experiences, of older adults participating in groups as a means of peer and support and social interaction is therefore warranted in order to provide a greater understanding of this phenomenon and to uncover evidence to demonstrate the benefits of social group membership as a potential ‘health promotion and illness prevention’ activity. This study explores and examines the impacts of belonging to a group as a means of generating social and peer support among older adults.

1.3 Study Aim

Primary aim of the research was to:

- explore and interpret;
- increase understanding of; and
- reveal the personal and social experiences;

arising from opportunities for well older people to engage in peer support groups and social network systems. While some participants may have had health issues their physical and mental health was not the focus of this study.

The secondary aim of the research was to:

- develop a rich and full description, and
- quantify the depth and extent, of those experiences.

1.4 Objectives

The specific research objectives were to:

1. Describe the lived experience of older adults participating in a group as a means of peer support;
2. Develop new knowledge and understanding of people and group participation in relation to older adults by nurses and other health professionals;
3. Assist conceptualising the meaning of social support for older people; and
4. Identify the resources necessary to establish and maintain more effective groups and social support mechanisms for older adults.

These objectives are consistent with measures of health outcomes for older adults and the community identified by NSW Health as being related to

- “physical and psychological well-being;
- social support or level of support, social contact, participation in community activities or ability to carry out normal activities;
- general perception of health status;
- quality of life;
- lifestyle changes such as diet or exercise, and
- general life satisfaction”

(NSW Department of Health, 1995, p. 14).

A number of authors (Finfgeld-Connett, 2005; Williams, et al., 2004; Carlson & Chamberlain, 2003; McKenzie, et al., 2002) have specified the need for further explanation of the meaning of social support.

This research explores the benefits of group participation in terms of the personal, intrapersonal and social benefits and possible health benefits for older adults living in the community across NSW to identify implications and recommendations for health recovery, nursing and the social needs of older people.

1.5 The Research Question

In this research, the question: "What is the lived experience of older adults participating in peer support groups?" is asked on the basis of its relevance to the research process and the methodological assumptions that underpin it. In this way, the data collected and the findings will be useful as suggested by Fleming, Gaidys & Robb (2003).

The title of the study, "the lived experience of older adults participating in a social support network group", reflects the research question which aims to explore *how* a human *is* rather than *what* a human *is*. Essentially the study characterises human Beings (Sic) as a modality rather than a thing (Heidegger, 1962, pp. 25-28). "... the emphasis is not on what a human is in terms of substance or particles or mere mental acts, but on the *way* that a human gets around in life, the "essence" of being human is to be found in human *existence*" (Streeter, 1997, p. 415; Gadamer, 1994, p. 47). This is where "people are inextricably immersed in their worlds" which was referred to by Heidegger as *Dasein* or being-in-the-world (Grbich, 2007, p. 90; Gadamer, 1994, p. 33).

The four aspects of the lived experience that are of interest in phenomenological research are identified by Heidegger (1962) as 'temporality' or *lived time*; 'lived space', or *spatiality*; 'lived body', or *corporeality*; and 'lived human relation', or *relationality* (Polit & Beck, 2008, p. 227; Grbich, 2007, p. 90). This research therefore draws upon the insights of previous researchers to explore the lived experience of older adults engaging in peer support groups.

This research question addressed a need for greater understanding by others of older adult's social world and their social support activities. Granerud & Severinsson (2007, p. 348) and Finfgeld-Connett (2005, p. 8) suggested the quality of life of individuals would be significantly improved if nurses and other care providers were to expand their knowledge about social networks and functions, so that psychosocial care alternatives could be offered. As Neno, Aveyard & Heath (2007) and Howat, Duncan & Horner (2004) suggested, nurses and others who have this understanding might also influence future

government directions for planning options related to the socialisation and support needs of an ageing population.

1.6 Research Design: Structure of the Study

In this study the lived experiences of older adults participating in a group as a means of social support are explored. Both qualitative and quantitative paradigms are used to investigate this phenomenon. Structurally, the research consists of the first study (Study One), which uses qualitative methods for data collection and analysis, and a second study (Study Two) which generates research findings ‘by using a ‘mixed methods’ approach in which both qualitative and quantitative data collection methods were employed to examine the experiences and benefits of group membership. This approach is recommended by Simons & Lathlean (2010) as enabling the researcher to “combine methods that cross two primary research approaches or paradigms in the same study” (p. 331). By using a mixed method approach the study is given greater breadth and depth by enabling many participants to represent their experiences as fully as possible through both numerical and language-based means, as suggested by Taylor (2006a, p. 422). It also responds to the advice of Holloway & Wheeler (2002) relating to the importance of not neglecting the participants’ perspectives within the context of their lives.

1.6.1 Study One

Study One provided an opportunity to test the qualitative research approach which used hermeneutic interpretive phenomenological methodology underpinned by the existential philosophy of Martin Heidegger (1889-1976) (Heideggerian hermeneutics) within a small group. Existential philosophy describes the way one views the world, stressing the personal ‘here and now’ experience (Grbich, 2007, p. 90; Stephenson & Corben, 1997, p. 117) of *Dasein* or ‘being- in-the-world’ (Grbich, 2007, p. 90). Narratives were acquired through conversations (interviews), and interpretation of conversation texts to reveal meaning and a greater understanding of the phenomena (experiences of older adults attending a support group), thereby adding to nurses’

knowledge of the many ways older adults benefit from participating in peer groups.

While the research methodology is based on Heideggerian philosophy, the method also reflects the ideas of Hans-Georg Gadamer (1900-2002), a hermeneutic phenomenological philosopher who uses language and a systematic approach in text analysis in order to reach understanding (Fleming et al., 2003). This process is explained in greater detail in Chapter 3, Theory and Method, Section 3.2 'Theoretical Foundation of the Study'.

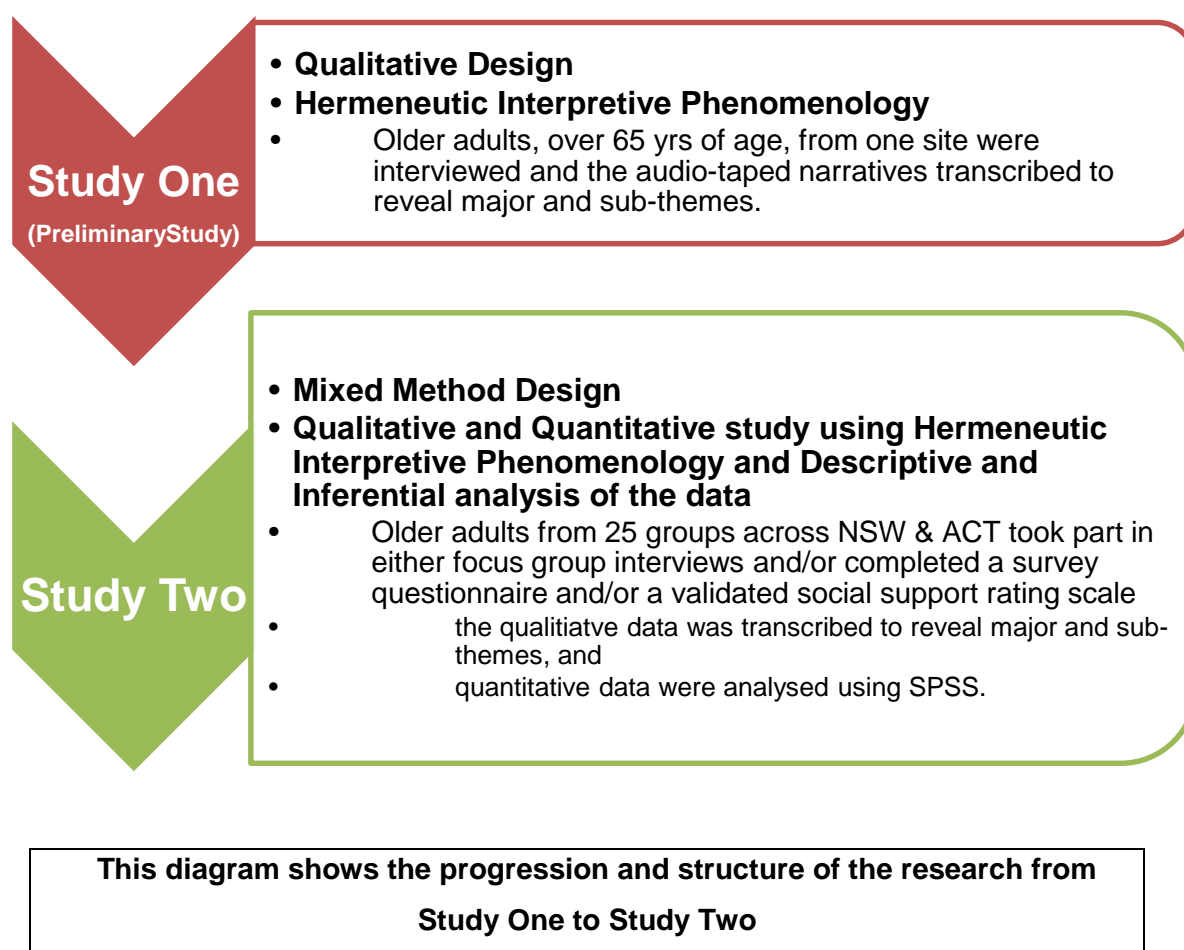
The purpose of phenomenology is to search for understanding rather than theory construction. Further advantages in using a phenomenological research design are that it rejects Cartesian duality (mind-body split or subjective-objective dualism) (Holloway & Wheeler, 2002, p. 172), it has both descriptive and interpretive elements (Van der Zalm & Bergum, 2000, p. 212) and describes the structure of *everydayness* (Heidegger, 1962, p. 38), or being-in-the-world (or embodiment) (Polit & Beck, 2008), which Heidegger found to be an interconnected system of history, culture, personal and social roles and experiences (Polit & Beck, 2008, p. 227; Burns & Grove 2005, p. 56). Furthermore, a key methodological element in this design is 'pre-understanding' or the disclosure of prior knowledge of the phenomena of interest. Drawing upon anecdotal evidence of the benefits that group participation may have, the researcher realised the desirability of establishing research evidence in relation to older adults' and group experiences. Therefore, bracketing or phenomenological reduction was not used in this instance as it is inconsistent with Heideggerian and Gadamerian hermeneutics (Grbich, 2007, p. 91; Polit & Beck, 2006, p. 221; Burns & Grove 2005, p. 56) (For an in-depth explanation of this methodology see Chapter 3, Section 3.5). Instead, pre-understandings were identified by the researcher. Fleming et al. (2003) reflecting on the work of Gadamer (1990-2002) considered that it is only through identifying pre-understanding that understanding is possible highlighting Gadamer's belief that if one does not recognise one's pre-understanding, there is a risk that one will fail to understand or will misjudge meaning (Fleming et al., 2003, p. 115).

1.6.2 Study Two

Study Two consisted of a mixed method approach which combined qualitative principles of hermeneutic phenomenology as the primary data source and a quantitative design using descriptive and inferential statistical analysis. In this way more information was gained about the features of group membership and the characteristics of older adults attending social support groups (Burns & Grove, 2005). By using this mixed method design the research was expanded to enhance diversity, enrich understanding and accomplish research goals (Elliot, 2003a, p. 31) and by combining it with descriptive studies, it was possible to “observe, describe, and document aspects of a situation” as suggested by Polit & Beck (2006, p. 189). The quantitative design complements the qualitative design of this research study because, similar to interpretive phenomenology, descriptive research is used when little is known about the phenomenon of interest (Kermode & Roberts, 2006a, p. 173; Burns & Grove, 2005, p. 26; Howat et al., 2004). Also, by collecting data using a combination of psychosocial instruments, interviews, and observations “the two approaches provide an accurate representation of reality” as suggested by Fain (2009, p. 7).

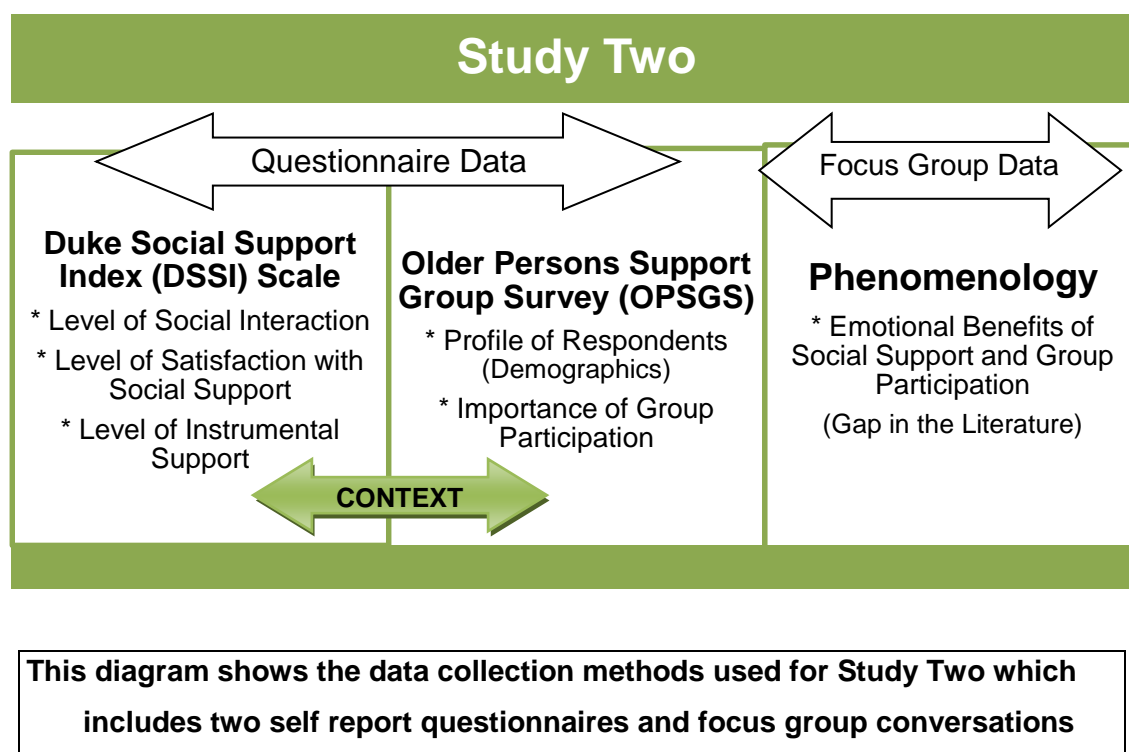
No attempt was made to establish causality therefore, “no manipulation of variables was involved” (Burns & Grove, 2005, p. 232). Rather, and in keeping with the principles of this descriptive method, data collection was undertaken using questionnaires inviting subjects to share their knowledge, attitudes and beliefs about group participation as suggested by Elliot & Hayes (2003, p. 284). This process is explained in detail in Chapter 5, Theory and Method for Study Two, Section 5.12.1 Descriptive Design. The structure of the research indicating the design employed in Study One and Study Two is depicted below in Figure 1.1.

Figure 1.1: Diagram Indicating the Structure of the Research



The two data collection methods used for Study Two is depicted in Figure 1.2.below which includes focus group interviews and/or the completion a survey questionnaire and/or a validated social support rating scale. The results were blended to provide a cohesive contextualised picture of the participants' experience of group membership.

Figure 1.2: Diagram Indicating Data Collection Sources for Study Two



1.7 Justification for the Research

At the time of the study, there was a lack of research available about the experiences of older adults participating in established groups. This gap in both published research and a perceived deficiency in understanding by nurses and others, prompted this research.

1.7.1 Policy Documents Supporting the Research Project

The decision to undertake the research was made in 2003 when the author was asked to formally evaluate an existing support group for older people. The group had been established by the author who at the time was employed as the Clinical Nurse Consultant for Aged Care Psychiatry. The group was established as a 'health promoting/illness prevention' project for older adults offering ongoing support to some who had experienced, or were at risk of, developing mental health problems. Additionally, the establishment of the group supported the directives of significant public health policies and strategic

documents (both from the Commonwealth and NSW Health) that became operational shortly after the establishment of the group. These were:

- The “Second National Mental Health Plan” (1998), with the primary focus on health promotion and illness prevention suggesting that strategies be developed aimed at building resilience and enhancing coping mechanisms for dealing with stresses across the life-span (Commonwealth of Australia, 1998, p. 12),
- “Caring for Older People’s Mental Health: A Strategy for the Delivery of Mental Health Care for Older People in New South Wales” (NSW Health, 1999) suggesting that with the change in demographic characteristics of the older population mental health services will need to adapt in order to provide effective care (p. 2) and an improvement in quality of life (p.3), and
- The “Mental Health Promotion and Prevention National Action Plan: 1998 – 2003” with the primary focus on health promotion and illness prevention by enhancing mental health and social functioning among populations and individuals (Commonwealth of Australia, 1999, p. 7).

The essence of this document is encapsulated in the following quotes:

“...although biological factors and, in many instances, genetic influences, may contribute to the prevention of mental health problems and disorder, evidence-based opportunities for prevention currently lie primarily in the field of psychosocial interventions” ... (Commonwealth of Australia, 1999, p. 7).

Also, within this document a specific section was devoted to the care and support of ‘Older People’ stating that:

... “Older people who are bereaved may be at higher risk in certain circumstances, as may be those who are isolated and lack social networks and support”... (p. 22).

Research questions suggested within the document were:

“What are the most effective preventative approaches and networks?”
and,
“What are the most effective interventions to prevent depression and decline in this age group?” (p. 23).

Therefore, national strategies in the MHPP National Action Plan indicated the need for research, and partnerships, that will:

Collect and analyse data, and identify needs, initiatives, partnerships and potential good practice relevant to mental health (and general health) promotion and prevention for this age group. Consider older people's focus groups and undertake qualitative research (Commonwealth of Australia, 1999, p. 23).

These directives offered justification for the establishment of a group for older adults and for undertaking Study One. Further support for this belief came from Stewart (2004) who stated that “the potential impact of resource variable, such as social support and intrapsychic factors (e.g. self-esteem, sense of control), which may mediate the stress-illness relationship, also needs consideration. Stewart (2004) also suggested “that if resources are lacking, a negative outcome (e.g. physical or mental illness), is more likely” (p. 279).

1.7.2 The Need for Clarification of Social Support/Social Capital

Williams et al. (2004) declared although there has been much published on the concept of “social support” various definitions have subsequently developed with none widely accepted (p. 942). The reason they claimed, is that it has been difficult to operationalise existing definitions because of the lack of exemplars grounded in experiences or specific context (p. 947) where people are asked “what social support means to them” and “what is socially supportive in what circumstance” and “at different times in life” (p. 957). These authors argued social support must be defined in a “contextually specific way for it to be relevant”, and that this can only be achieved by means of qualitative research (p. 944). Finfgeld-Connett (2005) held this belief and suggested, the concept of social support lacks clarity, and there is little empirical evidence about the phenomenon (p. 4). Furthermore, McKenzie et al. (2002) reported a lack of research and theoretical development related to social capital and mental health (p. 281). As well, Carlson and Chamberlain (2003) stated “the concept of social capital remains conceptually and operationally

underdeveloped and rigorous development is urgently needed" (p. 330). Carlson and Chamberlain (2003) proposed further work is required in defining and delineating the concept of "social capital", and Helliwell & Putnam (2004) advised further research is justified "to explore possible mechanisms linking social capital and subjective well-being" and "to look for contextual and interaction effects..." (p. 1445). Furthermore, Gray (2008) declared, "Further qualitative research is clearly needed to clarify the processes by which social contacts and social support are generated" and "we need to find out more about how older people develop and sustain relationships ..." (p. 29).

1.7.3 The Need for Research on the Effectiveness of Groups and Social Support for Older Adults

A review of the literature was completed on the effect and experiences of participation by older adults in groups as a means of social support. A more in-depth review of the literature can be found in Chapter Two. Over recent decades researchers have shown a particular interest in the phenomenon of social support and social capital and the impact it may have on individual's health and well-being (Reblin & Uchino, 2008, p. 201; Helliwell & Putnam, 2004, p. 1435; Berkman et al., 2000, p. 843) participation, social support and social capital. Current research, claim Reblin & Uchino (2008), has "focused on expanding several areas of knowledge in this field" particularly in relation to chronic disease and quality of life (p. 201). While there exists a wealth of research exploring the social perspective of health, older people have not been the focus of much of this research.

Limited published evidence was found on studies specifically evaluating and describing the benefits of social support for older adults through "expressive" means, or group association with older peers. As noted by Barr and Russell (2007), the National Strategy for an Ageing Australia (2001) acknowledged planning for an older Australia will require "understanding better the way social capital operates and benefits Australian communities" (Commonwealth of Australia, 2001, p. 35). Barr & Russell (2007) highlighted the fact that the strategy "did not discuss what was meant by the use of this

term or in what way it might have relevance to older Australians" (p. 94). This was however, despite the document stating that there is a "need to look at the potential to enrich communities by using the accumulated 'social capital' that is embedded in a larger older population" (Commonwealth of Australia, 2001, p. 32). Barr & Russell (2007) further stated that "little empirical research has been undertaken in Australia to determine the applicability of the construct to individuals or different age cohorts and very little has focused on older people" (p. 94). This information is crucial in order to increase service providers' and clinicians' understanding of the value of social support and social networks for older adults and to better understand any implication for service planning and delivery (Reblin & Uchino, 2008, p. 201) and for health promoting interventions.

A review of the literature is provided in Chapter Two.

1.8 Background to the Study

During 1996, a group of elderly individuals began meeting as a social group at a small hospital in Sydney, NSW. The group (previously mentioned in Section 1.7.1, Policy Documents Supporting the Research Project) was established for the purpose of providing social and psychological support to older adults living independently in the community. Some members of the group were considered 'at risk' of developing mental health problems due to loneliness and isolation and others had experienced significant mental health problems and had received treatment, but at the time of the study were well. These group members did not wish to attend mainstream groups such as Senior Citizens.

An additional benefit for the establishment of the group was that the hospital could offer an extended system for service delivery for older adults who had a previous or continuing, but treated mental health problem, or who were at risk of developing some form of psychological distress. Moreover, the group was established as a result of the 'health promoting hospitals campaign' which was initiated in 1995 by the NSW Department of Health. Further to this, the Centre for Mental Health had released the First National Mental Health Plan in 1992 (Commonwealth of Australia, 1992), which gave clear directives

for the development of health promoting and illness prevention initiatives to support people across the life-span who were living in the community. Thus, this group was established as a health promoting activity. However, it also complemented the ‘Continuum of Care’ concept, as identified in the Australian Council on Healthcare Standards (ACHS) and the ‘Community Living’ concept described in the National Standards for Mental Health Services – National Mental Health Strategy (Commonwealth of Australia, 1996), which stated that, services should provide “consumers with access to a range of treatment and support programs which maximise the consumer’s quality of life” (p. 36). The establishment of the group fulfilled each of these requirements. Since that time the three National Mental Health Plans that followed all identified health promotion as a key initiative and older people were specifically referred to in the 2003 – 2008 plan. Furthermore, in 2006 the NSW Health Department published the first service plan specifically related to mental health service delivery and care directives for older people. In this document the “NSW Service Plan for Specialist Mental Health Service for Older People (SMHSOP) 2005 – 2015”, health promotion and illness prevention, and recovery and rehabilitation programs were identified as key areas of clinical function (NSW Department of Health, 2006).

1.8.1 Evaluation of the Established Group for Older Adults

No evaluation had ever been undertaken of the group since its establishment in 1996. A need for a formal evaluation of the group’s purpose and outcomes therefore existed. Anecdotal evidence indicated that by belonging to the group, members had experienced some benefits. Additionally, members of the group had been informally interviewed by two committees, i.e. the Australian Council of Healthcare Services (ACHS) Accreditation Committee in 2001, and the National Standards for Mental Health Services Accreditation Committee in January 2002. Interviews occurred on two occasions as part of the broad evaluation of services offered to the community by the hospital. On both occasions, there was an overwhelming expression by participating group members of the personal commitment they had made to the group and how much being a member of the group meant to

them. Both accrediting bodies praised the initiative of establishing the group and recommended that a formal evaluation of the group be undertaken. No directives were given at that time regarding who should do the evaluation; the time-frame in which it should occur; nor how it should be carried out.

Hence, an underlying justification for this research was realised. The study was undertaken initially to comply with the recommendations from the two formal assessing committees, but also to provide evidence concerning the benefits of group membership for the hospital. It was anticipated that such evidence would support the need for continuing the group and, more significantly, lead to the establishment of similar groups across other area health services to promote older persons' mental health and physical well-being. Policy directives, the need for evaluation of the existing group and the lack of literature and research, convinced the researcher of the need for this research project.

1.9 Study Participants

Many groups for older adults meet across NSW for a variety of reasons (e.g. Senior Citizen Groups, Frail Aged Day Cares and Dementia Respite/Day Care Services). Criteria set for attendance at such groups restrict many older adults from attending (e.g. the need to be physical disabled or cognitively impaired). Thus, many such groups do not address the needs of “all” older adults living in the community. However, some groups, supported by government and other organisational funding, have been established for the purpose of providing social support and an opportunity for networking among peers as was the case for the group of participants in this study. Criteria for the present research focused on groups that had been established for more than one year.

In the current study older adult participants refers to males and females, the majority aged 65 years and over. Most participants live independently in the community, some with or without a family member or ‘significant other’ residing with them. A small number had experienced mental health problems

but were currently well. Some may have been at risk of developing psychological distress due to a variety of events and many were coping with some level of physical ill health or disability. All of the older adults involved in the study were attending at least one social group meeting each week.

1.9.1 Participants in Study One

Study One was undertaken prior to undertaking Study Two and engaged four females and two males. Data were collected from two focus group conversation sessions with three participants in each group and analysed using thematic analysis.

Consenting participants in Study One, (Section 1.8) were selected from a group established at the hospital, for the purpose of offering support to older adults at risk of experiencing mental health problems and who did not wish to attend mainstream groups for older people.

1.9.2 Participants for Study Two: The Main Study

Study Two participants, included eight members of a group established by the researcher for the purpose of social support (as described in Section 1.8) at a different location but in the same service setting as described for Study One. Additionally, other Study Two participants were drawn from other groups of older adults that met from across New South Wales (NSW) and the Australian Capital Territory (ACT) to offer social engagement (as described in Section 1.9 and 4.5). One hundred and ninety-two (n=192) older adults from these groups participated in the study making a maximum study sample of 200 participants. The research did not seek any background information or prior knowledge of any medical or psychological conditions about group participants before undertaking the study. The criteria for study participation were at least six months group membership and regular attendance. The participants were between 50 and 65 years of age or over, and able to provide informed consent.

Permission to access members of the RSL Day Clubs social groups, which operate across NSW and the ACT, was granted by the State Council of the Returned and Services League (RSL) NSW Branch. Anecdotal evidence existed that group members received benefits from belonging to these groups. The NSW Branch supported the research project to gain a better understanding of the benefits that the groups offered for their members. Data collected and analysed from these voluntary participants formed the research outcomes for Study Two and supported the findings from Study One. Findings from both studies were utilised as a basis for the recommendations of the overall research.

1.10 Overview of the Thesis Chapters

The thesis provides an overview of literature reviewed to formulate a philosophical and theoretical framework for the study. Following that, a description is given of the qualitative and quantitative methods engaged to achieve the study objectives for both Study One and Study Two, and the philosophical underpinnings which guided the qualitative methodology. The final chapters present a discussion of the study findings and conclude with reflection on the overall research. Recommendations for socialisation and best practice models of care (for nurses and other health care professionals) are provided along with suggestions for health promotion and illness prevention, and rehabilitation and recovery program options for older adults living in the community.

1.10.1 Organisation of the Thesis

Study One comprising a qualitative design with a small number of participants (n=6) is presented as an entry point to the research and context. The philosophical underpinnings that provided direction for the overall research project is described in detail in this section and further developed later in the thesis.

The main study, Study Two, builds on Study One with the addition of a quantitative paradigm designed to complement the study's major qualitative paradigm creating a mixed method approach. Study Two engaged a larger number of participants (n=200).

Thus, the Thesis is constructed as follows:

Chapter 1 consists of the introduction and background to the research. The research topic and background information that provided a rationale for the study are described along with research study designs. The problem statement is identified along with the research aims and objectives, and a description of study participants.

Chapter 2 provides an analysis of literature relevant to the study. The literature related to the topic of study, “social support networks for older people” is critiqued, to establish what is currently known about the topic and to present an overview of the literature on social theory describing and defining a number of associated concepts such as the ‘social support’, ‘social networks’, ‘social systems’. Additionally, the literature relevant to research methodologies and methods used to support the research strategy and to assist in the development of a philosophical and theoretical framework for the study was reviewed.

Chapter 3 explains the philosophical underpinnings used to define the study and the qualitative methodology and methods used to undertake both Study One and Study Two.

Chapter 4 presents the findings of the qualitative analysis from Study One. An in-depth description of thematic analysis is offered along with exemplars extracted from participants' conversations to support the themes created from the hermeneutic text.

Chapter 5 provides an overview of the qualitative and quantitative methods used in Study Two. It describes the qualitative and quantitative approaches that were blended in a mixed method approach. Key components

of the research process are presented and include ethics approval, a description of the study participants. Participant recruitment processes, and the consent protocol including information for participants. Data collection methods for both the qualitative and quantitative components of the study are described in detail along with the development of ‘cluster variables’ developed from the two questionnaires used in Study Two. The descriptive analysis of ‘cluster variables’ is given and the results of inferential analysis of the data from the two survey questionnaires used in the research is provided.

Chapter 6 describes in detail the methods by which themes were developed and presents findings from thematic analysis of narratives and field observations collected during the second study using exemplars from participant statements.

Chapter 7 presents a discussion of the overall study findings reflecting on the philosophical underpinnings used to develop the study and the results of descriptive and inferential analyses for Study Two. Also in this chapter a greater understanding and meaning of the construct of ‘social support’ is offered in the context of group participation by older adults and reflecting on the literature. The chapter also addresses the limitations, strengths and weakness of the research and suggests conclusions that can be drawn from the research study results and findings.

Chapter 8 provides conclusions and research reflections on the study process and findings. Recommendations for future research arising from the research are offered along with implications of this research for nursing practice generated are proposed.

CHAPTER 2

LITERATURE REVIEW

This Chapter describes and critiques the literature related to the topic “social support network groups for older people” to discover what is currently known about the topic. The chapter also presents an examination of the influences that shape people’s world from a sociological perspective, the many factors that impact on older adults’ socialisation opportunities and their relationship to the research study describing and defining a number of associated concepts.

2.1 Introduction

Human beings need to exist within a social context (Porter, 2000, p. 143; Benner and Wrubel, 1989, p. 324), within a network of relationships (Putnam 2000; Capra, 1989, p. 15), as part of a unified whole (Capra, 1989, p. 18) and an inseparable part of the world (Grbich, 2007, p. 91). “Men and women need other people”, wrote Baker & Buchanan-Baker (2007), “and that the virtue of independence, which we have trumpeted so much in health and social care, is an illusion” (p.120).

The older person is not exempt from the desire and need to be a part of a social world. However, psychopathology may disrupt lifelong competence across several domains of a person’s life and “ill health may adversely affect a person’s standing as a citizen through limiting the capacity for social participation” (Hazelton & Clinton, 2001, p. 220). Diminished levels of social support have been found to predict poorer health outcomes among the elderly population (Edelbrock, Buys, Waite, Grayson, Broe & Creasey, 2001, p. 177). The impact of this may be in accessing and managing the resources necessary for social well-being providing a sense of community belonging for older adults. Therefore, groups or social participation may be important ‘forums’ where all sociological concepts converge: social support, social networking which potentially provides social capital through a truly cohesive social system

formed from enduring patterns of social ties leading to mutual benefits (Putman, 2000).

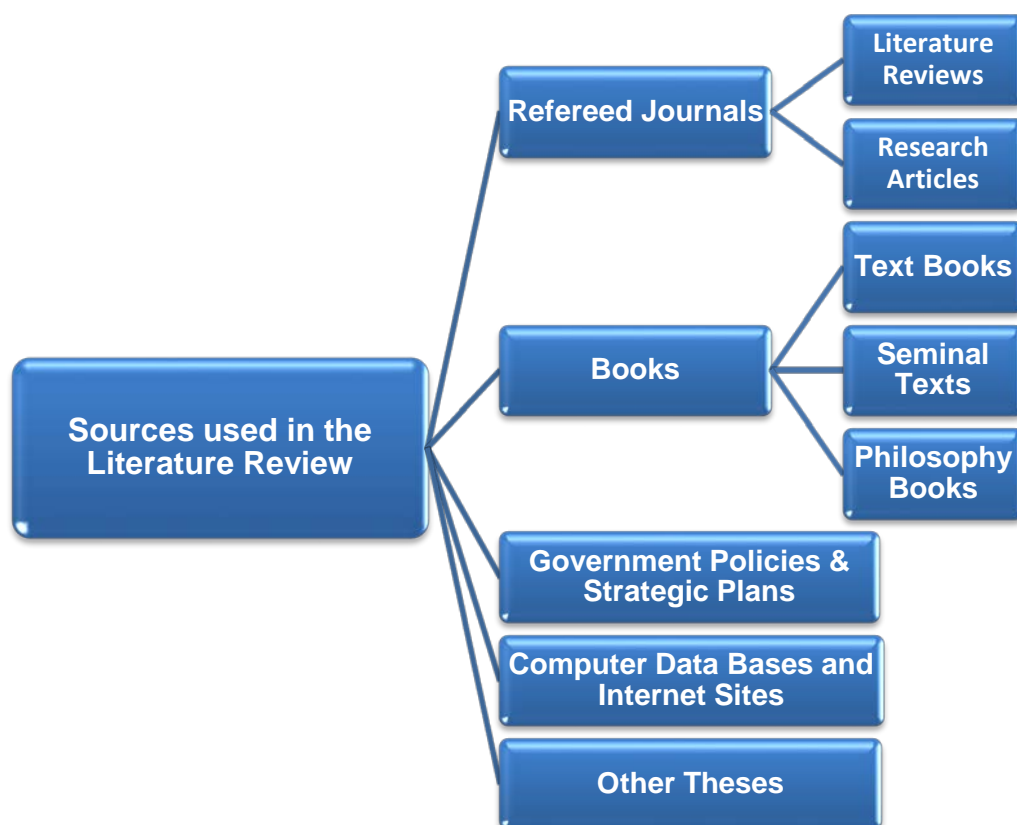
The research problem (presented in Chapter 1, Sections 1.2, and 1.5) was formulated from a number of the researcher’s pre-understandings (prior knowledge and beliefs) about the topic under study and from a relatively unstructured review of the literature. However, a more structured literature search and review to give direction to the study and the formulation of the research question as proposed by Burns & Groves (2005) and Porter and Carter (2000) was undertaken. Selected literature was reviewed for the purpose of identifying previous studies on the topic of the meaning and experiences of group participation (Fain, 2009, p. 53) by older adults and to gain a greater understanding of the social perspective for the study. An exploration of the social perspective was useful as it considers social patterns and behaviours of individuals and offers insight into how people are influenced by the world around them.

Additionally, the literature pertaining to research methodologies and methods as recommended by Burns & Groves (2005) and Holloway & Wheeler (2002) assisted in the development of a philosophical and theoretical framework for undertaking both the research.

2.2 Literature Search

The literature was reviewed at various stages during the research process. An overview of the literature took place prior to the research commencing and continued during the research study. The review consisted of seminal texts, classical studies on the subject (or landmark studies) of social theory, and included more recent writings and publications. Figure 2.1 lists the sources utilised.

Figure 2.1. Sources Used to Formulate the Literature Review.



This diagram shows the collective resource types accessed as part of the literature review

The literature search assisted in defining the topic under study and to provide ideas for the theoretical and methodological framework for the studies, as suggested by authors such as Taylor & Roberts (2006a, p. 73) and Elliot (2003b, p. 75), as well as only literature that was useful and identified as relating to the study topic was incorporated into the review.

2.2.1 Databases

Study One took place between 2003 and 2004. The databases used in the electronic literature search for Study One were Psychology Information (PsycINFO): 1887 to August 2002, 1967 to March 2002, 1974 to February 2003, 1984 to March 2002. Cumulative Index to Nursing and Allied Health

(CINAHL): 1980 to 2004, 1982 to February 2002, and Medline: 1966 to August 2002.

Study Two took place between 2007 and 2008. The databases searched for this main research was primarily CINAHL (2000 – 2009), PsychINFO (2000 – 2009), as well as a number of web-sites (using Google as the search engine) for definitions and statistical data related to the older population and associated demographics in NSW and Australia.

2.2.2 Key Words Used in the Literature Search

For Study One the literature search was undertaken using subject titles and consisted of both theoretical (conceptual analysis, theories) and empirical (other studies reported in journals and books) literature as recommended by Fain (2009, p. 56) and Burns & Groves (2005, p. 94). Key words used in the literature search were groups, social support and older adults, social networks, support systems, mental illness and the elderly, and loneliness. The term mental illness was included in the search as participants in Study One had experienced mental ill-health of varying severity.

For review of the literature on qualitative research methodologies the primary words used in the search were phenomenology, hermeneutic research, hermeneutic phenomenology, Heideggerian phenomenology and interpretive phenomenology.

For Study Two, search terms included various forms of the word “support” in combination with the words ‘lived experiences’ and ‘social support for older adults’, ‘peer support groups for older people’, ‘network systems’ and ‘social capital’. While there are literally hundreds of articles with the word ‘social’ and ‘social support’, very few articles could be identified with an extended using “the lived experience of older people in social support group networks”.

For quantitative research methods employed in the second study the key words used in the review of the literature were ‘descriptive analysis, and

‘factor analysis’. Additionally, research methods were explored in particular ‘research’ and ‘mixed method’ designs.

2.3 The Literature Review

The literature review provided a description of the philosophy, theory and social concepts related to the topic and highlighted the importance of the study. The literature assisted in defining the research process and design, and the theoretical framework as proposed by Taylor & Roberts (2006a, pp. 73-74) as well as providing a greater understanding of the sociological and philosophical perspectives required for the study. Moreover, the focus of this thesis and by this review the rationale for the research study was reinforced.

2.4 Structure of the Review

The literature review is presented in two sections. Section one describes the sociological perspective that supports the research, and section two provides an overview of articles related to the research study beginning in Section 2.5 below.

Section one includes:

1. A review of the social concepts related to the study which provides an overview of the meaning of social support, social networks and social systems,
2. The potential consequences for older adults not having a support network, and
3. The advantages for older adults having or being part of a social support network and in particular a social support group.

Within this structure, key concepts are defined providing a theoretical and conceptual framework for the research.

Section two reviews selected articles for Study One and Study Two under the following headings:

- Content - noting author, date and location of the studies
- Study participants

- Study aim
- Research design
- Results or study findings, and where appropriate
- Implications for further research.

The results and or findings of these papers are presented in tables using the above headings and classified into three categories:

1. Category one: Studies related to the characteristics and types of social support and the relationship to mental and physical well-being;
2. Category two: Studies examining the utility of the Duke Social Support Index scale for research; and
3. Category three: Articles related to the need for health professionals to understanding the importance of social support and social networks in health outcomes and quality of life.

2.5 Defining Key Sociological Terms

When writing about such terms as social support, social networks and network systems many investigators use these terms interchangeably as reported by Berkman, Glass, Brissette & Seeman (2000, p. 844) and a number of definitions are also used as indicated by Talbot & Verrinder (2005) and Williams et al. (2004). This may have eventuated because authors from different disciplines have applied a variety of meanings and usages to these common terms over time. Using them interchangeably could be challenged on the basis that these concepts have specific elements that define their meaning. On the other hand, it should be noted that these concepts in some cases have certain ideas and common elements or themes with shared meanings or areas of convergence (Talbot & Verrinder, 2005). For example, being part of a social network may alternatively provide social support and a social support system, or social support may be a result or an outcome of being part of a social network. Talbot & Verrinder (2005) claimed that these terms suggest two outcomes of the shared norm, one related to “process” or activity (the collective action) and the other to the longer-term “impact” of ‘mutual benefit’ (p. 61). Moreover, Kawachi & Berkman, (2001) have linked social support and social networks to social capital and Helliwell & Putnam (2004) appear to use social

capital and social networks interchangeably. Putnam (2000) wrote "social movements and social capital are so closely connected that it is sometimes hard to see which is chicken and which egg" (p. 152).

Social networks, Putnam (2000) claimed, are "the quintessential resource of movement organisers" (p. 152). However, an important feature of social capital reported by McKenzie, Whitley & Weich (2002) "is that it is the property of groups rather than individuals" with the distinguishing aspect from social support and social networks being the ecological nature of social capital (p. 280). Nonetheless, a common feature of social capital is the execution of social norms and the effect this has on communities' social relations and networks (Talbot & Verrinder, 2005, p. 62). Furthermore, Putnam (2000) and Bourdieu (1993) perceived these phenomena as resources that could be accumulated.

Despite a substantial body of work on the subject of social support, Williams et al. (2004) claimed that a definitive definition has not been accepted and that, as noted above, a consensus on its meaning is lacking. These authors also argue that a contextualised approach is required (p. 942). Furthermore, Finfgeld-Connett (2005) stated that attributes of social support, as opposed to support types, should be used as empirical referents (p. 8) and that "alternative research priorities should include examining ways to bolster existing networks or investigating ways to promote the development of new ones" (p. 7). This then provided the opportunity for these issues to be explored and some evidence found about the importance of groups as the source of social support and the experience of those participants.

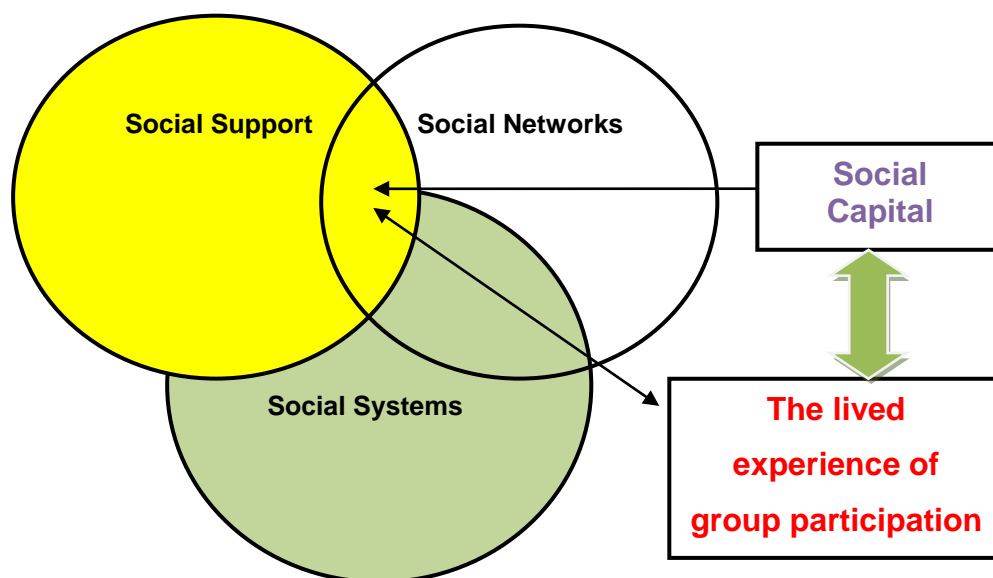
A brief overview of what is understood by these sociological terms is provided in Table 2.1.

Table 2.1. Definitions of Common Sociological Terms

Common Term	Definition
Social support	Refers to the interaction of events and processes (Sarason & Duck, 2001, p. 2).
Social networks	Webs of relationships that link the individual to other people and indirectly to even more people (Robertson, 1987, p. 662).
Social systems	In the social system all elements tend to fit together helping to maintain stability (Robertson, 1987, p. 18).
Group	<p>A collection of people interacting together in an orderly way on the basis of shared expectations about each other's behaviour (Giddens, 2001, p. 699; Robertson, 1987, p. 92). These may be referred to as agents of socialisation (Giddens, 2001, p. 28).</p> <p>Groups may be 'primary' (members interacting in an intimate way over a long period of time) or 'secondary' (members that interact in an impersonal way and less frequently) (Giddens, 2001, p. 28; Robertson, 1987, p. 168).</p>
Social capital	The dense network of reciprocal social relations or civic engagement in which individuals participate (Putnam, 2000, p. 19).

For the purpose of this current research, the focus is on the shared ideas of social support, social networks and social systems derived from the interaction of group participation as shown in Figure 2.2. A more in-depth description of these concepts is provided in Section .2.6.

Figure 2.2. Concept Analysis of Sociological Terms



This diagram depicts the shared ideas of social support, social networks and social systems derived from the interaction of group participation

2.6 Section One: A Review of Social Concepts Relevant to the Study

The following sections provide a review of several sociological concepts that underpin the current study highlighting some key issues that highlight older peoples' need and desire to be engaged with their peers, and some of the reasons why this may not occur. This section emerges from a review of the literature related to society and sociology, because sociology is the “scientific study of human society and social behaviour” (Robertson, 1987, p. 5), of groups and societies (Giddens, 2001) and of the definitions of social support and related concepts. The section does not seek to provide an historical account of the development of sociology as a discipline, nor all of the definitions that conceptualise social support. Nonetheless, it draws on prominent theorists in this area and refers to several influential and seminal texts in order to provide a deeper understanding of the concepts.

2.6.1 Social Support: What is it?

To be social means to be “concerned with the mutual relations of human beings and needing companionship” (Australian Concise Oxford Dictionary, 2009, p. 1366) and support is defined as to, “keep from falling or sinking, hold in position, bear the weight of; to give strength to, enable to last or continue; give strength to; encourage” (Australian Concise Oxford Dictionary, 2009, p. 1450). By combining these two concepts the researcher believes that Letvak (2002) has expanded the meaning of social support for Letvak (2002) considers social support to be a multidimensional construct (p. 251) as does Tomaka et al. (2006, p. 361). Additionally, Letvak (2002) suggest that the consensus by other researchers is that “social support refers to social interactions that are perceived by the recipient to facilitate coping and assist in responding to stress” (p. 251). Moreover, Koenig, Westlund, George, Hughes, Blazer & Hybels (1993) advocated that social support may play a part in buffering against the ill effects of stress on mental and physical health (p. 61).

According to Antonucci (2001) “social support” refers to the actual exchange of support or an interpersonal transaction (p. 428). Furthermore, Sarason & Duck, (2001, p. 2) suggested that, social support refers to the interaction of events and processes with psychological, behavioural, communicative and emotional components. Moreover, social support, as described by Beckley (2006), is “the perceived availability, or actual provision, of relationships, information, or assistance” (p. 129). Social support is therefore present, as stated by Baum (2008) “if a network of people are able, emotionally and materially, to support one another” (p. 285), and importantly highlighted that it is the quality not the quantity of the social support that is important to well-being (p. 286). Mills (1998) had also noted the importance of quality suggesting that it should be considered as well a quantity (p. 56).

A selection of authors opinion of what social support is may best be summarised by Cobb (1976) when he stated that social support is conceived to be information belonging to one or more of three classes: information leading to the subject believing that he is cared for and loved, esteemed and valued

and that he belongs to a network of communication and mutual obligation (p. 300). The generalised benefits of social support, as suggested by Cohen & Willis (1985), occur because social networks provide persons with regular positive experiences (p. 311) and Putnam (2000) would suggest that this is a form of social capital (p.19).

2.6.2 Types of Support

While it is acknowledged that not all forms of social support are beneficial nor supportive (Berkman et al., 2000) most social ties do provide some level and type of support. These may be multidimensional (Letvak, 2002) and include emotional, instrumental, appraisal and informational support (Cohen & Wills, 1985).

Social support may be classified as expressive and instrumental (Finfgeld-Connett, 2005, p. 5). Antonucci (2001) and Craven and Wellman (1973, p. 14), suggested that support may be tangible or intangible, intangible being in the form of encouragement, personal warmth, love, or emotional support, and instrumental or tangible support referring to direct care such as bathing or dressing (Antonucci, 2001, p. 429). Most research appears to focus on support systems that are 'instrumental' in nature (i.e. they refer to hands on care of clients) with little acknowledgement given to support systems that refer to 'expressive' or emotional support independent of any other form of support, particularly for the older adult.

Guiaux, Van Tilburg, & Van Groenou (2007) reported 'expressive support' as "talking about feelings and comforting each other" (p. 458) and Antonucci, (2001, p. 429) referred to this as "affect" support or emotional support such as love, affection and caring. Tomaka et al. (2006) described 'emotional support' suggesting that it is about "a feeling of group belonging or the feeling that one is cared for by some significant other or others" (p. 361). Kawachi & Berkman (2001, p. 458) and Kelly (1999, p 79) acknowledged the benefits of expressive support or interaction with others. Authors such as Bird & Parslow (2002); Kawachi & Berkman (2001) and Finfgeld-Connett (2005)

have written about instrumental support and suggested that expressive support is an area of study that demands further attention. This need was noted in research conducted by Edelbrock et al. (2001), who were of the opinion that "analysing the characteristics and levels of support is an important research agenda as lower levels of social support have been associated with mortality, poor health and lower levels of well-being" (p. 173).

Instrumental support may be summarised as support that offers help with daily chores, housekeeping, and shopping and cooking (Guiaux et al., 2007, p. 458). This form of support has been referred to as "aid or tangible" support (Antonucci, 2001, p. 429; Tomaka et al., 2006, p. 361). Instrumental support, while not the primary focus of this study, is included through enquiry about some aspects of instrumental support used by study participants and the relationship of this element to the research outcomes.

Appraisal support relates to help in decision-making, providing appropriate feedback or helping to choose what course of action to take (Berkman et al., 2000, p. 848). Likewise, information support is provided in the context of providing advice or information in the service of particular needs or resources (Berkman et al., 2000, p. 848).

A deeper outcome of social support is the way social relationships provide, for many, feelings of intimacy and attachment. Because primary attachment provides a sense of security and self-esteem, reported Berkman et al., (2000) individuals will form lasting and loving relationships (p. 845). When relationships are strong and genuine at the community level individuals also feel stronger bonds to the organisation (Thorlindsson, 2010, p. 22; Berkman et al., 2000, p. 848).

Meanings related to the understanding of social support and support types abound within the literature. In this research, social support is taken to mean expressive support or 'emotional sustenance' (intangible) from being in contact with others where psychological support is offered and received through mutual respect, companionship and friendship with an unlimited

timeframe. Therefore, it was anticipated that this study will confirm that experiencing social support, particularly by means of 'expressive support' (or as group participation and peer support), enhances older persons' mental, physical and social well-being.

2.6.3 Social Networks: What are they and how do they work?

"An intact social network is an antecedent to effective execution of social support", stated Finfgeld-Connett (2005, p. 6). In an early paper, Tolsdorf (1976) refers to Bott's (1957) definition of a network as "all or some of the social units (individual or group) with whom a particular individual or group is in contact" (p. 408). At a similar period Durkheim (1964) theorised that society was not "a mere sum of individuals" but that people were part of a system that "formed by their associations represents a specific reality which has its own characteristics" (p. 13). Capra (1997) also described communities and networks as "bound into a functional whole by their mutual relationships" (p. 34). This supports the concept that Speck and Attneave (1973) described in which social networks are viewed as the sum total of human relationships that have a lasting significance on individual's lives (p.11). In their somewhat dated, yet significant paper, Speck & Attneave (1973) suggests that social networks are relatively invisible structures, yet very real, in which an individual or group of people are embedded and where the social network may become the unit of treatment (p. 11). This is clearly supported by Tolsdorf (1976) who states that social networks have been identified as a mediating factor in human behaviour in terms of personal crisis and affirmed happiness, among other items (p. 407). Greenblatt, Becerra & Serafetinides (1982) also suggest, "social networks appear to protect and support mental health" (p. 977).

Craven & Wellman (1973) referred to Mitchells (1969) definition of social networks, which are "a specific set of linkages among a defined set of persons, with the property that the characteristics of these linkages as a whole may be used to interpret the social behaviour of the persons involved" (p. 4). Function variables are used to determine those linkages in which one individual serves some function for another individual. This type of support was identified by

Tolsdorf (1976, p. 410), which he defined as "any action or behaviour that functions to assist the focal person in meeting his personal goals or in dealing with the demands of any particular situation". This belief remains particularly for the older adult within a population that is ageing with many individuals needing to refocus on what one's personal goals may be.

Putnam (2000) had also proposed that social networks are the properties of individuals and that the connections between these individuals generate social capital (p. 19). According to Antonucci (2001, p. 431), "as with people of all ages, the social networks of the elderly consist mainly, though not exclusively, of close family and friends". But social networks are important, claimed Litwin (2001), their observed association with well-being outcomes, in general, and with morale, in particular (p. 517). In an early but relevant research study, Craven & Wellman (1973) reminded us that the car and telephone have greatly expanded network options (p. 18). This was also identified by Putnam (2000) who suggested that the telephone appears to reduce loneliness, but that it also reduced face-to-face socialisation (p. 168). However, these are not always suitable alternatives for present day older adults and Craven & Wellman (1973) reinforced the fact that the importance of kinship is in the availability of a set of people who can assist in times of need. This is reinforced by Putnam (2000) who argued that new friends could not be met on the telephone yet equally he proposed that the telephone may reinforce relationships generated from existing networks (p. 168). These networks may be "small groups that meet regularly and provide support or caring for those who participate in them" (Putnam, 2000, p. 149). Thus, social groups (like those in this study) may be the perfect medium for offering expressive support to older adults where, as Putnam (2000) advocated, "community, communion, and communication are intimately as well as etymologically related" (p. 171). As a result, networks of social support become what Capra (1997) described as "the web of life" (p. 35).

Additionally, Berkman et al. (2000) and Thorlindsson (2010) claimed that social network structures and functions influence interpersonal behaviour.

Berkman et al. (2000) claimed that this occurs through four mechanisms which include:

1. provision of social support
2. forces of social influence;
3. levels of social engagement and participation and attachment; and
4. access to material goods and resources (Berkman et al., 2000, p. 846).

This explanation of social networks correlates with Cobb's (1976) account of social support and like Cobb (1976), they explain that these mechanisms are not mutually exclusive and may in fact operate simultaneously and across multiple pathways (Berkman et al., 2000, p. 850). These authors give reasons for this by stating that firstly social networks via social influence or supportive functions influence positive and or negative health-promoting behaviours. Secondly, social networks via any number of pathways influence cognitive and emotional status such as self-esteem, self competence and or poor mood, and thirdly, “networks may have a direct effect on health outcomes by influencing a series of physiological pathways largely related to stress responses” (Berkman et al., 2000, p. 850). It is within these networks that the qualitative aspect of social relations is highlighted rather than the structural aspect of the network (Berkman et al., 2000, p. 846). Thus “social support is among the primary pathways by which social networks may influence physical and mental health status” suggested Berkman et al. (2000, p. 846). This, they proposed, is achieved by promoting social participation and engagement and by providing opportunities for companionship and sociability giving meaning to people lives (Berkman et al., 2000, p. 849). Furthermore, it is important to note Antonucci's (2001) formulation of social relationship via the “convoy model” in which the individual moves through life surrounded by peers that share each other's lived experiences and where support is reciprocated over time.

In more recent years the literature refers to social networks as “social capital” as reported by Helliwell and Putnam (2004, p. 1436). These authors suggest, social networks, or human capital, which comes in many forms, has value for the people in the networks where there is reciprocal trustworthiness and connectedness which is a powerful asset (p. 1437) and “the denser the

social relationships and networks, the more powerful they are" (Thorlindsson, 2011, p. 22). Bourdieu (1993) refers to social capital as 'connections' (p. 32) and something that can be "accumulated, transmitted and reproduced" (p. 33). Without doubt good and positive social connections are among the most robust correlate of subjective well-being, thus it is a powerful asset for both the individual and the community (Helliwell & Putnam (2004, p. 1437) including health care systems for as Talbot and Verrinder (2005) claimed satisfaction [with the network] will generate greater participation and therefore stronger social capital (p. 60).

2.6.4 Social Systems

Social systems are created by relationships among individuals, thus providing an environment for structure and regulation within a society, including organisations and groups. Theoretically, the functionalist perspectives in sociology focus on the various ways society functions and the consequences a given element may have on its members (Robertson, 1987, p. 17-18). Functionalists use 'organic analogy' to compare the functions of society to that of living organisms or the human body (Giddens, 2001, p. 16). The emphasis is on moral consensus and of the shared values of the members of a society (Giddens, 2001, p. 16). However, at the centre of this theory is maintenance of social order and thus this theory does not always accept any disruption to the social order even if it is beneficial (Robertson, 1987, p. 19).

Despite this perspective, 'social systems' have been described by Caplan (1974) as an enduring pattern of social ties that play a major role in maintaining the psychological and physical integrity of the individual. From that perspective he maintained that it is the social network that is the configuration of others: the social ties that are supportive because they meet some of our most basic human needs, providing a sense of belonging, raising self-esteem, self-confidence and self-worth. While a system, as identified by Capra (1997, p. 27), is an integrated whole whose essential properties arise from the relationships between its parts. To some extent this is what Durkheim's (1964)

theory suggested, that is, if we only look at the individual we will not see what is happening in the group (p. 104).

These ideas are not new and have persisted over time. Emile Durkheim, the French sociologist (1858 - 1917), developed themes around social solidarity (Millon, 2004, p. 418; Giddens, 2001; Durkheim, 1964) and argued that societies are held together by the shared values and the values of their members (Berkman et al., 2000; Robertson, 1987, p. 15). Durkheim explored the function, or positive consequence for the social system that a given element had (Robertson, 1987, p. 15) and "the ways and means employed by a social unit to hold its members together and avoid individual alienation" (Millon, 2004, p. 418; Durkheim, 1964), because with disintegration of the social norms and standards Durkheim proposed that an *anomie* had occurred (Millon, 2004, p. 418; Durkheim, 1952) or "a feeling of aimlessness and despair provoked by modern social life" (Giddens, 2001, p. 10). Durkheim's theory fits well within the discussion on social support and group participation, as it is through the solidarity of others that support and social capital can be sought and obtained thus avoiding *anomie*.

Ross (1991) reflected on the work of Giddens who claimed that social systems have structuring properties with social practices reproduced across time and space (p.123). According to Ross (1991) Giddens claimed that social systems vary to their degree of internal unity and integration depending on the structure and Giddens used the term "structuration" to describe the connection between the concept of structure and system (p. 123). Giddens (2001) claimed that societies are always in the process of structuration (p. 5) "whereby the structure properties of a system are drawn upon and reconstituted in the practices that constitute that system" (Ross, 1991, p. 123). Ross (1991) explained that Giddens work explored the way people create themselves through participation in ongoing social practices and that by interacting with others, people drew on the resources that are the structural elements of social systems (p. 123). Giddens theory is controversial, reported Ross (1991, p. 125), yet Branson & Miller (1991) claimed that his theory has much in common with Bourdieu's work in respect to 'structuration' (p. 38-39) and while

controversial, it has some relevance to this research as the study explores experiences of social integration with others and the way people create their own environment from resources available.

2.6.5 Social Support and Health and Well-being

In terms of health and well-being, social support has been found to be health promoting, health restoring and illness preventing (Sarason, Sarason & Gurung, 2001, p. 15). This hypothesis was reinforced by Ziersch, Baum, Gusti Ngurah Darmawan, Kavanagh & Bentley, (2009); Berkman et al. (2000) and Letvak (2002, p. 253) who reported that social support has a direct relationship with health and well-being and Helliwell and Putnam (2004) that health is an important determinant of subjective well-being which these authors stated "is best predicted by the breadth and depth of one's social connections" (p. 1437).

It is also noted, that those engaged in social support and social networks experience less stress and cope better in times of stress, bereavement and loss (Munn-Giddings & McVicar, 2006). Social support can provide people with a sense of security, worthiness and a sense of identity, along with decreased feelings of hopelessness (Letvak, 2002, p. 253). Feeling isolated and alone with a possible loss of identity can be restored to feelings of happiness and well-being as a result of group participation. This factor was identified from anecdotal evidence provided from discussions with group members described at the beginning of this Thesis and provided the impetus for the present research.

2.6.6 The Health of Older Adults

Ageing is a very subjective concept with multiple meanings (Schilling-McCann, 2002, p. 3). Ageing is generally associated with declining health status (Howat et al., 2004, p. 50). But there is evidence that older adults who are permitted to play a role, feel needed and remain active will retain their health longer than those who do not (Granerud & Severinsson, 2007; Howat et al., 2004). Equally, it is noted that contact with others and social relationships serve important functions (Uchino, Cacioppo & Kiecolt-Glaser, 1996), are important determinants of quality of life, and Wenger & Tucker (2002) reported that older people who have strong social networks are reported to be happier

and healthier. However, the increased size of the ageing population universally raises many social and public health concerns (Neno et al., 2007, p. 3; Howat et al., 2004, p. 49) some of which include the capacity for social engagement and for health and community services to provide appropriate and quality support resources.

Older adults have been chronologically divided into age categories. There are now three recognised cohort's referred to in the literature classifying older adults. They are: the young-old (65 -74); the middle-old (75 - 84) and the oldest-old (85 and above) (Schilling-McCann, 2002, p. 3). However, this classification does not necessarily correlate with one's capacity to function or the term 'functional age', referring to "a person's ability to contribute to society and benefit others and himself" (Schilling-McCann, 2002, p. 3) and that all people of the same age do not necessarily function at the same level (Schilling-McCann, 2002).

The chronological age of 65 years has been accepted by many Westernised countries as a definition of an older person. Older adults 65 years and over make up a little over one in eight Australians, about 13.5% of the population (3.01 million people at June 2010, ABS) (www.abs.gov.au/ausstats). Yet the fastest growing cohort are those 80 years and over and a significant problem associated with advancing age is the increase in frailty, the result of which increases morbidity and mortality and adversely affects quality of life (Levers, Estabrooks, & Ross Kerr, 2006, pp. 282-283). Factors contributing to frailty among the elderly were the subject of a study by Levers et al. (2006). They found frailty defined in ten different ways. Their study therefore sought to identify factors contributing to frailty, develop a definition and a conceptual framework for what constitutes frailty in the elderly. The study concluded that "physical factors (such as declining functional independence), ageing (particularly among the older age group) and disease (such as cardiac disease and arthritis) were the three main contributing factors" (Levers et al., 2006, p. 290).

2.6.7 Social Support and the Elderly

The ageing process, chronic illness, place of residence, restricted resources and multiple losses are variables that increase the need for older adults to experience social support (Tomaka et al., 2006. p. 360; Letvak, 2002; Johnson, 1998, p. 29) specifically by their peers, but also from family and friends. Tomaka et al. (2006), stated that “trends in these variables suggest that loneliness and social isolation will only increase as time passes particularly as the baby boomer generation ages” (p. 360). Helliwell & Putnam (2004), had claimed that people who have close friends and confidants are less likely to experience sadness, loneliness and low self-esteem” (p. 1437). Fortunately, findings from a study by Tomaka et al. (2006) into the relations of social isolation, loneliness and social support, concluded “that the data are encouraging of future study of the isolation, loneliness and social processes”, particularly in the fast-growing elderly populations.

Social support may be beneficial to the elderly (Letvak, 2002, p. 253) in a number of ways through different means. Social support acquired from a range of sources that are both instrumental and expressive in content (as described previously) allows older adults to live alone but independently (Letvak, 2002, p. 254). Social support provides the means to cope with but more importantly prevent loneliness and depression (Tomaka et al., 2006; Letvak, 2002, p. 255) among the older population and provides a social network system. This is particularly true in relation to expressive support and engaging with peers at a social level. Thus, social supports “may also moderate the impact of stressful circumstances” (Tomaka et al., 2006, p. 360), as do social bonds (Tomaka et al., 2006).

2.7 Consequences of Not Having a Social Support Network

2.7.1 Breakdown of Social Structure

Capra (1997 & 1983) claimed that the age in which we live is one of uncertainty that lacks social cohesion, political direction, economic stability,

and interrelatedness. This claim is relevant even today for as stated by Putnam (2000) it is "a world irrevocably changed" (p. 403). Capra (1997 & 1983) maintained that such disorder is underpinned by the Cartesian philosophy of a mechanistic world, unconnected to nature, the self and others.

Cartesian Dualism, or mind-body split, views the human body as a machine and has created the view of life in society as a competitive struggle for existence (Stewart, 2004, p. 277; Capra, 1997, p. 26). This view fails to acknowledge the need for people to be interrelated with body, mind, spirit and their environment. While the eminent philosopher Bertrand Russell (1946) argued that even in ancient times social cohesion was in a state of conflict (p. 15), this current period in history has created an intense emotional, and for many, an existential crisis (Capra, 1997, p. 5) of social and personal conflict and unquantifiable despair.

This belief is in keeping with Durkheim's original theory about social change and social breakdown which was related to different types of social solidarity: "mechanical" and "organic" (Durkheim 1964). Durkheim's theory, that society is more than the sum of its parts, suggested that although society operates independently of individuals, there needs to be interrelatedness of both for solidarity and cohesion to exist (Jureidine, Kenny & Poole, 2003, p. 9). This interrelatedness, which has analogies with biological organisms, is known as "organic analogy" (Jureidine, et al., 2003, p. 7; Giddens, 2001; Durkheim, 1964). Thus, social solidarity is fundamental to the social unit (Jureidine, 2003, p. 27) which sits in contrast to the Marxist or conflict view in sociology which identifies with a lack of cohesion in society along with social tension, competition and change (Jureidine, 2003, p. 39; Robertson, 1987, p. 19).

Consequently, social instability and interpersonal conflict combined with physical illness (Lau & Pritchard, 2001, p. 196) has had an effect on the ontology, or how people exist (Taylor, 2006a, p. 320; Porter, 2000; p. 143; Benner and Wrubel, 1989, p. 410; Durkheim, 1952) creating the potential for social isolation and exclusion and personal loneliness. Furthermore, it impacts on the nature and relations of being (Porter, 2000; Fain 2009, p. 202), and thus

the mental health and psychological well-being of people universally. The elderly population is not exempt from this dilemma. Issues associated with the ageing process such as physical disability and chronic pain exacerbate this, and might result in curtailed autonomy (Hazelton & Clinton, 2001, p. 220) reducing their capacity to have freedom of movement and participate fully in the social world (Giddens, 2001, p. 165).

2.7.2 Loneliness

Social isolation, loneliness, and a lack of adequate support reflect related but distinct social conditions that extract a significant toll on psychological well-being and physical health of older people (Tomaka et al., 2006, p. 359-360). Tomaka et al. (2006) reported social isolation as objective physical separation from others. However, loneliness is a totally subjective inherent human experience, which varies from person to person and with different causes and consequences (Tomaka et al., 2006, p. 361; Casey & Holmes, 1995, p 173). Capra (1997) has suggested that, individuals are autonomous, aware of the self and of their identity, shaped by history, political change and social turmoil, “yet, when we look for an independent self within our world of experience we cannot find any such entity” (p. 287). Casey and Holmes (1995) refer to Mijuskovic’s (1979) claim that humanity is “not only psychologically alone but metaphysically isolated” (p. 173). This he refers to as ‘psychological loneliness’ as opposed to ‘existential loneliness’ in which he suggested that not only do we feel alone, but also that we are alone. This may be captured in the concept of alienation where one may feel alone in the midst of a large social network. Casey & Holmes (1995, p. 172) stated, that the elderly in particular are vulnerable to feelings of existential loneliness because they are left without meaningful roles in their lives. Such loneliness is a subjective experience with the potential to create elements of detachment and disconnectedness (Casey & Holmes, 1995, p. 173). Social support however, in terms of a subjective perception, may be the counterpart to social loneliness and isolation as it offers a feeling of connectedness through a sense of group belonging as claimed by Tomaka et al. (2006).

2.7.3 Mental illness and Socialisation for Older Adults

Different forms of human behaviour demonstrate incapacity to cope with conflict and the lack of social cohesion as evidenced by a high incidence and prevalence of mental illnesses and suicide (Brady, 2001, p. 74) across the lifespan. Mental illness, including depression, is a serious problem occurring within a social and cultural context that increases morbidity and mortality often leading to exclusion (Feely, Sines, & Long, 2007, p. 393) from all that is meaningful to the individual, including relationships with others.

Satisfaction with social networks or social relations has been associated with a better subjective quality of life for people with mental illness (Hansson, 2006; Uchino, 2006; Hansson et al., 2002). Health promotion programs that advance social engagement and foster social relationships are to be encouraged (Howat et al., 2004). The benefits of social engagement for older people with (or without) mental health problems that foster mutual relationships, provide social support and promote better health outcomes have been explored by McDonald & Brown (2008). They found that support from peers involved in social support groups enhanced feelings of self-worth and self-esteem. As a result of such positive feelings, the mutual respect group members had for each other, and the companionship that was provided within the network of friendship, group members reported positive feelings of psychological health and well-being.

In an investigative study by Li & Browne (2000, p. 143), six themes were identified that defined a mental health problem, they were: a lack of a purpose in life, feeling lonely, difficulties understanding and dealing with a serious event, high levels of anxiety, descriptions of mental health problems as somatic illnesses, and perceptions of mental illness as serious and potentially not treatable. Furthermore, Parslow & Jorm (2002, p. 119) pointed out that the Australian public believes that the social environment contributes to depression. Authors such as Hart, Williams & Davidson (1988, p. 222) and Feely et al., (2007) suggested that a number of theoretical and research studies have indicated that mental illness, particularly depression, is not only a

consequence of, but, may contribute to increased social isolation, loss of close relationships and sense of connectedness, and impaired interpersonal communication which could potentially result in attempted suicide.

2.7.4 Suicide

Suicide is a human tragedy at any age. The incidence of suicide among the elderly, though somewhat unreliable because of poor reporting mechanisms, is estimated to be higher than for the population as a whole, particularly among older men (NSW Department of Health, 2010, p. 13).

Durkheim (1952) wrote that suicide is a social phenomenon (p. 326). Durkheim (1952) historically reported on the “social concomitants of suicide” (p. 14) and suicide rates, and offered the theory that suicide was not only an individual’s act but influenced by social structure (p. 13). Durkheim (1952) further noted that such actions may be ascribed to extra-social factors (p. 13) and “a lack of integration of the individual into society” (p. 14). The lack of social integration resulted in what Durkheim coined “*egoistic suicide*”. Durkheim believed that if people are integrated into social groups they are less likely to commit suicide (Giddens, 2001).

Advancing on Durkheim’s theory, Hart et al. (1988, p, 222) examined the relationship of suicidal behaviour with social network deficits. They reported that suicidal behaviour across the lifespan was associated with loss of personal contact with others. Furthermore, Lau & Pritchard (2001, p. 199), in an international comparison of the behaviour of older people in Asian societies and other countries, found that mental illness and social isolation were common factors which helped to explain the increasing rates of suicide among elderly people in both Asian and a number of Western countries. This is supported in the findings of a study by Turvey, Conwell, Jones, Phillips, Simonsick, Pearson & Wallace (2002, p. 404) that identified significant predictors of completed suicide among the elderly and highlighted the importance of the presence of a relative or friend to confide in as a protective factor. This reflects Durkheim’s (1952) theory, which reinforced the need for

individuals to be integrated into social groups and participate actively in social life to reduce suicide rates (p. 14 -15).

In light of these findings, there is a need to identify and promote protective factors that have the capacity to build resilience and encourage social connectivity that will assist people to deal with difficult life situations (NSW Health Department, 2010, p. 5). Therefore, the NSW Suicide Prevention Strategy (2010-2015), published by NSW Health, suggested a key direction was to: “Building individual resilience and the capacity for self-help” with the outcome being to “improve individual resilience and well-being” and develop “an environment that encourages and supports help seeking (p. 29). Unlike the National Strategy for an Ageing Australia (2001) this strategy does provide a number of suggestions about how to attain these outcomes. To meet some of the needs of older people, such as reducing social isolation, the researcher believes that such outcomes may be achieved by means of social support network groups as described in this study.

2.8 Regaining Social Connectedness for Older Adults

In addition to defining and describing social support, networks and systems we need to ask the question: Where can such social support for older adults be found? How can this support be achieved, and how do elderly persons living in the community experience social support? Clearly, social support systems (in terms of group participation) may offer a solution to the problem by assisting older people to regain or maintain social connectedness and enhance individual and community resilience.

To overcome the Cartesian paradigm, the unconnectedness with nature and its influence on social structure and function, Capra (1997) suggested that, “we need to think systematically, shifting our conceptual focus from objects to relationships” (p. 287). This he suggested would allow us to regain our experiences of connectedness to each other, nature and being in the world (p. 288) a philosophy, I believe, also supported by Putnam (2000). When one’s body is in harmony with the world a system is formed, as suggested by

Merleau-Ponty (1964), which may be created through life experiences and the interaction and connectedness of people and objects (p. 52). The capacity for this to occur may be accomplished through the interaction of others by such means as peer support and group participation. By involving people in community activities based on trust, mutual reciprocity and common purpose, social cohesion is strengthened, “for it is not only the presence or absence of social support that affects an individual’s physiological and psychological well-being, rather it is the strength of these ties and a sense of belonging” (Griffiths, Horsfall, Moore, Lane, Kroon, & Langdon, 2007).

2.8.1 Groups for Older Adults: What are the benefits

Movement through the lifecycle creates a new need for all types of support and new challenges for acquiring that support (Craven & Wellman, 1973, p. 19). It can be argued that a sense of connectedness for older adults could be achieved through social network systems and systems of social support such as peer group participation, to facilitate quality of life, inhibit the development of, or reduction in, the recurrence of mental health problems, and encourage interpersonal relationships (Finfgeld-Connett, 2005; Kawachi & Berkman, 2001; Putnam, 2000).

Older people with mental illness, according to van Dongen (2001, p. 383), experience a series of disruptive events and episodes of suffering often associated with losses and major physical health problems. Moreover, they are extremely vulnerable but have the ability to reconstitute a social self if given support and the opportunity. Support, through group participation, may encourage and facilitate resilience and vitality in an individual’s body, mind and spirit.

Durkheim (1964) reported that “the more solidarity the members of a society are, the more they sustain diverse relations, one for another, or with the group taken collectively ...” (p. 64). Thus, group participation can provide a type of social support (expressive) and a social network. It may also be a source of social capital and offer a form of therapy. In Moffatt, Mohr & Ames'

(1995) study, group therapy refers to participating in and benefiting from others "in which the goal is to adjust and cope with an illness or crisis in one's life" (Yale, 1999, p. 58). In their study, which focused on group therapy for depressed and anxious elderly inpatients, it was found that "the group environment offers a consistent source of support and empathy to the participants" (p. 39).

Group participation has been identified as being important, and can be particularly useful, in the mental health care context and in the continuum of care of the older client. This may be because, as Kelly (1999) suggested, groups for older persons with a mental illness are extremely beneficial in assisting members as they overcome life's transitions and try to cope with the challenges of mental illness in late-life. Yet, despite the claim by Greenblatt et al. (1982, p. 977), that mental health practitioners were becoming more interested in the effects of social links and interactions as stress-buffering and providing social support, the literature, describing the benefits of group therapy as a mutual aid in achieving optimal outcomes in mental and physical health of the older person, has been limited. Several authors, such as Kawachi & Berkman (2001); Hall & Nelson (1996) and Tolsdorf (1976), had suggested that this area of study demands further attention. Furthermore, Edelbrock et al. (2001, p. 173), stated that exploring the benefits of social support is an important research priority as lower levels of social support have been associated with higher mortality rates, poor health, and lower levels of well-being. Also Procter & Alwar (1995) suggested that, groups are "a cost effective means of improving mental health in the elderly" and "should be more thoroughly investigated" (p. 36) as a means of social support and as a network system. Recommendations from Kelly's (1999) work with peer support groups for older adults with a mental illness, was that more investigation into the benefits of group therapy, as a form of social support for older adults, is needed.

Other authors such as Ussher, Kirsten, Butow and Sandoval (2006) believed that "psychosocial determinants of health may be transmitted through social connections" and a study by Sarason, Sarason & Gurung (2001, p. xvi)

focused on how social support may contribute to health outcomes and concluded that, "a model in which the quality of close relationships serves as a partial mediator between personality and social support would be most appropriate for further research". Equally, Reblin & Uchino, (2008) reported that "support groups may be particularly useful because of the gaps they fill in the support needs of patients and the experiential similarity within the group" (p. 203). These authors refer to cancer groups identifying their unique role as sources of information and acceptance, in contrast to waning support from overburdened families.

From a general health perspective, a study by Munn-Giddings & McVicar (2006) in the United Kingdom on self-help groups, also referred to in the study as 'mutual-aid groups', concluded that "self-help/mutual aid groups, based on reciprocal peer support, offer a valuable type of resource in the community that is not replicable in the professional-client relationships" (p. 26). This study is the one most closely linked to the current research in terms of aim and outcomes. But again this study was not specifically related to older adults, and its participants were specifically carers. However, from a review of the literature Munn-Giddings & McVicar (2006) concluded that group membership offered "a range of personal, intrapersonal and collective benefits, such as: improved self-esteem and self-confidence; mutual support; sharing coping strategies; and an expanded worldview" (p. 27). Munn-Giddings & McVicar (2006, p. 27) and Barker & Buchannan-Barker (2007, p. 159) noted that many of these benefits are derived from the reflection and development of personal experiences shared over time and that they assist group members' to re-evaluate confronting issues and provide options for resolving problems of living. Thus, social supports "may also moderate the impact of stressful circumstances" (Tomaka et al., 2006, p. 360), as do social bonds (Tomaka et al., 2006) simply by participating in social groups consisting primarily of peers.

2.9 Summary

Social support is a broad construct which has been described in terms of one's social network as indicated by Pachana, Smith, Watson McLaughlin &

Dobson (2008), and the quality of interactions with the network. Social support has an important role to play in promoting positive health and well-being especially in the elderly (Pachana et al., 2008; Powers, Goodger & Byles, 2004; Goodger, Byles & Higginbotham, 1999) and buffering the ill effects of stress (Koenig et al., 1993).

Social support can be categorised in many types (Pachana et al., 2008), but the most frequently recognised types of support are instrumental and or expressive (Powers et al., 2004; Pachana et al., 2008). Examining social support in older adults is important, stated Pachana et al. (2008), “because they are at risk of declining social support networks due to a number of factors such as the death of friends....” (p. 666). Group participation may provide many forms of social support including a network of relationships and a support system. Thus, social support networks are a feature of social capital (Putnam, 2000).

2.10 Section Two: Articles Reviewed for the Research Study

The literature defining and conceptualising several social constructs did not reveal studies undertaken on the experiences of social support by means of group participation for older people as a method of socialisation.

This research explores the experiences of older adults who were part of a social group or peer support network. It is therefore interested in conceptualising the outcomes in terms of psychosocial benefits as opposed to specific health benefits. However, no studies specific to the topic of interest nor the research question were identified. Many studies investigated the association of social support and the health and well-being of people with specific health conditions, such as a study by Ussher et al. (2006) that explored the experiences of people with cancer engaged in peer support groups. In this qualitative study, support groups were found to offer information and acceptance in contrast to waning support from overburdened families and friends (Ussher et al., 2006). Nonetheless, studies investigating the value of social support to health were reviewed to seek an understanding of the possible mechanisms by which such links exist between social support

and health outcomes. These are in Section 2.8 and relate to the benefits of social support in terms of health and well-being.

In further support of the current research and studies selected for the literature review, Lyyra & Heikkinen (2006) in their article on “Perceived Social Support and Mortality in Older People” suggested that social integration is provided by a network of relationships but concluded that the results of their “study presents a challenge for society to find and develop new social innovations and interventions in order to promote a sense of emotional social support in older people, thereby contributing to their health” (p. 147). Their study did not give any reference to group membership as a way of addressing this issue. Additionally, studies by Carson & Chamberlain (2003), Barr and Russell (2007) and Ziersch, Baun, Darmawan, Kavanagh & Bently (2009), examined the relationship between social capital and health and health promotion with Carlson & Chamberlain (2003) suggesting that further work is needed to advance the concept. Moreover, a paper by Howat et al. (2004) suggested that health promotion aimed at increasing the health status of seniors in Australia should be given increasing importance (p. 50). The studies investigating social network types considered the collection of interpersonal ties that older people can maintain in varying degrees (Litwin & Shiovitz-Ezra, 2006; Fiori, Antonucci, & Cortina, 2006; Litwin, 2001). At the conclusion of the Danish study on elderly twins by Rasulo, Christensen, & Tomassini, (2005) investigating the influence of social relations on mortality in late life, the authors declared that the research: “lacked qualitative measures that could have provided insight into the differential effects of gender on the relationship between contact frequency with friends and mortality, and about the meaning of later life friendship for men and women” (p. 608).

Eighteen of the most relevant articles with the key word “social support”, “social networks”, and “groups” were reviewed. Only six had the word “elderly” in the title. One used the word “self-help groups” but this was not specifically related to the elderly although they were included in the study as it focused on the value of such groups for carers and provided correlating evidence around the benefits of support groups. Almost all the articles referred to “sources of

support” and included spouses, children, siblings and friends, and to ‘types of support’, such as instrumental and expressive support. Only those pertaining to the elderly were retrieved.

More than twenty articles discussed the mental and physical health benefits of engaging in social support through a variety of sources across all adult age ranges (or the adult lifespan). However, there were no studies that described or reported on older people’s “lived experiences” nor the specific benefits older people receive from being a member of a peer support group or a social network system.

Using the key words identified in Section 2.2.1, over 60 articles were identified and reviewed. Articles were retrieved that considered concepts and constructs related to social support, social networks, social systems and social capital. From the literature 32 articles were identified and reviewed concerning the psychosocial needs of adults with psychological distress, mental health problems, including suicide. Eighteen were research articles and the remainder were journal articles and articles related to social networks, mental health problems and preventing mental illness across the lifespan. Of the 18 research articles, seven related to older adults. Thirteen articles reflected on the association of mental illness, depression and suicidal behaviour and the need for social network systems across the lifespan. Of these, four articles were specifically related to the elderly but only two reflected specifically on the benefits of group participation as a means of social support and health maintenance and illness prevention. In addition, ten journal articles on social and peer support generally relating to instrumental support were reviewed but were not age specific with only two research studies in this category involving the elderly.

Selected articles retrieved and reviewed were categorised in specific headings such as:

Category One identifies research studies related to the characteristics and types of social support, including social capital, and the benefits of social support and group participation related to mental and physical health;

Category Two examined the Duke Social Support Index (DSSI) scale; and

Category Three highlights the need for health professional to understand the importance of social support and social network for improved quality of life in older people.

A summary of several selected articles are presented in tables identifying the authors and year of the study or when the article was published, the study participants, and the aim of the study, the study design and study findings.

2.10.1 Category One Studies

Category One studies are studies related to the characteristics and types of social support, and the benefits of social support and group participation related mental and physical health are presented in Table 2.2. Included in Table 2.2 are three studies related to social capital and health and the characteristics as a network.

The first two research articles involved participants over 60 years of age and focused on social support types such as ‘instrumental support’ and the support that is gained through domestic services and family and friends. The first article is a major Sydney study evaluated the benefits of social support received by those over 75 years of age, referring to support received by “instrumental” means or direct client care such as nursing care or domestic services (Edelbrock, Buys, Waite, Grayson, Broe & Creasy, 2001). Recommendations from that study were that further research on the characteristics of social support was warranted because the findings reported that mortality was related to poor social support. The second study is an Asian study, which included China, Hong Kong, Korea, and Singapore (Lau & Pritchard, 2001), and a study from the U.S.A. (Hays, Steffens, Flint, Bosworth & George, 2001) concluded that even instrumental support (hands on care and contact with another) was a protective factor against suicidal behaviour and worsening functional decline among the elderly.

The five articles related to the importance of social support and social networks as a means of maintaining mental and physical well-being are also provided in Table 2.2. These studies identify the disadvantages of not having a positive social support network but importantly reveal some of the potential benefits. The studies were undertaken across a variety of countries. Participants in two of the studies were over 60 years of age the other two did not identify participants' age. Study participants in all four studies had attempted suicide and experienced depression. The last three articles are on social capital: two on health and health promotion (one being a literature review) and one a study on social capital and social network characteristics.

Table 2.2. Category One Studies
Studies Related to the Characteristics and Types of Social Support and the Relationship to Mental and Physical Well-being

Author, date, location & title	Study participants	Aim of the study	Study design	Study findings
Edelbrock, D., Buys, L., Waite, L., Grayson, D., Broe, T., & Creasey, H. (2001). Australian Study. <i>“Characteristics of social support in a community-living sample of older people: The Sydney older persons study”.</i>	n=647, 75 years or older community - dwelling males and females.	Described the characteristics of social support and identified socio-demographic variables associated with support.	The sample was interviewed using a structured instrument to assess social support. Chi-square tests were used to compare levels of support between males and females and linear regression was used to analyse the relationship between social support and socio-demographic variables.	Low levels of social support were associated with a range of variables including increased age, being single, and lower socioeconomic status. These groups were perceived to be at risk of poor health outcomes.

Author, date, location & title	Study participants	Aim of the study	Study design	Study results
James, C., & Swindell, R. (1991). Australian Study. <i>“Senior Australians who join groups: Effects on quality of life”.</i>	Preliminary Study. A total of sixty (n= 60) participants from three study groups who were defined as ‘seniors’ using the chronological marker of 60 yrs for women and 65 yrs for men. Study Two. Eighteen (n=18) randomly selected older adults. Age range for study two was 58 to 92 years the average being 76.8 years.	To examine whether quality of life factors associated with groups could be integrated into the lives of socially isolated individuals.	Two stage study using both taped focus group interviews and the completion of the “Salamon-Conte Scale” and “Life Satisfaction In The Elderly Scale”. Quantitative data were analysed using paired T tests. Qualitative findings were not reported.	This study found that feelings of belonging and participation in voluntary groups could have a marked effect on perceived quality of life.
Lau, B., & Pritchard, C. (2001). Study involving older Chinese people. <i>“Suicide of Older people in Asian societies: An international comparison”.</i>	Males and females 75 yrs and over.	To verify in a systematic study if the Chinese tradition of venerating older people results in lower suicide rates compared to other countries.	This was a comparative analysis of suicide in older people in 40 countries with a focus on China. The ratio between suicide rates and the older population and total population were calculated and used to compare these in 40 countries. Spearman Rank Order Correlation using Chambers’ formulae.	The study findings raised questions about the adequacy of support to older Asian people. High suicide rates were found in Hong Kong, Korea, Japan and Singapore. Whether this was the results of ageism is discussed. Country-specific research is needed to improve suicide prevention measures,

				especially for older people.
<p>Hays, J., Steffens, D., Flint, E., Bosworth, H., & George, K.</p> <p>(2001).</p> <p>Duke University, USA.</p> <p><i>“Does social support buffer functional decline in elderly patients with unipolar depression?”</i></p>	<p>60 yrs and older males and females. n=113 patients with uni-polar depression</p>	<p>To test whether social support protects against functional decline in the severely depressed elder patient.</p>	<p>Prospective cohort study design. The analysis employed multivariable ordinary least squares models.</p>	<p>Instrumental social support was protective against worsening performance on activities of daily living among the elderly with depression.</p>
<p>Carrigan, J. T.</p> <p>(1994).</p> <p>Northern Ireland.</p> <p><i>“The psychological need of patients who have attempted suicide by overdose”.</i></p>	<p>Not age specific. Six people (three female, three male) who had survived an attempted suicide.</p>	<p>To investigate and highlight psychosocial needs of those who have survived an attempted suicide.</p>	<p>Exploratory, descriptive design using qualitative methods of analysis. Data were collected using focus group interviews and analysed using the principles of content analysis devised by Field and Morse.</p>	<p>Major needs identified included the need to be loved, the need to maintain a high level of self-esteem, the need to have control over their life, to be loved and supported.</p> <p>The findings indicated that these needs are not being met by the current mental health delivery system and that nurses need to pay greater</p>

				attention to assessment and planning of care for patients who have attempted suicide.
Hart, E., Williams, C., & Davidson, J. (1988). Australia. <i>“Suicidal behaviour, social networks and psychiatric diagnosis”.</i>	Not age specific. n= 104 subjects – 52 suicide attempts and 52 non-suicidal. Gender not specified.	To examine the relationship between social network deficits and the occurrence of suicidal behaviour.	Two questionnaires formed the basis of a structured interview. Analysis involved comparison of three groups over time using unweighted means analysis of variance.	The findings added support to the importance of the nature and adequacy of the social networks in relation to suicide.
James , C., & Swindell, R. (1991). Australian Study. <i>“Senior Australians who join groups: Effects on quality of life”.</i>	Preliminary Study. A total of sixty (n= 60) participants from three study groups who were defined as 'seniors' using the chronological marker of 60 yrs for women and 65 yrs for men. Study Two. Eighteen (n=18) randomly selected older adults. Age range for study two was 58 to 92 years the average being 76.8 years.	To examine whether quality of life factors associated with groups could be integrated into the lives of socially isolated individuals.	Two stage study using both taped focus group interviews and the completion of the “Salamon-Conte Scale” and “Life Satisfaction In The Elderly Scale”. Quantitative data were analysed using paired T tests. Qualitative findings were not reported.	This study found that feelings of belonging and participation in voluntary groups could have a marked effect on perceived quality of life.

Author, date, location & title	Study participants	Aim of the study	Study design	Study results
<p>Fiori, K, Antonucci, T & Cortina, K.</p> <p>(2005).</p> <p>University of Michigan.</p> <p><i>"Social network typologies and mental health among older adults".</i></p>	<p>African American male and female adults aged 60 years and older (n =1,669).</p>	<p>The aim of the study was to test the robustness for previous social network research, and to determine if support quality is one mechanism by which network types predict mental health</p>	<p>K-means cluster analysis was used in order to determine network types.</p> <p>Relationships were examined between the background variable and network types using chi-square.</p> <p>Multiple regression analysis was used with depressive symptomatology as the dependent variable and network types as the independent variable.</p> <p>Findings:</p> <p>Positive support quality partially mediated the association between network types and depressive symptomatology.</p>	<p>The results suggest that the presence of family in the context of friends is less detrimental than the absence of friends in the context of family, and that support quality is one mechanism through which network types affect mental health.</p>

Author, date, location & title	Study participants	Aim of the study	Study design	Study results
<p>Carlson, E., & Chamberlain, R.</p> <p>(2003).</p> <p><i>"Social capital, health, and health disparities"</i>.</p>	<p>No participants.</p> <p>Literature review</p>	<p>To synthesise the empirical evidence that links social capital to population health with the aim of identifying implications for health disparities research</p>	<p>A literature search.</p>	<p>The lack of conceptual development diminishes the usefulness of social capital as a variable for public health research. However, the empirical evidence is sufficient to warrant further work to advance the concept.</p>
<p>Barr, F & Russell, C.</p> <p>(2007).</p> <p><i>"Social capital among older residents of a coastal resort: A survey of social resources and vulnerabilities"</i>.</p> <p>NSW Australia.</p>	<p>200 older coastal dwelling Seniors' Card Holders, stratified by age and gender, and residents of three post codes in coastal NSW. 103 responded.</p>	<p>To document the characteristics and social networks of older residents of a coastal resort and to contribute to understanding the nature of social capital in an Australian context</p>	<p>Part one of a two stage Qualitative study.</p> <p>A 15-item questionnaire was mailed to 200 older coastal residents</p>	<p>This stage of the study found that variations in social patterns both reflect and foreshadow the vulnerability of individuals to changes in life circumstance.</p>
<p>Ziersch, A., Baum, F., Darmawan, I., Kavanagh, A., & Bentley, R.</p> <p>(2009).</p> <p><i>"Social capital and health in</i></p>	<p>2,013 residents of South Australia.</p> <p>No age specified.</p>	<p>To compare the relationship between social capital and health</p>	<p>Telephone survey (1,402 urban and 611 rural).</p>	<p>Higher levels of networks, civic participation and cohesiveness</p>

<i>rural and urban communities in South Australia”.</i> South Australia.		for rural and urban residents of South Australia.		were reported in rural areas. Social capital was associated with good mental health for both rural and urban participants.
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2.10.1.1 Summary of Category One Studies

The findings of the first two studies suggest that there is a relationship between low levels of social support and poor health and that group participation is a means of improving older adults’ quality of life.

The findings of the following five studies highlight the importance and need for social support and a network system to build resilience through comradeship, connectedness and to be loved and supported, and as a protective factor against developing mental illness particularly depression and suicidal behaviour in the elderly population.

The three social capital papers suggest that social networks may provide social capital and that further investigation is required to develop this concept. Articles in this category highlight the need for further research into the benefits of social networks and of those who may benefit from such activities. They provide the motivation and rationale for the present study as more research is needed to deepen the understanding of the need for social network systems for older adults and the role they may play in preventing physical and mental ill health while assisting them to maintain independent living options within the community.

2.10.2 Category Two Studies

Within this category four studies, presented in Table 2.3 (over) address the capacity of the Duke Social Support Index (DSSI) scale to measure the essential elements of social support in the elderly. In the studies presented in

Category Two the abbreviated form of the DSSI scale 11-item was used. Both the 11-item and the 23-item scales were developed from the original 35-item scale (Koenig et al., 1993) which measures multiple dimensions of social support. The DSSI scale using the 23-item instrument has been used in the current study to measure levels of social interaction, satisfaction with social support and instrumental support. The 23-item scale has both objective and subjective measure with the subjective scale having an internal reliability of Cronbach's alpha of 0.71 (Koenig et al., 1993, p. 65).

**Table 2.3. Category Two Studies
Studies Examining the DSSI Scale**

Author, date, location & title	Study participants	Aim of the study	Study design	Study results
Study 1. Koenig, H.G., Westlund, R. E., George, L.K., Hughes, D.C., Blazer, D.G., & Hybels, C.H. (1993). North Carolina, USA. <i>“Abbreviating the Duke Social Support Index for Use in Chronically Ill Elderly Individuals”.</i>	Completed data for analyses were on 2,954 community participants of which 1,294 were 60 years and over. The sample was a mix of younger and elderly individuals from urban and rural areas.	To examine the possibility of reducing the length of the 35-item DSSI scale to facilitate its use with samples of chronically ill elderly individuals.	Quantitative design using inferential analyses.	Both abbreviated scales i.e. the 11-item and the 23-item are suitable for use in the elderly with nonpsychiatric medical illness.

Author, date, location & title	Study participants	Aim of the study	Study design	Study results
<p>Study 2.</p> <p>Goodger, B., Byles, J., & Higganbotham, N. (1999). Newcastle, NSW, Australia.</p> <p><i>"Assessment of a short scale to measure social support among older people".</i></p>	<p>565 community dwelling people (male and female) aged 70 years and over.</p>	<p>To test the validity and reliability of the 11-item DSSI scale on community dwelling older people.</p>	<p>Quantitative design using inferential analyses.</p>	<p>The DSSI provides researchers with the opportunity to use a brief measure of social support which has been assessed specifically with older people instead of single-item measures or scales which have limited psychometric evidence.</p>

Author, date, location & title	Study participants	Aim of the study	Study design	Study results
<p>Study 3.</p> <p>Powers, J., Goodger, B., & Byles, J. (2004). Newcastle, NSW, Australia.</p> <p><i>“Assessment of the Abbreviated Duke Social Support Index in a cohort of older Australian women”.</i></p>	<p>Women over 70-75 years from rural and remote areas of Australia n=12,939.</p>	<p>To assess the acceptability, reliability and validity of the 11-item Duke Social Support Index (DSSI) in community-dwelling older women, and to describes its relationship with the women’s sociodemographic and health characteristics.</p>	<p>Quantitative design using inferential analyses.</p>	<p>Ten of the 11 DSSI items provided acceptable, brief and valid measures of social support for use in mailed surveys to community-dwelling older women.</p> <p>Internal reliability was reasonable for 10 of the 11 DSSI items and its factors, social interaction (4 items) and satisfaction with social support (six items; Cronbach's alpha of 0.8, 0.6, 0.8).</p> <p>Higher social support was associated with better physical and mental health.</p>

Author, date, location & title	Study participants	Aim of the study	Study design	Study results
Study 4. Pachana, N., Smith, N., Watson, M., McLaughlin, D., & Dobson, A. (2008). Queensland, Australia. <i>“Responsiveness of the Duke Social Support Index sub-scales in older women”.</i>	Australian women aged 70-75 years and 73-78 respectively.	To examine factors that might be expected to affect social support for older women over time.	Quantitative design using inferential analyses.	The DSSI are responsive to changes in the lives of older women and can be useful in community-based epidemiological studies.

2.10.3 Category Three Studies

The most relevant articles for Study Two are provided below in Table 2.4. The articles offer a range of perspectives on social support and social network systems; and the importance of such features to health outcomes and in mediating life events.

Articles 1 to 6 in the Table investigated group membership as a means of social support in the context of an illness but did not discuss or investigate ‘group participation’ specifically as a method of social support. More importantly these papers highlight the need for health professionals to have a better understanding of the importance and impact of social support and social network systems in rehabilitation, improving health outcomes, and considering interventions that would achieve such effects.

Article 7 however, also focused on social support in an elderly Hispanic population (along with social isolation and loneliness) from a health perspective but identified social support from two sources: family and friends, and groups.

The focus of the study was to examine how subjective and objective social isolation, subjective loneliness, family support, and support from family and friends and social groups (i.e. "belongingness support") was related to health outcomes in a sample of New Mexican seniors (Tomaka et al., 2006).

The remaining three articles investigated Social Network Types; the first, investigating the relationship between social network typologies and mental health among older adults, the second studied social networks and mortality risk in late life, and the third studied the relationship between social networks and morale in late life.

Table 2.4. Category Three Studies

Articles Related to the Need for Health Professional to Understand the Importance of Social Support and Networks: Implications for Practice

Authors & Title	Age of the Subjects	Aim of the paper	Design and Findings	Implications for Research
ARTICLE 1 Beckley, M. (2006). Division of Occupational Therapy Ohio State University , USA <i>“Community participation following cerebrovascular accident: Impact of the buffering model of social support”.</i>	95 older adults who had sustained a stroke.	<p>The premise of this study is that the influence of social support on functional limitations enhances the ability of stroke survivors to participate in their community.</p> <p>The purpose of the study was to examine the impact of the buffering model (rest on the hypothesis that an identifiable form of social support has a beneficial effect in the presence of stress) of social support and stroke outcomes.</p> <p>The aim was to test the impact of the buffering model on reported functional limitations with regard to community participation 3 to 6 months post hospitalisation for stroke</p>	<p>Design: Interviews at home. Social support was measured with two scales. The Social Support Inventory for People With Acquired Disabilities (SSIPAD) was used to measure the quality and quantity of support and The Duke Social Support Index was used to measure instrumental and subjective support.</p> <p>Findings: The findings indicate that for people who had sustained a stroke, community participation was more related to their ability to do for themselves rather than the support that was available to them.</p>	<p>The findings suggest the need for occupational therapy to expand their practice to include the promotion of social support to increase stroke clients' ability to participate in the community. The study also indicated that examining factors other than functional level and support may yield results that could support people who want to participate in their community and that this would improve discharge planning.</p>

Authors & Title	Age of the Subjects	Aim of the Paper	Design and Findings	Implications for Research
<p>ARTICLE 2</p> <p>Beckley, M.</p> <p>(2007).</p> <p>Division of Occupational Therapy Ohio State University USA.</p> <p><i>“The influence of the quality and quantity of social support in the promotion of community participation following stroke”.</i></p>	<p>59 stroke survivors.</p> <p>No age specified.</p>	<ul style="list-style-type: none"> • The purpose of the study was to examine the impact of social support on community participation after stroke rehabilitation. • The aim was to determine whether the <i>quality</i> of social support played a greater role in a stroke survivor's ability to participate in the community than the <i>quantity</i>, or number, of social support. 	<p>Design:</p> <p>Stroke survivors were interviewed at home.</p> <p>Multivariate analysis was used to determine the effects of social support on community participation as measured by the Reintegration to Normal Living Index, following stroke rehabilitation.</p> <p>Findings:</p> <p>The quality of social support did not have a greater relationship than the quantity of social support. Both quality and quantity of social support were seen to be significant.</p>	<p>The implication from these results is to expand occupational therapy intervention practices to include the assessment and development of stroke survivors' social support. This would be used as a method to improve stroke rehabilitation outcomes and increase the opportunity for community participation.</p>

Authors & Title	Age of the Subjects	Aim of the Paper	Design and Findings	Implications for Research
<p>ARTICLE 3</p> <p>Granerud, A. & Severinsson, E.</p> <p>(2007).</p> <p>Hedmark University and Stanvanger University, Norway.</p> <p><i>“Knowledge about social networks and integration: a co-operative research project”.</i></p>	<p>Norwegian community mental health workers, (including Nurses) and social workers.</p> <p>Participants were aged between 32 and 53 years.</p>	<p>The aim of this study was to investigate how knowledge of social network and integration influenced professional understanding and practice.</p>	<p>Design:</p> <p>Qualitative study using a co-operative research approach based on knowledge of social network and integration was used to develop participants' knowledge of social networks and social integration theory using focus group interviews.</p> <p>Qualitative content analysis was employed to develop the themes and categories.</p> <p>Findings:</p> <p>The main theme identified was the potential of experiential knowledge-based competence, which was characterised by the following categories: (1) increased knowledge, (2) awareness of social interactions, (3) cross-disciplinary professionalism and (4) potential for change practice.</p>	<p>Participants' knowledge and awareness of the potential of social integration as a tool for social network interventions considerably strengthened. However, this knowledge needs to be implemented into practice.</p>

Authors & Title	Age of the Subjects	Aim of the Paper	Design and Findings	Implications for Research
<p>ARTICLE 4</p> <p>Lyyra T., & Heikkinen, R.</p> <p>(2006).</p> <p>The Finnish Centre for Interdisciplinary Gerontology and Department of Health Sciences, Finland.</p> <p><i>“Perceived social support and mortality in older people”.</i></p>	<p>206 Finnish men (n=61) and women (n=145) aged 80 years.</p>	<p>Aim was to examine the association between all types of mortality (illness) and different dimensions of perceived social support at a 10-year follow-up. The hypothesis was that the lack of perceived social support would be associated with mortality in this group of older adults.</p>	<p>Design:</p> <p>Longitudinal research program that measured perceived support in 206 Finnish men and women aged 80 yrs old using the Social Provision Scale.</p> <p>Findings:</p> <p>The study found a strong association between non-assistance-related perceived social support (consisting of feelings of self-worth, emotional closeness, belonging, and an opportunity for nurturance) and survival in older Finnish women.</p>	<p>The authors concluded that the results present a challenge for society to find and develop new social innovations and interventions in order to promote a sense of emotional social support in older people.</p>

Authors & Title	Age of the Subjects	Aim of the Paper	Design and Findings	Implications for Research
<p>ARTICLE 5</p> <p>Guiaux, M., Van Tilburg, T., & Van Groenou, M.</p> <p>(2007).</p> <p>VU University Amsterdam.</p> <p><i>“Changes in contact and support exchange in personal networks after widowhood”.</i></p>	<p>Older adults: no age was specified.</p> <p>Two hundred and twenty-seven (n=227) widowed and 408 married older adults.</p>	<p>The study aimed to contribute to the notion of networks as convoys (those that come and go) in later life.</p> <p>The study described changes in contact and support older adults experienced in the different relationships of their personal networks, starting before they were widowed until sometime after being widowed.</p> <p>The general premise in this study is that widowhood, a change from being spouse to being single, is accompanied by a change in need for contact and support.</p>	<p>Design:</p> <p>This prospective study examined how contact and support in several relationships changed due to widowhood.</p> <p>Two hundred and twenty-seven (n=227) widowed and 408 married older adults were part of a Longitudinal Aging Study in Amsterdam. They were observed from 1992 to 2002.</p> <p>Findings:</p> <p>Contact and support were low before widowhood and increased in all relationships after widowhood.</p>	<p>The findings increased the researchers’ understanding of the heterogeneity of network changes in old age and of the instability of the network as a social convoy in late life.</p>

Authors & Title	Age of the Subjects	Aim of the Paper	Design and Findings	Implications for Research
ARTICLE 6 Reblin, M & Unhino, B. (2008). University of Utah. <i>“Social and emotional support and its implications for health”</i>	No age specified	Literature review. This paper presents a collection of research findings focusing on links between social support and physical health. This paper gives reference to the use of support groups in influencing health outcomes of people with e.g. cancer where one author suggested that by belonging to such groups patients found support from each other which augmented other network support.	The authors explain that researchers are learning and understanding more about the influence of social support on health and that studies are concentrating on linking measures of social support to physical health. They state that a few studies are now investigating health links with support received and support provided by others.	The authors' state that “recent findings often show a robust relationship in which social and emotional support from others can be protective for health. The next generation of studies must explain, however, why this relationship exists and the specificity of such links. This research is crucial in order to better tailor interventions that can impact on physical health outcomes”.

Authors & Title	Age of the subjects	Aim of the paper	Design and findings	Implications for research
<p>ARTICLE 7</p> <p>Tomaka, J., Thompson, S & Palacios, R.</p> <p>(2006).</p> <p>University of Texas and Border Research Solutions, El Paso Texas</p> <p><i>“The relation of social isolation, loneliness, and social support to disease outcomes among the elderly”.</i></p>	<p>Average age was 71.1 years (range 60 – 92).</p> <p>The majority were female (59%), and 72% reported ethnicity as White or Anglo (i.e. Caucasian) and 23% reported ethnicity as Hispanic. 5% reported other origins.</p>	<p>The aim of this paper studied relations between social isolation, loneliness, and social support to health outcomes in a sample of Mexican seniors.</p>	<p>Design:</p> <p>Quantitative study using phone questionnaires. The data were analysed using correlational and logistical analysis.</p> <p>Findings:</p> <p>The findings indicated that ‘belongingness support’ related most favourably to health outcomes and that loneliness and social support play important roles in the health of the ageing population, including ageing Hispanics.</p>	<p>The data were encouraging of future study of the isolation, loneliness, and support process, particularly in fast growing populations such as the elderly.</p>

Authors & Title	Age of the subjects	Aim of the paper	Design and Findings	Implications for research
ARTICLE 8 Litwin. H. (2001). The Hebrew University Jerusalem, Israel <i>“Social network type and morale in old age”.</i>	The sample (n=2,079) represented people aged 60 years and older from the Jewish community residing in Israel from 1990 and earlier.	The aim of this research was to derive network types among an elderly population and to examine the relationship of network type to morale.	Design: Secondary analysis of data compiled by the Israeli Bureau of Statistics was employed, and network types were derived through K-means cluster analysis. Respondents' morale scores were regressed on network types, controlling for background and health variables. Findings: Five network types were derived: family, friends, neighbours, restricted and diverse.	Classification of network types allows consideration of the interpersonal environments of older people in relation to outcomes of interest.

Authors & Title	Age of the subjects	Aim of the paper	Design and findings	Implications for research
<p>Article 9</p> <p>Litwin, H & Shiovitz-Ezra, S.</p> <p>(2006).</p> <p>School of Social Work and Social Welfare, Hebrew University, Mount Scopus, Jerusalem.</p> <p><i>"Network type and mortality risk in late life".</i></p>	<p>Adults aged 60 years and older (n= 5,055).</p>	<p>To examine the association of baseline network type and 7-year mortality in late life</p>	<p>Design:</p> <p>Cox proportional hazards regression for the entire sample</p> <p>And separately by age group at baseline: 60-69, 70-79, and 80 and older.</p> <p>Findings:</p> <p>Network types were associated with mortality in the 70-79 and 80 and older age groups.</p>	<p>Practitioners should address older adults' social networks in their assessments of clients and tailor interventions they implement to different network types in which elder clients are embedded.</p>

Authors & Title	Age of the subjects	Aim of the paper	Design and findings	Implications for research
ARTICLE 10 Kawachi, I., & Berkman, L. (2001). Harvard School of Public Health, Boston. <i>“Social ties and mental health”.</i>	Not age specific	It is generally agreed that social ties play a beneficial role in the maintenance of psychological well-being.	<ul style="list-style-type: none"> • The pathways by which social networks and social support influence mental health can be described by two causal models • Protective effects of social ties on mental health are not uniform across groups in society • Gender differences play a part in engagement on support networks, and • Egocentric networks are nested in a broader structure of social relationships. 	Despite some success reported in social support interventions to enhance mental health, further work is needed to deepen the understanding of the design, timing, and dose of interventions that work, as well as the characteristics of individuals who benefit the most.

Authors	Age of the subjects	Aim of the paper	Findings	Implications for research
Greenblatt, M., Becerra, R., & Serafetinides, E. (1982). University of California. <i>“Social networks and mental health: An Overview”.</i>	A selective review paper. Not age specific.	Selective review by the authors of the patterns and characteristics of social networks that maintain health and help prevent illness, explore the relationship between social networks and the course and outcome of treatment for mental illness, and describe clinical interventions that have been used to facilitate inpatient care and maximise performance of ex- patients in the community.	The patient's mental illness may be improved by interventions that make existing social networks more supportive or by the provision of new or additional supports.	Social network concept introduces a new element of rationality in a field that has lacked structure. More research into the mental-health promoting aspects of social networks is necessary.

2.10.3.1 Discussion of Category Three Studies

Beckley (2006) and (2007) focused on the influence of social support for older adults following a cerebro-vascular accident (CVA). Within the two papers different elements of social support derived from the same study are compared. The 2006 article describes the use of the Duke Social Support Index (DSSI) scale (11 items) to measure ‘instrumental’ and ‘subjective’ support. However, in the current research study (The lived experience of older adults in participating in a social support network group) the 23-item DSSI scale was used that additionally measured ‘social interaction’ and ‘satisfaction with social support’. Berkley’s (2007) two papers also highlight the need for health professionals to consider and address what social support and social

network systems are needed by older people when being discharged from hospital.

Granerud and Severinsson (2007) in their qualitative research investigated how knowledge of social networks and integration influenced mental health professionals' understanding and practice. The study identifies the need to expand mental health workers' knowledge about social networks and their functions. The findings highlight that professionals can facilitate a stronger sense of belonging to the local community for people with mental illness. Similar to the study by Beckley (2007), their findings may have implications for professional practice.

Lyyra and Heikkinen (2006) identify social support as a means of maintaining health status where as Guiaux et al (2007) investigate the impact and describe the "changes in contact and support exchange in personal networks after widowhood". These articles do not reference 'group' membership as the specific means of support. The first study is of 80-year-old subjects from the Finnish population, and the second relates to widowhood in older adults highlighting a change in need for contact and support following the loss of a spouse.

Reblin and Unhino (2008) present a comprehensive review of the literature related to "social and emotional support and its implications for health". The authors identified studies that investigated group membership as a way of augmenting other support systems in circumstances of significant illness. Likewise, Tomaka et al (2006) studied relations between social isolation and loneliness and social support to health outcomes. Litwin (2001) reports on network types on an elderly population and the relationship of network type to morale in persons aged 60 years and over in Israel. This quantitative study identified five network types: diverse, friends, neighbours, family and restricted (Litwin, 2001, p. 519).

Litwin and Shiovitz (2006) investigated the relationship of social networks to mortality in older Israelis in a qualitative study and suggested that clinicians be more mindful of including assessment of older peoples' social

networks in client assessment (Litwin & Shiovitz-Ezra, 2006). The outcomes identify implications for professional practice.

Kawachi and Berkman (2001) report on research undertaken to "test the robustness of previous social network research and extend this work to determine if support quality is one mechanism by which network types predict mental health", as the authors claimed that little research had examined the influence of network types on well-being (Fiori, Antonucci, & Cortina, 2006). The study sample included Americans' aged 60 years or older.

Additionally, more than 20 articles on qualitative research methodology and methods were reviewed in relation to the different types of qualitative research methodologies; half of these related to phenomenological research and hermeneutics and hermeneutic phenomenological research methods. In addition, 29 research and philosophy texts, and texts referring to Social Support and Social Networks were reviewed to support the development of the research methodology and methods used to undertake the current study and provide a historical and sociological perspective to the research.

2.11 Summary: Identifying a Gap in the Field of Research

In summary, studies that are strongly associated with the ideas of social support and lower levels of morbidity and mortality were identified and reviewed. While the studies addressed mechanisms by which social support influenced health, none reported on the benefits or experiences that older people receive from coming together with their peers. Continually the recommendations at the conclusion of many papers were for further research into the effects of social participation. Maier & Klumb (2005) make particular reference to the need for further research on social participation through "an examination of the interaction between activity content and social context" (p. 31). Similarly, Howart et al. (2004) suggested that little work had been carried out in Australia to identify priorities for health promotion programs and research in relation to older people (p. 50). Furthermore, Fiori, Antonucci, & Cortina (2006, p. 25) suggested that "very little research has examined the influence of

network types on well being”, and Rasulo, et al. (2005) proposed that “future research investigations should include, when available, some qualitative aspects of older adults’ social ties in later life in order to better examine the underlying dimensions of the social contact” (p. 608). Thorlindsson (2011) supports this claim stating that “we need to employ multiple methods and more mixed method research designs that help us look at ongoing social processes as well as demographic and epidemiological data”(p. 24). Although social network research has had a substantive focus as suggested Berkman et al. (2000), these authors stated that “little of this work becomes integrated with health issues in a way that might guide us in the development of policies or intervention to improve the health of the public” (p. 853).

Such statements from more recent published literature reinforce the need for the current study and justifies the expansion of the research to include a larger sample size and additional quantitative data to offer a robust review and evaluation of social support networks to generate new knowledge and a greater understanding of the experiences of social support and the social support systems of older people.

2.12 Conclusion

Through an extensive review of the literature spanning several decades and a variety of authors, the need for this research study is well established. The benefits of belonging to a group as a means of social and peer support may have for all adults were explored and the analysis revealed that:

1. No studies have explored or described the “experiences” of older people participation in ‘groups’ with peers unrelated to any health condition
2. Limited research studies have sought to evaluate the impact of group participation as an example of a social network system in supporting the quality of life for older people living in the community unrelated to any health condition;
3. Several authors highlighted the need for such groups, identified as ‘mutual aid groups’, and their proposed efficacy for support for

people with mental illness but only one author noted the benefits for older people with mental health problems;

4. Several authors, in their evaluation of social support networks focused on 'instrumental' support, and identified this means of support as social support. However, they also suggested that social support in terms of 'expressive support' needed further investigation to understand the true impact and benefits that this form of support may have on reducing morbidity and mortality among older adults living in the community;
5. More recent research was undertaken on the benefit of social support and social support networks as part of the recovery and rehabilitation process of people with chronic illnesses;
6. Several authors discussed loneliness and social isolation in the context of social support suggesting that these may be addressed by engagement with others through social connectedness and group participation;
7. Howart et al. (2004), in an important paper involving the review of health issues for older adults, identified priorities for both more health promotion programs and health promotion research in relation to older people in Australia;
8. There is a need for health professionals to improve their understanding of patients' needs for social support and access to support networks;
9. The importance of exploring and recording a comprehensive history of older people's social history when undertaking a comprehensive assessment was highlighted, and
10. The need to undertake more work on the conceptualisation of social capital in the context of older people's well-being was proclaimed.

Continuous exploration of the literature further justified the research. Literature on hermeneutic phenomenological, hermeneutic philosophy and interpretive research inquiry provide guidance as to definitions and appraisal of nursing studies using this methodology and accompanying methods along with

many texts on the subject of philosophy and phenomenology. Texts describing qualitative research designs and statistical analysis methods were also identified along with research articles using similar analytical techniques, which are further discussed in Chapter 3 on Theory and Method.

2.13 Reflection on Chapter Two

The literature review continued across the different stages of the research study. However, despite a diligent and ongoing search, no literature was found that investigated the “experiences” of older adults participating in a group as a mean of social support unrelated to a health problem. This significant gap in published research provided justification for the current study.

The reviewed literature focused on social cohesion and the lack of it, and the influence that this has had on the deterioration of social structures and social systems. Definitions of social support and network systems were mentioned and group participation suggested as a means of social support that can be an effective method to assist people of all ages, but particularly older adults, to maintain physical health and functioning and attain feelings of psychological well-being.

While published evidence was found to support the belief that social support can provide significant benefits particularly in terms of health and feelings of well-being, it has not provided adequate empirical evidence of the “lived experiences of social support and group participation” by older adults; and what the constructs of that experience may be. Several authors suggested that it was an issue that warrants further investigation. Published research reviewed for the current study has augmented the researcher’s anecdotal knowledge gained from involvement in the group described in the opening chapter, and supports this current research.

CHAPTER 3

STUDY 1 AND STUDY 2

QUALITATIVE THEORY AND METHODS

This chapter describes the philosophical underpinnings related to Heideggerian phenomenology and hermeneutical philosophy as the qualitative research approach used in study. It describes the qualitative methodology, method and data analysis applied to all aspects of the study to elicit information and a greater understanding about the experiences of older adults living independently who were attending a group for the purpose of social support and networking.

Additionally, Chapter Three describes the development of the study, and the qualitative research model, which was tested with a small number of group members in Study One.

3.1 Introduction

In the previous chapter, reviewed literature pertaining to social support for older people revealed little indicating that the area of interest was understudied (Lopez and Willis, 2004, p. 729). To explore this phenomenon further and to address gaps identified in the literature (Fain, 2009, p. 53; Porter & Carter, 2000, p. 22), a two stage study was developed to increase an understanding, and produce useful knowledge, of social support and of the experiences and benefits of group membership for older adults.

Thus, the two part study employed both qualitative (naturalist or interpretive/constructivist) and quantitative (empirical or positivist) research methods to structure the study, and to gather and analyse information relevant to the study question (Simons & Lathlean, 2010, p. 331; Polit & Beck, 2008, p. 15). Qualitative research is the basis for this type of research and lies within

the interpretive approach to social reality and in the lived experience of human beings (Holloway and Wheeler, 2002, p. 3). The concurrent quantitative methodology further tested those relationships (Porter & Carter, 2000, p. 19) using survey questionnaires.

Building on Study One (n=6) where qualitative methods for data collection and analysis were tested, Study Two used a mixed method (qualitative and quantitative) approach and engaged a larger sample size (n=200). The study has a qualitative foundation, with quantitative methods used to provide complementary information (Elliot, 2003a, p. 31) to add value and perspective to the study outcome.

This chapter introduces the research designs employed to undertake the research. The method and methodology used to undertake the qualitative research component of the study are explained through a detailed examination of the qualitative paradigm and philosophical underpinning of the study and the methods used to complete the research. Methodology and methods for the quantitative paradigm are presented in Chapter 5.

3.2 Research Paradigm: An Overview

Study One tested a qualitative research (naturalist) paradigm to generate knowledge using methods of inquiry that emphasise subjectivity and the meaning of the experience (Polit & Beck, 2008, p. 17; Burns & Grove, 2005, p. 24) for the older adults participating in a group and to develop an understanding of their interpretations of and motivations (Polit & Beck, 2006, p. 220; Porter, 2000, p. 142) for this activity.

Phenomenology, or more specifically Heideggarian hermeneutic (interpretive) phenomenology, which is both interpretive and descriptive (Todres & Holloway, 2010, p. 180; Holloway & Wheeler, 2002, p. 170; Cohen, Khan & Steeves, 2000, p. 9), was chosen as the research methodology because little was known about the phenomenon of interest. Phenomenology is well suited to answering "what" and "how" questions about human issues (Polit & Beck, 2006, p. 19; Whitehead, 2004, p. 514; Holloway & Wheeler,

2002, p. 171; Heidegger, 1962, p. 50). Moreover, the aim of hermeneutic interpretive phenomenology is to identify and provide an understanding of the experiences of others (Polit & Beck, 2008, p. 229; Crist & Tanner, 2003, p. 202). Furthermore, hermeneutic phenomenology, using an interpretive approach states Lopez and Willis (2004), "does not negate the use of theoretical orientations or conceptual frameworks as a component of inquiry" which is then used to focus the inquiry and make decisions about the research question, sampling and the subjects, interpret the data and generate the findings (p. 730).

3.3 Metaparadigm of Nursing

By using hermeneutic interpretive phenomenology, new knowledge and understanding concerning older adults and their socialisation and social networks systems, can be gained highlighting the meanings and motives of those older adults. This new knowledge is gained from an authentic source, i.e., in this study, from the members and participants of groups. In doing so the metaparadigm, or conceptual framework of nursing, which includes the person, the environment, health and nursing are engaged (Fain, 2009, p. 66; Munhall, 2007, p. 84). Nurses, suggested Mullis and Byers (1987, p. 19) and Finfgeld-Connett (2005, p. 4), should be attuned to social support as a factor that affects mental health and pursue methods that bolster the support systems of their patients (p. 19) and nurses, states Finfgeld-Connett (2005, p. 4), should reconsider investigating social support as a nursing intervention.

This metaparadigm is fundamental in formulating the research questions (Munhall, 2007, p. 47; Polit and Hungler, 1999, p. 112) for the current study. It is imperative for nurses to gain appreciation and understanding of the older person in the context of their environment and life events and the relationship that this may have on their health in order to promote or enhance the older adult's wellbeing. So, phenomenology's knowledge development (epistemology) is about revealing meaning rather than developing theory (Crist & Tanner 2003, p. 202; Van der Zalm & Bergum, 2000, p. 212). Hermeneutic phenomenology is about providing identification and understanding of a variety

of constructions that exist related to a phenomenon, and Lopez and Willis (2004) suggested that it is "inquiry about what humans experience rather than what they consciously know" (p. 728). It is the ontology of 'caring' (referred to by Heidegger as *Sorge*) that is concerned with the essential, inescapable part of the make-up of human beings (Edward, 2001, p. 168) for as Heidegger (1962) writes, "Dasein, when understood ontologically, is care" (p. 84). Thus, this research is a caring act, or an act of caring (e.g., about older adults), as suggested by van Manen (cited in Munhall, 2007, p. 163), as the research questions asks for meaning, with the purpose of understanding the human experience (Munhall, 2007, p. 163; Crist & Tanner, 2003), of social support and older adults in the contexts of their psychological and physical needs.

In this study the researcher sought to gain an understanding of the experiences of older adults participating in groups as currently little information existed about this phenomenon. Understanding could be achieved through language and the use of narratives as the linguistic form (Gadamer, 1994, p. 42), which produced autonomous (stand alone) text that was then interpreted to express the meaning of this participation and of group members' "being-in-the-world" (Lindseth & Norberg, 2004, p. 148) or *Dasein* (meaning to exist) as described by Heidegger (Heidegger, 1962, p. 67; Farrell Krell, 2004, p. 19; O'Brien, 2003, p. 195). "Heidegger's notion of being is an explanation of the nature of being and existence and, as such, a concept of personhood" suggested Holloway & Wheeler (2002, p. 174). However, in order to create new knowledge from the inquiry, or research process, several elements (theoretical perspectives) needed to be presented and are discussed in the next section. These formed the foundation for the inquiry and the underpinning philosophical position of the research.

3.4 Theoretical Foundation of the Study

Qualitative research is founded on a number of assumptions (Jackson, Daly, & Chang, 2003, p. 141; Porter, 2000, p. 142). These can be classified into four elements: epistemology, theoretical perspectives, methodology and method (Porter, 2000, p. 142), but Geanellos (2000, p. 112) adds ontology to

this list stating that there are clear connections between epistemology and ontology as does Taylor, (2006b, p. 320). Streubert-Speziale (2003b, p. 4) however, claimed that ontology exists alongside epistemology and Taylor, (2006) stated that Heidegger (1962) considered that ontology and epistemology were one and the same thing (p. 320). The interrelationships of these concepts suggest that: ontology provides the worldview that guides a study, epistemology provided focus for the study, and methodology provides a design for constructing the study (Jackson, Daly, & Chang, 2003, p. 141). Both words, Taylor (2006b, 320) suggests are relevant and integral to nursing research. The following sections will describe all five elements and the relationship of these to the framework of this study.

3.4.1 Ontology

Ontology refers to the study of reality and of being (Grbich, 2007, p. 4; Porter, 2000). According to Porter (2000, p. 143) ontology asks questions about what exists. He suggests that in qualitative research the question is asked about what the subject matter is. He declares it to be 'social reality', of which he states, only "exists as meaningful social interaction between individuals" (p. 143). For the researcher, this is a key principle to discovering where social interaction between older adults and their peers is meaningful to them and the potential impacts on their health and well-being. Because phenomenology asserts that reality is found in people's consciousness rather than in external objects, it is influenced by people's experiences and the social context within which they are situated (Porter, 2000, p. 143). The emphasis on social context is important because it is through contact with others, suggested Porter (2000), "that our understanding and preconceptions about the nature of reality are formed", and "that social reality only exists as meaningful social interaction between individuals" (p. 143).

Heideggerian phenomenology emphasises an ontological foundation of understanding, which is reached by 'being-in-the-world' (Lopez and Willis, 2004, p. 729; Farrell Krell, 2004, p 55; Crist and Tanner, 2003; Annells, 1996, p. 706) or people involved in situations through their concerns, skills and

everyday activities (Polit & Beck, 2006, p. 219). Thus, as Annells (1996) suggests, for hermeneutic thinkers, ontology is primary, where meaning lies in the individual's transaction with the situation and visa versa (p. 708).

Heidegger emphasised the 'Ontology of Being' as opposed to the epistemological question of knowledge (Barkway, 2001). Heidegger (1962) wrote, "Only as phenomenology, is ontology possible" (p. 60). Heidegger (1962) also explained that, "Ontology and phenomenology are not two distinct philosophical disciplines among others. The terms characterise philosophy itself with regard to its object and its way of treating that object" (p. 62).

By understanding 'what it is to know' (ontology) about the participation by older adults in groups, knowledge (epistemology) can be enhanced about this phenomenon, and that will assist in the selection of appropriate methodologies and methods that will aid discovery (Streubert-Speziale, 2003a, p. 20).

3.4.2 Epistemology

Benner and Wrubel (1989, p. 409) in their seminal text "The Primacy of Care", stated that epistemology refers to how and what people know. In the present study, epistemology asks questions about what can be known about what exists or what is our knowledge of older adults' 'social reality?', as suggested by Porter (2000). According to Porter (2000, p. 144), "knowledge of social reality equates with our understanding of the meanings and motives which guide the social actions and interactions of individuals". It is this concept that he believes is the connection between epistemology and ontology, for if social reality is about people's experiences and the understanding of those experiences, then knowledge of reality will be knowledge of those experiences and understandings (Grbich, 2007, p. 8; Porter, 2000, p. 144). Thus, the concept of experience, according to Gadamer (1975), "is the epistemological basis for all knowledge of the objective" (p. 59). This epistemological stance is referred to as meaning and knowledge that is 'constructed' (constructionism) not discovered (Grbich, 2007, p. 8; Crotty, 1998, p. 42) and which is also intertwined with phenomenology (Crotty, 1998, p. 12) for "meanings are

constructed by human beings as they engage with the world they are interpreting” (p. 43). It is socially constructed, coming into being in, and out of, human interaction (Barkway, 2001, p. 192). Thus, constructionism brings the objective and subjective worlds together and mirrors the concept of “intentionality”, described by Crotty (1998, p. 44), as ‘aboutness’ or where “consciousness is always consciousness about something” (Munhall, 2007, p. 160; Holloway & Wheeler, 2002, p. 171; Crotty, 1998, p. 79). It is this concept that rejects the Cartesian Dualism assumption between mind and body or subjective-objective dualism, allowing for the creation of an interaction between subject and object (Munhall, 2007, p.161; Holloway & Wheeler, 2002, p.170; Crotty, 1998, p.45) or human beings (subject) and their world (object).

3.4.3 Theoretical Perspective

Theoretical perspective refers to the philosophy that guides methodology (Crotty, 1998, p. 66). Phenomenology and specifically hermeneutic phenomenology guided development of the qualitative elements of this research. The purpose of phenomenological research is to describe particular phenomena as lived experience (Polit & Beck, 2006, p. 219; Streubert-Speziale & Carpenter, 2003, p. 51-52) and to explore the inner world of human beings describing the essences (related elements) of that lived experience (Fain 2009, p, 203; Polit & Beck, 2006, p. 219). The “phenomenology of everydayness” reflects the totality of human existence that includes mood, the capacity for the individual’s authenticity, and one’s involvement in the world and with others (Fain, 2009, p. 203; Polit & Beck, 2006, p. 219; Audi, 1995, p. 317; Heidegger, 1962, p. 38). Through this study the older person’s involvement in the world is explored, via that part of it that represents their participation with other group members and the influences that their involvement has on their lives.

3.4.3.1 Phenomenology

The term ‘Phenomenon’ comes from the Greek work *phainomenon* meaning an appearance, and *logos* meaning a reason or law (Shand, 1994, p. 237).

Phenomenology wrote Heidegger (1962) is “*the science of phenomena*” and “signifies primarily a *methodological conception*” (p. 50). The formal meaning to phenomenological research, as stated by Heidegger (1962), is “to let that which shows itself be seen from itself in the very way in which it shows itself from itself” (p. 58). ... “With regard to its subject-matter, phenomenology is the science of the Being of entities-ontology” (p. 61).

Phenomenology, according to Carpenter (2003, p. 52) and Burns & Grove (2005, p. 55), is the study of phenomena and Grbich (2007), suggests that it be used “when the rich detail of the essence of people’s experiences of a phenomenon is to be explored, described, communicated and possibly interpreted” (p. 84). Through the phenomenology that informs this study, the researcher examined older people’s perceptions about being involved in a group setting, and reported on accounts of situations and events in their lives and explored the subjective experiences of group participants. Furthermore, phenomenology allowed the researcher to concentrate on the participants’ experiences rather than concentrating solely on them or on objects (Polit & Beck, 2006, p. 219) or events. It also allowed the researcher to view human experience in the complexity of its context, and its relationship to things and events (Polit & Beck, 2006, p. 219). This description of older people’s lives created a new epistemological paradigm in that new knowledge and a deeper understanding was acquired about the meaning of everyday lived experiences (Burns & Grove, 2005, p. 55) of older adults living in the community and their engagement in social support and social network systems.

3.4.4 Methodology

Methodology is the design or plan that guides the research method to gain knowledge about ‘what exists’ (Porter, 2000, p. 145). In both Study One and Study Two, hermeneutic phenomenology used intuitive knowledge to provide a pathway for identifying the essence (essential meanings, e.g. emotions) of the experience of older adults attending a self-help group (the phenomenon of interest) (Polit & Beck, 2008, p. 64; Grbich, 2007, p. 84). Because the aim of the present research was to explore the experiences of

group members, by capturing what it means for them to be a member of a group and understanding the impact the group has on their current life situation, quantitative research alone would have been limiting in that it would have restricted data collection and not explained the meaning of group participation for each older person.

Philosophical hermeneutics underpins hermeneutic phenomenology, and is the basis of interpretive enquiry where the aim is to provide interpretation and understanding about the phenomenon under study (Grbich, 2007, p. 91). In this methodology Cartesian duality is rejected (Streubert-Speziale, 2003b, p. 3) but the opportunity to understand and reconnect with others is offered (Grbich, 2007, p. 91). With this methodology the researcher was able to focus on investigating, describing (Polit & Beck, 2008, p. 229) and identifying the features, characteristics, or attitudes that made the group phenomenon what it was (Polit & Beck, 2008) therefore, gaining a greater understanding of the human experience (Crist & Tanner, 2003, p. 202) in this study of group participation and group membership. This methodology provides a greater insight into our world and those within it (Lindseth & Norberg, 2004, p. 151) through interpretation of the phenomenological text or ‘transcript’ (Lopez & Willis, 2004; Van der Zalm & Bergum, 2000, p. 212). Hermeneutic methodology, claimed Gadamer (1975), provides a means to “understand what the human sciences truly are, beyond their methodological self-consciousness, and what connects them with the totality of our experience of the world” (p. xiii).

3.4.5 Method

Method refers to the set of activities or actions employed to achieve the research outcome consistent with the methodology (Holloway & Wheeler, 2002, p. 35; Crotty, 1998, p. 6). Both Husserl (1857 – 1938) and Heidegger (1889 – 1976) developed philosophies referred to as phenomenology, Heidegger introducing hermeneutic interpretive phenomenology. However, neither developed methods these methodologies; hence no standard method exists for text analysis (Taylor, 2006b, p. 339; O'Brien, 2003, p. 198) other than

different methods developed over time derived from German texts (Geanellos, 1998a). Therefore, despite the distinct philosophical schools of phenomenology (Husserl being Transcendental and Heidegger Existential) there are no specific rules for conducting phenomenological research that reflect these schools of philosophical thought. Thus, there is no one legitimate way to proceed with phenomenological investigation (Carpenter, 2003, p. 57) and a number of procedural interpretations of method may be used in mixed or combined ways.

Despite the different approaches used to conduct hermeneutic phenomenology, there is consensus that phenomenology in general terms is the study of ‘essences’ (elements) (Grbich, 2007, p. 84), of the way people experience their world, what it is like for them and how best to understand it (Grbich, 2007, p. 85), thus, emphasising the individual’s construction of their ‘life world’ (Carpenter, 2003, p. 53). To achieve this, the present researcher collected descriptions from elderly group participants using focus group conversations (interviews). These were used to gather data about what existed, specifically about the meanings and motives of the social players, by allowing participants to describe and explain the meanings and motives, which provided the basis for their actions and interactions with others (Grbich, 2007; Harrison-Barbet, 2001).

3.5 Hermeneutic Phenomenology

This section describes the hermeneutic phenomenology used to achieve the research objectives. In this methodology there are no specific methods identified for data collection and analysis, however, several philosophers, such as Heidegger and Gadamer (Heidegger’s pupil) offer options to guide the research process. Heidegger (1962) wrote that “the meaning of phenomenology description as a method lies in *interpretation*” (p. 61) ... or “hermeneutic as an interpretation of Dasein’s Being” (p. 62).

In this study, the researcher used interpretive hermeneutic phenomenology to describe and interpret the members’ experiences and

'essence' of their experiences (Grbich, 2007, p. 84). The method recognised the "emic" (natural) perspective (Polit & Beck, 2008, p. 225; Jackson, Daly, & Chang, 2003, p. 140) of the group members by allowing participants to express what was significant to them, thus reducing the potential to produce superficial narratives of the social phenomena under study (Grbich, 2007, p. 92). It also encompassed inter-subjectivity, or "gestalt", where each person was filled with the realisation of 'the Other' and had access to those experiences through association with others (O'Brien, 2003, p. 195). Existentially, "one is never without others" and 'Being-in', suggested Heidegger (1962), is 'Being-with Others' or the social element of engagement and connection with others. This was obvious during the interview process where all participants acknowledged each other's opinions and lifelong experiences. The nature of being human, Heidegger further suggested, is awareness or concern about one's own being-in-the-world (existence), which allows people to care about each other and acknowledges that each of us have physical ties to the world through our body's interaction with the world, a concept often referred to as "embodiment" (Polit & Beck, 2008, p. 227). Heidegger's perspective, and his concept of being-in-the-world or 'Dasein', coupled with the acknowledgement of the lived experience, is the foundation of phenomenological research (Grbich, 2007, p. 90). Additional elements of interpretation and understanding create hermeneutic phenomenology, which according to Polit & Beck (2008, p. 223) locates us historically in time and place and culturally through beliefs and values, in relation to others and the world in general.

In hermeneutic phenomenology there are three main steps: naïve reading, structural analysis, and interpretation of the whole text. This process is referred to as the hermeneutic circle where the analysis proceeds from the naïve reading to the explicit understanding of the data (Streubert-Speziale & Carpenter, 2003), i.e. the researcher moves back and forth between excerpts from the data and the emerging description from what was recorded and transcribed (p. 63) considering each part of the text in relation to the whole (O'Brien, 2003, p. 198).

In this study, the ideas of Hans-Georg Gadamer (1900 - 2002) also informed the inquiry. The key ideas identified in Gadamer's writings are the exposure of prejudices or biases (referred to as pre-understandings or fore-structures), dialogue or the hermeneutic conversation, reading and interpreting the text referred to as entering the 'hermeneutic circle' (of whole and part), and confirming the interpretation of the text resulting in "the fusion of horizons", the aim being to understand (the text) through the fusion of horizons (Grbich, 2007, p. 91; O'Brien, 2003, p. 196; Koch, 1999, p. 31; Gadamer, 1975). Therefore, in order to correctly use hermeneutic phenomenology as the method for this research, the following steps were acknowledged.

The first step was identification of the researcher's pre-understandings "or foreknowledge", "that is, a prior awareness of situations" (Harrison-Barbet, 2001, p. 415), knowledge and experiences that have developed over time, and have been influenced by tradition, culture, history and language (O'Brien, 2003, p. 196; Harrison-Barbet, 2001, p. 415). The second step was interviewing participants, or creating a hermeneutic 'conversation' (Koch, 1999, p. 26) between participants and the researcher. Step three is naïve reading, the text being read several times to gain understanding as a whole, enabling the identification of themes and guiding 'thematic structural analysis' (Lindseth & Norberg, 2004, p. 149). Step four is about interpreting the text characterised by a forward-backward movement (Harrison-Barbet, 2001, p. 416) (including the smaller elements in relation to the whole text and the researcher's understanding of the text) or the analytic movement between the whole and the part (Whitehead, 2004, p. 513), described as entering the 'hermeneutic circle' (Lindseth & Norberg, 2004, p. 149; Harrison-Barbet, 2001, p. 416). As dialogue progresses, argues Gadamer, understanding of the text "can be achieved and an approximation to the ideal meaning attained" (Harrison-Barbet, 2001, p. 416). The final step is the researchers confirmation of the interpretation, commonly referred to as the 'fusion of horizons', where mutual understanding of the text is achieved by bringing past understandings of the researcher, together with the new understandings (O'Brien, 2003, p. 196; Annells, 1996, p. 707) as expressed by the participants. The 'horizon', was described by Gadamer as, "the field of vision, which includes and comprises

everything that can be seen from one perspective" (Fleming, Gaidys & Robb, 2003, p. 117).

To reflect the described methodology and undertake this method of hermeneutic inquiry, the researcher, therefore, acknowledged her pre-understandings (knowledge, beliefs and assumptions about the benefits of group participation) in order to allow the experiences expressed by participants in the interview texts (Lindseth & Norberg, 2004, p. 146), to be interpreted and thus reveal what they thought was important about the phenomenon (Todres and Holloway, 2010. p. 183; Geanellos, 1998b, p. 238). The pre-understandings or biases of the researcher in relation to this study was that support, through regular peer group participation, would enhance participants' psychological and physiological wellbeing and form a significant social network system of support for older adults.

Unlike the phenomenology described by Husserl, Heideggerian hermeneutic phenomenology does not use bracketing or "phenomenological reduction" in its method despite the practice permeating through other phenomenological methods (Todres & Holloway, 2010, p. 181; Polit & Beck, 2006, p. 221). The hermeneutic approach interprets human action from a practical perspective through which the larger social context of meaning is embedded (Grbich, 2007, p. 90; Polit & Beck, 2006, p. 221). Therefore, it is more interested in the social meaning rather than the individual meaning of actions (Grbich, 2007, p. 90). The ethos embedded in existential (experience as it exists) phenomenology is respect for the social and cultural nature of being human, says Benner (1994, p. xv), of which aspects such as participation, relationships and human concern, constitute membership (p. xvi), and thus the bracketing of existence is denied (Grbich, 2007, p. 91). Instead, the researcher acknowledged her preunderstandings (knowledge, beliefs and assumptions) or forestructures in order to allow the experiences expressed in the interview texts (Lindseth & Norberg, 2004, p. 146) to be interpreted to reveal what was important to the participants and of the phenomenon being studied (O'Brien, 2003).

Since interpretive phenomenology aims at not merely describing but also interpreting and documenting as completely as possible it is vital that the lived experience and subjective feelings of what is being studied is seen from the participants' perspective by engaging in discussion with them. As the accounts of those experiences, through language, created the primary data source, the researcher found that this produced rich and descriptive data (Grbich, 2007, p. 92). Hermeneutic phenomenology was chosen because it has both descriptive and interpretative elements (Van der Zalm & Bergum, 2000, p. 212) and the primary focus of philosophical hermeneutics is on interpreting (Grbich, 2007, p. 91) and understanding (Gadamer, 1994, p. 42). Furthermore, the interpretive dimension of phenomenological research enables it to be used as the basis for practical implementation, allowing it to inform, support or challenge policy and action (Munhall, 2007, p. 154) and broaden possibilities for nursing interventions (Crist and Tanner, 2003, p. 205).

3.6 The Participant Recruitment Process

In Study One only six of the ten possible participants who met the inclusion criteria for the study, agreed to participate, despite all members acknowledging that the study was worthwhile. This response was disappointing, as the researcher had experienced prior eagerness by group members who had clearly articulated their interest in and support for the group to the administering authorities (see Chapter 1, Section 1.7.4). While the small number reduced the information able to be gathered it enabled various practical aspects of the methodology to be trialled and tested. Potential participants were identified for the second study through meetings with group advisors (RSL NSW Branch Office) to engage groups that they facilitated (see Chapter 1, Section 1.9). However, for Study One the researcher met with the group facilitator to organise a day to meet with group members. On two separate occasions, on a day when the group regularly came together, the researcher organised to meet with group members. The purpose of these early meetings was to inform all group members about the research project and why it was important, also, to invite members who were interested in volunteering to participate in the study. Following these information sessions,

study participants were recruited. The focus group interviews for Study One were conducted with the six participants, undertaken in their natural setting (Polit & Beck, 2006, p. 31).

3.7 Ethics Application

Originally, ethics approval was received for this study from two sources. These were: the Australian Catholic University Human Research Ethics Committee (ACU HREC) (Appendix 1) and the Ethics Committee of the Hospital, where Study One participants met together in their routine meeting place. For this particular group, the study took place in the grounds of the hospital facility; therefore, written approval was sought from that organisation. Participants from other groups, for example, those from the Day Club Groups, who could be involved in the Main Study, came under the jurisdiction of the Australian Catholic University (ACU) Human Research Ethics Committee (HREC) guidelines.

3.7.1 Ethics Approval

Following Ethics approval, Study One using focus group interviews was conducted. While hospital approval was given, as members of that Ethics Committee were familiar with the group's activities, the ACU HREC initially gave only conditional approval. There were two key ethical protocols that underpinned the ethical endorsement of the study by the ACU HREC. Two issues required further clarification before approval was given:

- Written confirmation that, participants, because they were elderly, were not at risk of distress or ill health and that they could provide informed consent.
- Details of participants' access to counselling needed to be arranged for any participant who became distressed or required emotional support as a result of the interview.

The researcher, to the satisfaction of the ACU Ethics committee, addressed the issues of concern and written approval was received in October 2003. Ethics approval provided by the ACU HREC also covered Study Two.

3.7.2 Ethical Protocols

The researcher observed all ethical protocols for the groups engaged in the study, which included the issues of respect for the participants and integrity in conducting the research. Guiding these values were beneficence, which included confidentiality and anonymity.

3.7.2.1 Beneficence - Confidentiality and Anonymity

The study protocols included the distribution of ‘Participant Information Letters’ (see Appendix 2) ensuring that all participants fully understood the reason for the project and detailed information of what was expected of their participation in the project. The purpose of the study was explained to participants along with potential benefits that the study could yield. Participants were informed that information collected at interview would be audio-taped and transcribed into a ‘password’ protected computer: the password only known to the researcher. Hard copy data would be safely stored in the office of the researcher in a locked cabinet.

Because of the nature of group conversations, anonymity could not be guaranteed (Holloway & Wheeler, 2002, p. 115) as group members were able to identify each other. However, participants’ identities, after the focus groups concluded, would be protected through the assignment of a pseudonym, only known to the researcher. Focus group data collection meant those participants’ identities would be known only to each other. Thus, the researcher ensured confidentiality and informed the participants of the protocols for recording and storing the information collected from interviews and questionnaires, and that individual participants would not be identifiable by others. It was also explained that the study findings would be published in journals and presented at conference meetings, or used for educational

purposes. No objection to these activities was expressed by intending participants.

3.8 Study One

Study One took the form of a small-scale trial of the research method using a small sample size (n=6) to ensure that the design was appropriate for the study of the phenomenon of interest.

3.8.1 Why a Preliminary Study was Undertaken

While a preliminary study is not considered necessary for qualitative research, Lacey (2010) suggests it is advisable (p. 22). The researcher on this occasion believed that it would be useful as it would represent an exploratory exercise and allow potential problems to be discovered and avoided (Burns & Grove, 2005, p. 42) before moving on to undertake further data collection in Study Two.

Study One facilitated trialling of questions and interview procedures (Lacey, 2010, p. 22). The questions were piloted in order to determine their usefulness in achieving the research aim which was to explore and interpret, increase the understanding, and reveal personal and social experiences of well older people engaging in peer support groups and social network systems who may have had a range of health problems including mental illness, and to develop a rich and full description of that experience (Polit & Beck, 2006, p. 221).

In keeping with the phenomenological methodology, it was anticipated that key questions would provide direction for the second study. Therefore, the aim of Study One was to:

- Test an interview tool (semi-structured questions asking "What is being a member of the group like?")
- Try out interview techniques (the method used by the researcher to engage study participants)

- Test interviewing equipment (audio-taping), and
- Evaluate the need for any changes to the planned method for Study Two.

3.8.2 Inclusion Criteria

Each participant had to be a regular and consistent member of the group for at least 6 months in order to be able to discuss their experiences and what the group meant to them over time. Participants were over the age of 65 years.

3.8.3 Engaging the Study Participants

The researcher approached members of the existing hospital-based group (see Section 1.6) who were regular attendees of the social group, to engage in a one-off focus group interview. Six members (two males and four females) of the group agreed to participate in the first study. All participants were informed of the purpose of the research, reasons why the research was important, how it would be conducted, and what would happen with the findings. Participants provided their written consent to participate in the study at the time of the focus group interview.

Members who volunteered to participate in Study One were provided with specific details of the study and a clear explanation of their right to withdraw at any time from the study. As research participants they were also informed that:

- Names of participants would only be known to the researcher
- There would be potential publication of results in a refereed journal relevant to the area of study, however, participants' names would not be published
- There would be presentation of results at conference meetings
- Information would be kept in locked filing cabinet drawer of the Chief Investigator and only accessible by the researcher, and

- Counselling would be made available should this be required, e.g. if participants became upset during the interviews. The name of a nominated professional person was identified as per the Ethics Application.

The venue and meeting time was also discussed. The focus group was conducted as part of a regular group meeting time, but in a separate section of the hospital where the group met.

3.8.4 Study Participants

Two males and four females made up the focus group. Five participants were living in the community independently. The sixth participant was currently in residential care but had been living independently at the time he first joined the group having lived with his son until his sudden death. Two participants were carers; one was caring for her sick husband, the other for her ill son. There was no suggestion of cognitive decline in any of the participants. All group members reported being keen to participate in the study group and expressed their opinions about the group, and their experiences within the group.

3.8.5 Consent to Participate in the Study

Consent letters were provided, along with Participant Information Sheets as required by the two Ethics Committees and in the format identified by the Australian Catholic University Human Ethics Research Committee and the Hospital where the first study took place.

Each participant provided written informed consent to participate in the first study. Consent protocols were addressed and all participants were provided with the opportunity to sign the Consent Form prior to the study which briefly highlighted the aim of the study, an outline of the study, and possible implications of the study, a copy of the Participant's Information Letter (Appendix 2), and the Consent Form (Appendix 3) which was kept by

participants (if requested) and a copy kept by the researcher. The researcher assured each participant that their involvement in the study was purely voluntary and that they had the right to withdraw from the study at any time without penalty and without their association with the group being compromised in any way.

3.8.6 Setting

The research setting for Study One used a “naturalist paradigm” (Polit & Beck, 2006, p. 31; Munhall, 2001, p. 68), which was the familiar setting (hospital environment) where these elderly people, group members regularly met for the purpose of support and companionship.

For Study One, two focus group interviews were conducted by the researcher in a small room, where the group usually met, located on the ground level at the rear of the hospital. This area was familiar to all study participants and was easily accessed. A date was chosen when there would be no outpatient’s clinic held on the day of the interviews. Therefore, the area was quiet and privacy maximised. The room was also chosen because of the nearby availability of facilities such as a bathroom (toilet) and a beverage bar for refreshments. Cold water was supplied to the participants during the interview. The room had climate control (air conditioning), which was important as the first study was undertaken during the summer and the comfort and health of these older participants was of central concern and importance to the researcher.

3.8.7 Questions

The primary question for the preliminary focus group interview was: What is the essence of this phenomenon as experienced by these older adults? (Fain, 2009, 208; Taylor, 2006b, p. 341). The essence of the question related to the elements or patterns linked to the true meaning of something that will give common understanding to the problem being investigated (Munhall, 2001, p. 106; Fain, 2009, p. 212). In other words, they were asked, “What has been the

experience of group membership for you?” (Grbich, 2007, p. 84), which reflects Crist and Tanner’s (2003, p. 203) suggestion in their study on ‘Receiving Family Care’, “How central, for elders, in their everyday concerns and practices, is the experience of group participation?” The questions were designed to “elicit both definitive and unexpected kinds of information” (Munhall, 2001) and to guide the discussion and encourage free verbal interaction and comments by all participants regarding their social support network systems; the impact that this may have been having on their health and well-being; and any other variables that may have been influencing their current life situation. The in-depth conversation, between researcher and study participants, was guided by such questions as:

- Why does this group meet?
- What does the group mean to you?
- Tell me about the group in your own words?
- How were you introduced to the group and how long have you been a group member?
- How important is the group to you? Can you give me some examples?
- What are three features of the group that you really like or find particularly helpful or haven’t found helpful?
- What is it that this group contributes to your situation that other social support groups do not?
- What would it mean to you if this group did not exist?

As the first study was a trial of the methodology, it was not necessary to ask all of these questions nevertheless most were addressed through the natural flow of the conversations between researcher and participants.

3.8.8 Data Collection

Data collection for Study One involved two semi-structured audiotaped informal group conversations (“interviews”) on the topic under study, which ensured that the whole interview was captured as suggested by Polit & Beck (2008, p. 60 & 389) and Carpenter (2003, p. 68). This method allowed the researcher to discover and understand each participant’s perspective

concerning the group, its aims, purpose, process, style and outcomes and in particular the lived experience of group membership and what affect this had on each of their lives.

Several predetermined semi-structured interview questions were designed by the researcher to guide the discussion, should that be necessary, but importantly, to generate discussion and allow participants to build on the responses of others in the group creating unexpected kinds of information (Burns & Groves, 2005, p. 545). However, following the initial question of Why does this group meet? and What does it mean to you? there was free verbal interaction by all participants regarding their social support network systems; the impact that this had on their health and well-being; and the identification of other variables that influenced the experiences of the group. Many responses confirmed the researcher's pre-understandings of the phenomenon under study (Geanellos, 1999, p. 40). Any questions that followed were for the purpose of clarification.

3.8.9 Focus Group Conversations

There were two conversation (interview) sessions for Study One each with three participants. Both focus group interviews (three in each: one male and two females) lasted for approximately 1.5 hours each. The interviews were audio-taped using a TDK D90 IEC/Type 1 audiocassette tape and a Marantz CP 430 cassette recorder. This ensured that the whole interview was captured as recommended by Hancock (1998, p. 14) for analysis.

As the participants already knew the researcher, a sense of mutual trust developed quickly between the researcher and the participants, which allowed for enthusiastic and genuine discussion. The word "qualitative conversation" is preferred (Jackson, Daly, & Chang, 2003, p. 146) as opposed to interview as it implies discussion that captures the attitude that interaction between the parties involved and is therefore, not one sided. This was found to be the case throughout the focus group process as all participants engaged in conversation supported each other's comments and spoke freely about their experiences as

a group member. These conversations allowed the researcher to discover and understand each participant's perspective concerning the group, its aims, purpose, process, and outcomes and in particular, what was the lived experience of older people in relation to group membership and how this impacted on their lives. This process created the hermeneutic conversation, and along with clarification of comments with participants, enhanced the researcher's understanding of the text and was a way of promoting the 'fusion of horizons' as noted by Harrison-Barbet (2001, p 416) and Geanellos (1998a, p. 157).

Each participant expressed gratitude for the opportunity to be interviewed about the group's role, purpose, and the benefits they experienced from being a group member. Despite expressed problems with transport for the group (such as inconsistent access to a bus and some other logistical issues, e.g. lacking a permanent area within the hospital grounds that they could call their own), all participants reported being very grateful that the group existed. At the completion of the focus group interview, the researcher thanked all participants for their time and participation in the study.

3.8.10 Analytical Methods

Although there are no standard methods (O'Brien, 2003, p. 198), several data analysis methods exist in phenomenological research, all requiring inductive reasoning and synthesis (Taylor & Roberts, 2006b, p. 7; Fain, 1999, p. 175).

Phenomenology was developed into interpretive philosophy by Heidegger and became the basis for philosophical hermeneutics, a method of inquiry which, according to Holloway & Wheeler (2002), involves "interpreting the messages for the recipient to aid understanding" (p. 175). "Gadamer (1975) suggests that human beings' experience of the world is connected with language" (Holloway & Wheeler, 2002) and according to "Gadamer's view, language gains its authentic life only in conversation..." (Silverman, 1991, p. 4).

Regardless of the methods used, the primary activity of the researcher is to become immersed in the data in order to identify the themes that will reflect the study participants' experiences as described by them and extract significant statements (Taylor, 2006c, p. 459; Carpenter, 2003, p. 69; O'Brien, 2003, p. 198). Hermeneutic phenomenological interpretations derive their entire content from what is normally hidden in the human experience (Taylor, 2006a, p. 337; Lopez and Willis, 2004, p. 728). Therefore, the purposes of data analysis in this hermeneutic phenomenological study were to "uncover and produce a description of the lived experience" (Polit & Beck, 2006, p. 219; Lopez and Willis, 2004) and describe the essences (or characteristics) of the lived experiences explored (Burns & Grove, 2005, p. 55; Lopez and Willis, 2004, p. 729). According to Lopez and Willis (2000, p. 729), "it is the interpretation of the narratives provided by the participants in relation to various contexts that is foundational to hermeneutic phenomenology".

3.8.11 Thematic Analysis

The recorded conversations were transcribed onto computer disks, within a week of the interview, for storage by the researcher. Transcribing produced a written version of the conversation (interview) (Hancock, 1998, p. 14) that then became the descriptive material, or as described by Lindseth & Norberg (2004) "a text that expresses its own meaning" (p. 148). Following this process the text was read several times (naïve reading) and interpretation of the text was undertaken, the data being explored and analysed to reveal themes, or threads of meaning that frequently occurred in the text known as "thematic structural analysis" (Taylor, 2006c, p. 459; Lindseth & Norberg, 2004, p. 148). This was undertaken by searching for specific words or combinations of words within the transcribed text, e.g., companionship, feel like family, friendship. Collections of these words or phrases were then clustered together to develop themes. The themes were recognised as they resembled what was being explored as suggested by Taylor (2006c, p. 461). The themes being drawn together were from smaller patterns (Taylor, 2006c, p. 461) of fragmented ideas or experiences, behaviours, and patterns of living, which assisted in the explanation of participants' experiences of the group (Leininger,

1998, p. 60-61). Where relevant, tone and inflection of participants' responses were noted giving insight into the feelings and meaning within the text. The repetitive nature of the data suggested to the researcher that saturation had been reached (Streubert-Speziale, 2003a, p. 25). No new information was being generated from the conversations and the possibility of new ideas had been exhausted.

The method of analysis for Study One reflected the work of the hermeneutic phenomenologist Gadamer (1990-2002) who identified six key principles, and these were adopted for this research study:

1. All subjects' oral or written descriptions were read in order to obtain a feeling for the whole.
2. Significant statements and phrases related directly to the phenomenon were extracted.
3. Meanings were formulated from these significant statements and phrases.
4. Meanings were clustered into themes.
5. Results were integrated into an exhaustive description of the phenomenon.
6. The researcher returned to the participants with a description of the themes identified for validation by the participants (Attride-Stirling, 2001; Munhall, 1994, p. 259).

During the interpretive process, the research reviewed the project aims and objectives in order to assist in recognising the themes and address what the study was about (Taylor, 2006c, p. 460). Importantly, the researcher reviewed her pre-understandings of the benefits of group membership, which allowed entry into the “hermeneutic circle” and the movement from parts of the text to reflect the whole of the text (Whitehead, 2004, p. 513). Thus, three common themes were drawn together from smaller patterns of fragmented ideas categorized as sub-themes with particular characteristics relating to experiences, behaviours, and patterns of living as stated by the participants and interpreted by the researcher. These contributed to the development of a central theme and assisted in the explanation of human behaviour (Lopez and

Willis, 2004, p. 730). A number of quotations are used to support the findings as interpreted by the researcher using pseudonyms. These are provided in Chapter Four: Qualitative Findings for Study One.

3.9 Reflection on Chapter Three

This chapter described the methodology and processes undertaken to conduct Study One and to introduce to Study Two. In so doing, philosophical paradigms were examined, in particular Heideggerian phenomenology and Gadamerian hermeneutics. Key components of the research process were presented and discussed and included ethics approval, a description of the study participants and the recruitment process, and the consent protocol, including information for participants. Additionally, the researcher declared her pre-understandings, which along with the processes described, ensured research credibility. Data collection methods for the qualitative part of the research study were described in detail.

CHAPTER 4

STUDY 1: QUALITATIVE FINDINGS

This Chapter presents the findings developed from qualitative analysis of data collected during focus group conversations for the preliminary study.

4.1 Introduction

Heideggerian phenomenology and Gadamerian hermeneutics were employed to analyses data collected from conversations with group attendees with the aim of providing interpretation and understanding about the phenomenon under study. Themes were developed from this data and the findings are presented in this chapter.

4.2 Findings

The global or overarching theme that emerged from Study One findings was named **Support** by the researcher as it depicts the “true meaning” of what was described by participants and provides a focus for the three common themes and sub-themes that emerged from the data.

Support as an essence or element that emerged from Study One findings, and as described by the participants, had several characteristics. These characteristics were classified into common themes, which reflected a variety of other elements further classified into sub-themes. The frequency of the occurrence of the characteristics within the text determined the importance they had for the participants and thus contributed to the development of common themes and sub-themes. The three common themes identified from within the text were:

- i. ‘Finding Friendship’, with four sub-themes of companionship, trust, respect and bonding,

- ii. 'Essence of Life' with four sub-themes of acceptance, being needed, understanding, and achieving, and
- iii. 'Learning to Adapt', with three sub-themes of confidence, disclosure and giving.

Figure 4.1: Model of Support Group Experiences.

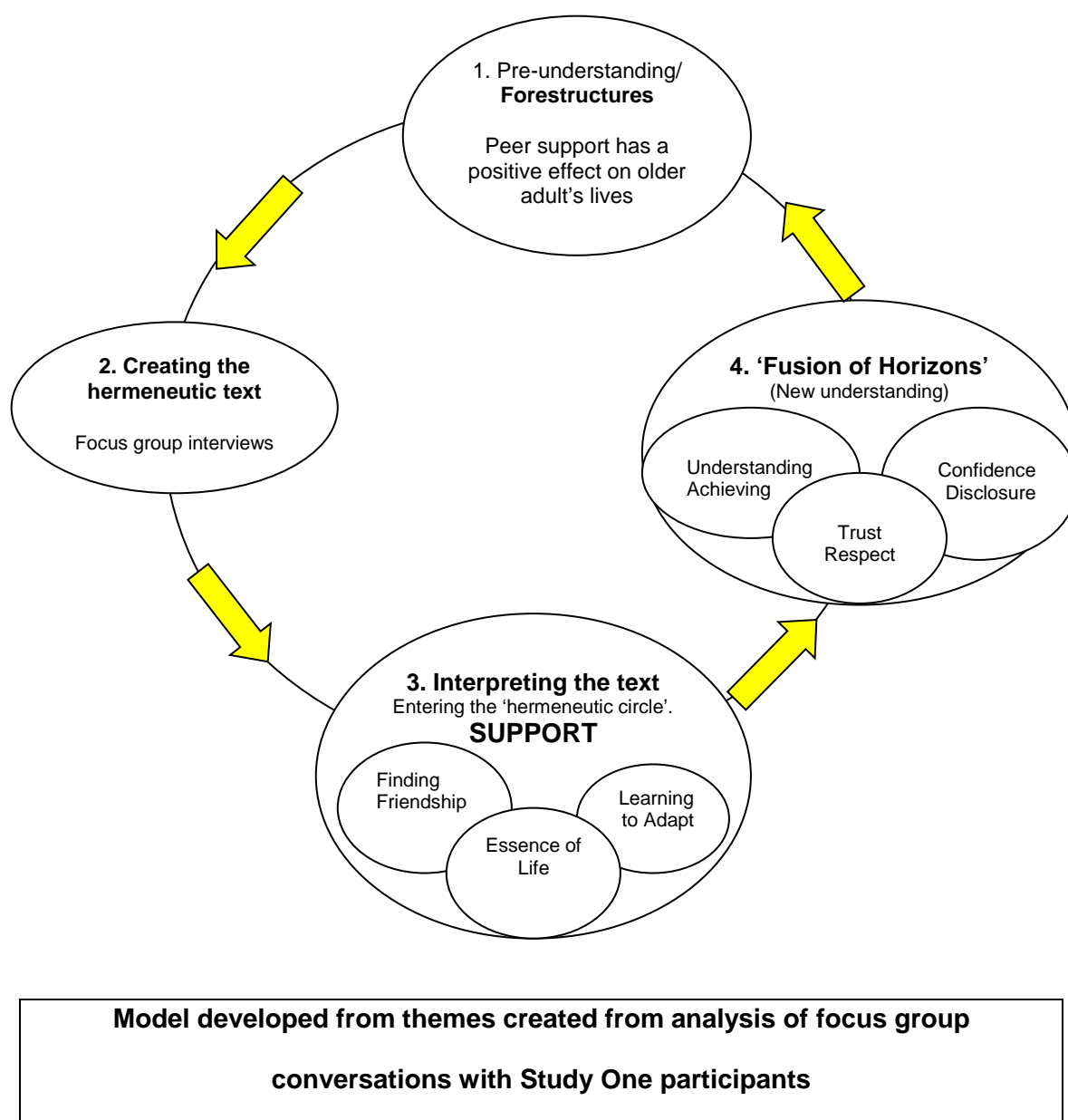


Figure 4.1 illustrates the four steps in the process of gaining understanding of the whole text which is the point of analysis and influences the understanding of other parts of the text. The first step involved identifying the researcher's pre-understandings, second: the creation of the text, third: the identification of themes from the text, and finally, the fusion of understanding of

the text between researcher and participants. Movement back and forth within the text created the identification of sub-themes and allowed the pre-understandings to be fused with new understandings expressed by the participants creating the "fusion of horizons".

4.2.1 Central Theme: Support

The findings of Study One reflect the idea of Support described by the seminal author Caplan (1974) as being, "...of a continuing nature mediated by an enduring set of relationships with one or more significant others or groups that help the individual with the general issues of life..." (p. 6).

Support, as the central theme, was expressed as an experience that was fundamental to all other themes identified. All sub-themes were identified as concepts within each of the common themes and have some connection or interrelationship with each other describing the "hermeneutic circle" where there was movement from the whole to part and from part to whole of the text. This interpretation is expressed diagrammatically in Figure 3.1 and acknowledges that the importance of received support encapsulates all the elements identified in the themes that were real and important to the participants. The sub-themes described what Support meant to the participants as individuals and what they experienced by engaging with other group members. The identification of these themes clearly correlated with the description offered by Caplan (1974) as to what constitutes support. Support provides the members of the group with a set of relationships, a sense of belonging and self-worth and acceptance. Furthermore, the themes and sub-themes offered a rich and detailed understanding of what group membership meant while challenging and enhancing the researcher's pre-understandings.

When asked by the researcher, if the group provided support for the participants, there was an overwhelming and unanimous positive response. They acknowledged that it was the support element that was unique to this group compared to other types of groups or social support network systems

that they had experienced. Such support also offered companionship, the group being their main support and for most, their only social network system.

When the researcher began the focus group interview with the initial question of, What does this group mean for you? Betty, without hesitation, explained that being a member of the group had

.....been a salvation for her as a carer.....

and provided her with an

.....extended family who really care.....

When asked by the researcher, if the group provided support for the participants, there was an overwhelming positive response by all. When asked what it is about this group that contributed to the participants' situation that other social supports groups did not, the response from Betty was that:

*This group is so important because they can give us
that support because they know our situation....
because really we're in another form of
rehabilitation.*

For some, the group is their main support and only network system. They believed that meeting with other group members created companionship and support and allowed information to be transferred between each other.

Immediately following this statement by Betty, Ben proclaimed that the group was his:

.... main support,

and the person identified as Sue, declared that the group gave her the opportunity to have:

...Someone to talk to and get away from my worries...

She said that through the group she received:

Companionship

from other members of the group and this statement was reinforced by others.

The group participants stated that this sense of support was unique to this group compared to other types of groups or social support and network systems because everyone knew their situation and accepted each other as they were.

4.2.1.1. Finding Friendship

The first common theme to emerge within the context of support was *Finding Friendship*. For the purpose of this study friendship is defined as companionship, trust and bonding (as identified in the sub-themes) among a group of people who shared common problems and common health issues. Participants appreciated the fact that all members of the group experienced similar situations such as being old, alone, unwell and not able to do the things they had done in the past. These features were fundamental to them and very helpful because the group felt comfortable discussing issues and felt they could relax and 'be themselves' among people of their own age whom they trusted, and felt mutual support. This was highlighted in Betty's reflections on the group as follows:

...we all recognize that each one of us has a problem... which we're willing to share with each other.

Friendship means different things to different people and across different age groups. The following statement illustrates and highlights that

friendship is also seen as being essential for older adults, as declared by Sue in her statement of:

.... I've found it's what's needed for older people...friends that talk their troubles over...

When asked by the researcher what common thread drew the group together, Betty immediately said:

Friendship is the main thing,

and Ben declared that:

Friendship is a big help...

and further highlighted the importance of companionship and social contact.

4.2.1.2 Essence of Life

Essence of Life was the second theme to emerge from Support. It appeared that group membership acted as an 'energising force' or 'life force' that positively affected the health and well-being of the participants. It contained concepts of being needed, understood and achieving. Being a member of the group had positive effects on the health and well-being of the participants. For example, Ben expressed that:

...this group is my life...

and that as a result of being part of the group his:

*health had improved one hundred percent
and saved his life,*

He stated that if the group did not exist:

I would be dead

and Betty added:

"I hate to think [.....]"!

These statements indicate that the group acted as a "life force" and served a real purpose for all who participated in the group, such as maintaining their health status.

Being a member of the group had become an important part of participants' lives. A particular feature that the group members liked was that:

....everybody joins in....

and this gave participants a sense of belonging. Also they thought highly of each other and they enjoyed the outings and each other's company.

Furthermore, several members had observed that other members of the group had become more motivated and achieved happiness after joining the group. One participant, Betty, affirmed that:

Since I've joined the group I've noticed ... how much they have benefited by the group

giving the example of:

[group member's name]..... for instance was very, very down and what have you, now he can't get on the bus quick enough, he's so much fun it's unbelievable....

All three study participants described being very much part of the group and that they had observed other members benefiting from membership of the

group also. Betty reinforced this as she explained with great enthusiasm and delight that:

"[group member's name].... Just blossomed, she gets her nails painted to come, she has her hair permed to come and....she lives to come....".

4.2.1.3 Learning to adapt

The third theme, *Learning to Adapt*, reflected elements of compassion, disclosure and giving. There was holistic acceptance of each other by participants and group members fully accepted each other as they were and displayed compassion for each other as exemplified by Sue in the following statement:

....we all recognise that each one of us has a problem.

Group members were also grateful to have the opportunity to disclose and tell someone about their problems as suggested in the statement by Betty that:

We're willing to share [problems] with each other.

Participants also expressed this concept, as part of what they believed friendship was all about:

...friends that talk their troubles over and give a lot of help [about] the things we can do, and help we can get.

Furthermore, being part of the group is not just about having fun, but it was also about helping each other to adjust to different life stages and life events. This was noted in Betty's statement that:

Its not just a fun thing, it is also helping us to adjust to the stages [of our lives].....its knowing people know the situation [their illness and life experiences] and how they deal with you in that situation.....

Betty further suggested, that she believed that it was this fact of "realizing the situation", that was the difference between this group and other groups. Accepting and recognising each other's limitations was important and provided the foundation for supportiveness and connectedness between group members.

Written information about what people believe and experience is also a rich source of data. One participant had written on a piece of paper her thoughts about the group in anticipation of her attendance in the first study group. The researcher was given permission at the time of the focus group interview, to use her words as part of the study and data collection. It has been transcribed verbatim and is as follows:

"I think this is a project that is commendable as it benefits the person both Physical and Mentally and is a continuation of Rehabilitation, it helps them to mix once more in the community and regain their mobility, and after a short time it is no longer a club, but an extended family where they feel wanted and loved, which is a state not often shown to people with mental illness of any kind, which can lead again to Deep Depression or Withdrawal Syndrome.

A lot of people in our club are widows or widowers, and have no one to share their troubles and fears with and in some cases have no other social meetings till the following week and then when they do meet they discuss what they have been doing ect and they all share there own activities.

Caring staff who go way beyond their duties to make us feel wanted and show they love in many ways keeping us stimulated active and creative, things they had forgotten how to do, but in doing so show them how great it is to be alive".

This letter clearly encapsulates what being a member of the group meant to many of the participants who had experienced mental health problems and the support they received from staff and other members of the group to move on with their lives in a meaningful and productive way.

It was noted from the interview data that many positive and favourable statements were made by group members concerning the care given by staff and in particular the facilitator. Clearly, the interest shown by the facilitator of the group (a Diversional Therapist) in the lives of all group members was important and influenced the group dynamics. For instance statements like:

She [the facilitator] goes out of her way to help people"

from Sue and:

She [facilitator] makes each one, each person feel special

from Betty.

Unfortunately, the general logistics behind the group operations were marred by difficulties with transport and the lack of a venue within the hospital where the group could meet and call it their own. This was emphasized when members were asked whether there were any problems or challenges for the group. The general response from all three participants was that there were no problems within the group but there were certainly problems in terms of having transport and a venue to call their own. This had been an ongoing issue for

the group where attempts to address the problems (at that time) had been initiated with only some success. (At a later date, the issues were resolved).

4.3 Discussion

Each participant expressed that they enjoyed taking part in the interview process and were eager to discuss the benefits received from being a member of the group which served as a means of social support for each participant and as a network system which had broader implications and benefits for all concerned.

The researcher listened several times to the taped interviews, which were then transcribed, read, analysed, synthesised and the discoveries reported as suggested by Streubert-Speziale (2003c, p. 36). This resulted in a greater understanding by the researcher, of the experiences that group membership had for the participants and the effect this had on their lives.

The global theme that emerged from the data was interpreted as *Support*. This encompassed multiple dimensions and concepts, which included caring, bonding and companionship, these concepts being interpreted as *finding friendship*. The text offered examples of participants' *essence of life*, which was expressed as feelings of being needed and a strong sense of belonging. The text also offered examples of *learning to adapt*, expressed by the participants as the ability to gain confidence within themselves and to provide others with encouragement to meet, not only their own, but each other's needs.

Clearly, the group members positively affected each other's emotional wellbeing, which in turn supported their general health status and resulted in more positive attitudes towards their current life situations. They valued the sense of friendship and acceptance they had for each other and the life situations that they all found themselves in. Being a member of the group acted as a support system or '*life force*' in so many ways that they now felt they could not do without it.

4.4 Validation of Findings

Measures for ensuring validity in qualitative research as suggested by Taylor (2006a) include "asking the participants to confirm that the interpretations are correct, that they represent, faithfully and clearly what the experience was/is" (p. 321).

Therefore, the researcher met all Study One participants to present the findings and to seek verification. The purpose was to clarify that the data collected at different stages of the study were accurate and that the participants' felt that their experiences and statements were validated and had been correctly recorded and interpreted by the researcher. This assisted in validation of the data collected as "truth" as described by the participants and recorded by the researcher which represented participants' reality and supported the concept of "trustworthiness" referred to in qualitative research as a form of validity and a method whereby rigor is ensured as suggested Taylor (2006c, p. 400) and supported by Fain (2009, pp. 209 - 211).

All six participants were happy to endorse Study One findings and confirm that the themes developed from the data collected at the focus group interviews reflected what they felt and that the examples used, which were extracted from the interview, reflected what they were trying to convey to the researcher about the benefits of the group. The participants were also happy and excited at the prospects of the study findings being presented at education and conference forums.

Many of the researcher's pre-understandings were confirmed. However, from the interpretation of the text new understandings were identified including the value of trust and respect; the capacity to achieve and adjust to different life events; the support and companionship they had developed between each other, which allowed them to feel confident enough to disclose and seek advice from each other on personal issues.

4.5 Reflection

This preliminary inquiry, reflected the subtle and subjective realities about the meaning and experiences of health of six older adults living in different settings but reliant on other avenues for support and belonging (Leininger, 1998, p. 5). As suggested by van Manen (2002), this phenomenological study provided concrete portrayals of the lived experiences of older adults, and offered insightful reflections on the meanings of those experiences (p. 49), as described by the participants, and their everyday experiences.

The research questions and procedures used in Study One allowed the researcher to gain insight into participants' lived experiences associated with being a member of a group who met as a means of support and a member of a social network system. From Study One, the researcher identified interview strategies that needed to be altered to reduce the problem of group participants in other studies speaking over each other, as their eagerness to speak sometimes did not allow people to complete what they were saying. This made transcription more difficult. It also became evident that each question should be purposeful, and serve as a stimulus, which can be used to guide the conversation without being repetitive.

In order to seek additional data (such as age, type and location of residence, period of retirement, etc) a questionnaire was developed which was trialed during Study One. The questionnaire was developed to enhance data collection and to incorporate an alternate method for data to be collected. The questionnaire, named "Older Persons Support Group Survey" had 39 questions and was piloted with the six participants from Study One group and modified to 35 questions for Study Two as participants felt the 39 question survey was too long.

Following this trial the modified "Older Persons Support Group Survey" (OPSGS) was used in study Two. This survey comprised thirty-five (35) questions, of which fifteen (15) were related to demographic facts, three (3) to

health, six (6) questions explored general information about community supports and the group attended, and eleven (11) were Likert-type (five point) scaled questions developed to elicit participants' experiences associated with being a member of a group. There was also free text space provided at the end of the survey giving participants an opportunity to describe or make other comments they considered important about the group and their experiences of being part of it.

4.6 Outcome of Study One

In conducting Study One the key elements of the method of hermeneutic phenomenological research were trialed. The findings offered a greater understanding of the meaning of group membership, and the need for older adults to engage with their peers in social support systems such as group participation and that this had a positive effect on their health and well-being and was a strategy for recovery and rehabilitation for those that may have been experiencing ill health.

The findings of Study One were used to lobby for the existing group to continue and to argue for the establishment of other similar groups for the purpose of health promotion and illness prevention for older adults in a variety of appropriate health care and community settings. The Older Person Support Group (OPSG) Survey was also developed, trialed and modified ready for subsequent use in Study Two.

4.7 Conclusions

As a result of Study One experience, further focus group conversations were organised for Study Two, which involved members of another existing hospital group and older adults attending groups across NSW and the ACT. These participants are described in detail in the following chapter. A simplified OPSG questionnaire (Appendix 4.1: OPSGS) was developed by the researcher for members of the groups participating in the second study, for the purpose of further data collection specifically related to demographic profile

and other information requested by group coordinators. The modified questionnaire had thirty-five questions and was structured as described in the Section 4.4 above.

Focus group conversations remained the primary form of data collection for Study Two and these focused on identifying and interpreting group participants' experiences among members of the older population participating in groups which engaged a larger sample size. However, additional quantitative data were also collected, with the interpretation of some responses explored in the context of these conversations. It was planned that the findings from Study One would be compared and evaluated against findings from Study Two.

4.8 Reflection on Chapter Four

The findings of Study One have been presented and demonstrated the processes involved in interpretation and understanding of the text created from conversations with Study One participants. Data analysis reflected the principles of Gadamerian hermeneutic methods and allowed the construction of a major theme identified as Support, defined through sub-themes organised into clusters of ideas that unveiled concealed meaning and new ideas about the phenomena. These were confirmed by study participants. Resulting from this analysis, a Model of Social Support Experiences (depicted on p. 110), was therefore developed that illustrated the findings of Study One using the key ideas for structural thematic analysis suggested by Gadamer and reflected the stated hermeneutic phenomenology methodology. Direct statements or quotations from study participants and confirmed by the participants, supported validation of the findings. In Study One, the principles associated with the philosophical foundations, which guided the development of the research study and stated at the beginning of Chapter Three, were adopted as an appropriate research method for Study Two.

CHAPTER 5

STUDY TWO: QUANTITATIVE METHODS AND RESULTS

This chapter provides an overview of the research methods used to complete Study Two. Key components of the research process are presented which includes ethics approval, a description of the study participants, the recruitment process, and the consent protocol including information for participants. Quantitative and qualitative data collection methods for the Study Two are described in detail.

Included in this chapter are descriptive and inferential analyses of the cluster variables developed from within the two survey questionnaires used in the research study. A descriptive analysis of the data offers a profile of the study participants. Through inferential analysis the relationship between the dependent and independent variables developed were examined that may have contributed to participants' satisfaction with group membership, level of social interaction, and satisfaction with social support and instrumental support received. Analysis of the data in these ways offered a greater understanding of the benefits and importance of group participation to older adults.

5.1 Introduction

Study One undertaken from the inductive (qualitative) perspective (Streubert-Speziale, 2003b, p. 8) allowed the discovery of concepts that best capture both the objective and subjective aspects of the phenomenon (group members experiences) formed from data collected from individual interviews and analysed, as suggested by Fain (2009, p. 6) and Porter (2000, p. 141-142), to reveal meaning of group members experiences. Qualitative research is commonly referred to as the naturalist method of inquiry

(Polit & Beck, 2008, p. 17), as it explores the human experience as it is lived from within an "emic" perspective (Polit & Beck, 2008, p. 225; Streubert-Speziale, 2003a, p. 18). However, Study One also revealed the need to expand the research in order to ask more in-depth questions about the benefits of group participation by older adults and to construct a profile of characteristics of group members. The initial assumption that older people receive a number of benefits from participating with peers, through group membership, has not changed (see Section 1.8.). Yet, the extent to which these benefits influenced members' lives was not explored in Study One. Study Two therefore, examines the extent of these benefits using mixed methods design. This chapter describes the blending of quantitative and qualitative research, data collection methods and data analyses that comprise Study Two.

5.2 Study Two: Design

As recommended from Study One (described in Section 1.4), Study Two was developed so as to increase the number of study participants and to add design components in order to learn more about the phenomenon of interest, as suggested by Carpenter & Jenks, (2003, p. 300). For this to occur a mixed method was employed in which two research methods were blended to investigate the phenomenon (Whitehead and Elliott, 2007, p. 250). A quantitative component was added into the primary qualitative design to give depth to the study. A larger sample size (n=200) provided a better understanding of the benefits older adults experience when participating in social support groups, as recommended by Carpenter & Jenks (2003, p. 305). This "offered a wider scope for constructive, contained and appropriate research, with the potential to present a more complete and comprehensive research opportunity" as suggested by Whitehead and Elliott (2007, p. 252). Along with the choice of participation in focus group conversations, two questionnaires were used to capture supplementary items that could identify some of the determining constructs or characteristics of social support networks for older adults. The overall research purpose, aims, objectives and justification for the study remained constant with recordings of participants'

narratives in Study Two remaining consistent with Study One. Study Two maintained hermeneutic phenomenology as the methodology for analysis of focus group conversations (interviews). A descriptive/explorative design was chosen as it allowed the researcher to examine more characteristics of a particular subject or group, and similar to phenomenology, it is used when little is known about the phenomena under study (Burns & Grove, 2005, p. 44; Elliott & Hayes, 2003, p. 297). Using descriptive techniques, data was condensed and organised into meaningful units, thus allowing for interpretation to be undertaken (Fisher & Schneider, 2007, p. 226).

5.3 Data Collection

Data collection procedures used two questionnaires, unstructured conversations and participant observations on a range of items (including health), as a means of identifying the possible effects of social factors on subjective well-being. Quantitative data collection consisted of the completion of:

- The Older Persons Support Group Survey (OPSGS) (Appendix 4.1) and/or,
- The Duke Social Support Index (DSSI) (23-item) Scale (Appendix 4.2).

Focus group conversations used the same interview questions as for Study One (See Section 3.8.7). Previously interviewed participants in Study One were not re interviewed for Study Two.

In Study Two, data collection was consistent for all subjects in terms of instruments (questionnaires) used, equipment used (e.g. Sony digital audio-tape recorder), environmental conditions (church halls or similar venues), timing of data collected (week days between 10am and 12 midday), transcription procedures (some online transcription and some manual transcription by the researcher), and general data collection protocols as described in Chapter 3.

5.3.1 Questionnaires used in Study Two

This section provides a description of the two questionnaires used in Study Two.

5.3.1.1 Development of the Older Persons Support Group Survey

The Older Persons Support Group Survey (OPSGS) was developed in conjunction with the researcher’s supervisor and group coordinators/advisors to ascertain particular personal qualities of group members. Items were tested on a small sample of people in the original group (Section 4.5) for clarity and time needed to complete. The questionnaire was revised and modified (shortened in length) for ease of completion by participants. The new questionnaire was entitled the ‘Older Persons Support Group Survey’ (OPSGS). The revised questionnaire was approved by the Australian Catholic University Higher Research Ethics Committee (ACU HREC) for use in Study Two.

The OPSG survey incorporates both quantitative and qualitative response options. It consists of 35 questions and is divided into two parts (See Appendix 4.1). Part One (Questions 1-24) refers to general demographics of age, sex, country of birth, living arrangements, and past occupation, a question on health problems and other social support network participation the participants may have been involved in such as use of community support services (instrumental support e.g. home care services). Part Two (Questions 25–35) uses a Likert scale to enable participants to subjectively score ‘the extent’ to which group membership affected their health and well-being: ‘0’ being the least important to ‘4’ being the most important. The survey closed with a section for other free comments.

For the purpose of data analysis and reporting, the questionnaire items were then divided into five clusters representing five specific areas of interest:

Part 1 had four clusters: Group members’ demographics, health problems, service use and group characteristics (see Table 5.1), and Part 2 had one cluster of 11-items: exploring the influences of group participation and membership on group members (see Table 5.2). Free comments were incorporated into the qualitative analyses and theme construction.

Table 5.1: Cluster Variables for OPSGS – Part 1 of Questionnaire (Study Two)

Cluster Variable	Descriptive Title	Question Number
Part 1		
Cluster One	Group members demographics	
	Group/type (RSL or hospital)	Q 1
	Age group	
	Sex	Q 2
	Membership type	Q 2
	DVA/Pension	Q 3
	Pension type	Q 4
	Australian born	Q 5
	Country of birth	Q 6
	Years in Australia	Q 7
	Postcode	Q 8
	Years at this address	Q 9
	Accommodation type	Q 10
	Living status	Q 11
	Living arrangements	Q 12
	Occupation	Q 13
	Years in job	Q 14
	Years retired	Q 15
Cluster Two	Health characteristics	
	Physical health status	Q 16
	Emotional health status	Q 17
	Health conditions	Q 18
Cluster Three	Service characteristics	
	Community service	Q 19
	Types of support	
Cluster Four	Group characteristic	
	Years a member	Q 20
	Group activities	Q 21
	Other groups attended	Q 22
	Group types	Q 23
	Differences in groups	Q 24

Table 5.2: Cluster Variables for OPSGS – Part 2 of Questionnaire (Study Two)

Part 2		
Cluster Five (11 items)	Influences of group on group member	
	To what extent is this group important to you?	Q 25
	To what extent does this group provide you with social support?	Q 26
	To what extent does this group provide you with emotional support?	Q 27
	To what extent does belonging to this group keep you physically well?	Q 28
	To what extent does belonging to this group influence your feelings of well-being?	Q 29
	To what extent does belonging to this group affect your emotional health?	Q 30
	To what extent does belonging to this group help you feel that others support you?	Q 31
	To what extent does being a member of this group provide you with a “sense of belonging”?	Q 32
	To what extent does being a member of this group raise your self-esteem?	Q 33
	To what extent does being a member of this group increase your self-confidence?	Q 34
	To what extent does being a member of this group increase your feelings of self worth?	Q 35

5.3.1.2 Duke Social Support Index Scale

Permission was granted to use the Duke Social Support Index (23-item) scale in May 2006 along with a copy of the scale.

The DSSI scale is an instrument which has three forms: an 11-item, 23-item and 35-item. The DSSI scale according to Goodger et al. (1998) “includes both a subjective evaluation of the adequacy of support received as well as a more objective evaluation of type and number of social interactions” (p. 260). The 23-item scale was selected for the current research study as it includes the objective instrumental support scale (Appendix 4.2 and 4.4). The scale consists of three (3) sub-scales:

- 1. “Social Interaction” with 4 items measuring level of social interaction;
- 2. “Satisfaction with Social Support” (subjective sub-scale) with 7 items measuring the perceived satisfaction with the behavioural and emotional support obtained from a network;
- 3. “Instrumental Support” with 12 items measuring types of instrumental support (hands on support) received by the participants from family or friends.

Goodger et al. (1998, p. 260) suggested that the DSSI scale can be interviewer administered or self administered; as used in the current research study.

However, apart from the study by Koenig et al (1993) on abbreviating the DSSI (from 35-items to 11-item and 23-items), difficulties were encountered in (1) locating evidence for the 23-item scale and (2) obtaining guidance on interpreting the indices generated by the DSSI.

Research using DSSI pertains to a validated 11-item scale (Goodger et al., 1999) and the 23-item scale which included instrumental support (Koenig et al., 1993). In the study by Pachana, Smith, Watson, McLaughlin, & Dobson (2008), using only the 11-item DSSI scale (which only includes the first two sub-scales noted above), the subscale “social interaction” was referred to as the ‘Network’ which had score ranges from 4 to 12 with higher scores indicating more social contact (p. 667). In their study the “Satisfaction” with social support sub-scale had a Cronbach’s alpha of 0.8 (Pachana et al., 2008, p. 667).

5.4 Ethics Approval

A revised Ethics application was submitted to include the addition of the quantitative data collection scales/surveys. The ‘Participant Information Letter’ (Appendix 2) and ‘Consent Form’ (Appendix 3) were also revised to reflect these differences in data collection methods.

Ethics approval was granted by the Australian Catholic University Higher Research Ethic Committee (HREC) for the second study. Ethics approval was

granted by the then hospital ethics committee to access participants meeting on the Hospital site located in Sydney (see Section 5.5 below).

5.5 Study Participants

The main recruiting source was from groups of older people living in the community. Study Two participants (n=200) were a homogeneous sample of older people attending weekly social programs across New South Wales (NSW) and the Australian Capital Territory (ACT), usually sponsored by a local area Returned and Service Leagues (RSL's) sub-branch club. These groups were referred to as “Day Clubs”.

The second recruiting source was a small group of older adults (n=8) who met fortnightly at a hospital in Sydney. This group was similar in profile to the group in Study One, which was set up for the same purpose. This second group was established as a result of the outcome of Study One which found that older adults who may require a period of rehabilitation from an episode of ill health used socialisation and support during periods of recovery and beyond. As part of the evaluation process, members of this hospital group participated in Study Two.

5.5.1 RSL Day Clubs

In this section an overview of the RSL Day Clubs is provided including background information, a description of the Day Club structure along with criteria for Day Club membership.

5.5.1.1 Background

RSL Day Clubs have been operating throughout NSW and the ACT since 1977. The Day Clubs, run by volunteers, meet on different days of the week for eleven months of the year, closing only for the Christmas period.

The Day Clubs are community-based programs offering social support for older people living in the community. The Day Clubs are open to all members of the community and members of the Day Clubs are not required to be members of mainstream RSL sub-Branch licensed Clubs or war veterans.

The Day Clubs have two advisors who supervise the overall functioning of the Day Club programs and operations across the state, but volunteer coordinators from the local regions, in which the Day Clubs met, facilitate the Day Clubs and their programs. Support for the general running of the Day Clubs, such as catering and transport, is also provided by volunteers who make a substantial contribution to the success of the Day Clubs program. While anecdotal evidence highlighted the value that older adults received from group membership there was support for this to be explored further using research methods.

In 2007 the Day Clubs celebrated thirty years of operation. While every Day Club functions in a slightly different way they all exist to promote active ageing and foster a sense of community and social engagement. The groups provide a stimulating program of activities, including games, quizzes, gentle exercise and guest speakers presenting on topics of interest (Australian Government, Department of Veterans' Affairs, 2006). Throughout the year they celebrate a variety of events with great enthusiasm. Lunch and morning tea are provide and transport can be arranged (Department of Veterans' Affairs, 2006).

5.5.1.2 RSL Day Club Structure

The Day Clubs are managed through a partnership between the Returned and Services League of Australia (RSL) NSW Branch and the Australian Government Department of Veterans' Affairs (DVA), NSW Office (Department of Veterans' Affairs, 2007).

At the time the study was undertaken (2007/08) there were 69-Day Clubs operating across NSW and the ACT. The largest Club had

approximately 140 members and the smallest about 14 (Department of Veterans' Affairs, 2007). In 2008 there were 24 Day Clubs in the Sydney metropolitan region and 44 in regional and country areas of NSW, and one operated on Norfolk Island.

Day Clubs met in licensed RSL Club function rooms; RSL sub-branch halls; and in local community or church halls. The most geographically isolated Day Clubs were on Norfolk Island and at West Wyalong in central NSW (Department of Veterans' Affairs, 2007). When these Clubs (excluding Norfolk Island) were organised into different regions (in 2009 such as far North Coast, Central Coast, Greater West region) there was a lower distribution of Day Clubs across parts of NSW particularly rural NSW.

5.5.1.3 RSL Day Clubs Members

As of August 2007, 23% of the total Day Club membership was male and 77% female (Department of Veterans' Affairs, 2007). There is no strict criteria for membership of these social groups other than the capacity for participants to be independent with mobility and toileting, and to be cognitively alert.

5.5.2 Hospital Based Older Persons' Support Group Members

The second hospital group was established for the same purpose as Study One (Section 1.9.2). This hospital group was part of the data collection for Study Two. At the time of data collection this group had been meeting for almost two years. Eight of the twelve (or 66%) group members completed the same two questionnaires as those in the Day Clubs.

5.6 Recruitment of Study Two Participants

Participants for Study Two came from both the Day Clubs and the hospital group. The process of recruitment is explained in following sections.

5.6.1 Day Club Older Persons’ Support Groups

Permission was given by the State Council of the RSL (NSW Branch) in 2005 for the researcher to access the Day Clubs for the purpose of inviting members to participate in the study. To access the Day Club members, a letter of request to visit the Day Clubs was sent by the researcher to the Day Club coordinators nominating a day for the researcher to attend when the Day Club meets.

5.6.2 Hospital Based Older Persons’ Support Group

The hospital group met fortnightly on Fridays. To access the hospital group members, the researcher arranged with the coordinator to meet with the group on a date suitable to all.

5.7 Participant Information and Recruitment

The same Participant Information and Consent protocols were used for the hospital based group as for the RSL Day Club groups.

Upon visiting all groups the researcher spoke to group members present on the day to explain the research project and the process of data collection. Information was provided to group members about participation in the research and included information as described in the “Participant Information Letter”. The researcher ensured that all group members understood the research project. Following a detailed explanation of the research purpose, data collection activities and how the data would be used, a verbal invitation to participate in the study was then offered to all group members in attendance on the day of the visit. The need for participants to sign a “Consent Form”, should they wish to participate in the study, was emphasised.

Many participants were eager to tell of the appreciation they had for the group’s existence and were keen to describe the many pleasures they experienced from being a member of the group. Participants who did not wish

to take part in the research study were assured by the researcher that that was acceptable and thanked them for their attention.

5.8 Consent

If group members agreed to participate in any of the data collection methods they were asked to sign a Consent Form which was also signed by the researcher. The signed consent form was retained by the researcher as part of the research records. Participants were asked which data collection method they would like to take part in (completion of the survey questionnaires and/ or participation in audio-taped focus group conversation/interviews). Although most chose completion of the surveys, using either of the two means, many were eager to engage in group or individual conversations with the researcher but they did wish for this to be too long as they wanted to spend time with friends and other group members.

5.9 Confidentiality

Participants were assured of confidentiality and informed that the data collected and analysed could be published but participants' identities would be protected.

5.10 Anonymity

When targeting specific groups of participants to engage in focus group interviews, anonymity is difficult to maintain (Burns & Groves, 2005, p. 543). In this research, study participants were not asked to record their name on any data collection material. Completed Consent Forms were not tracked to participants' completed surveys but were identified by group location, e.g. town or suburb. Completed forms did not allow identification of individual persons; however they were able to be tracked using a coded number system for data entry purposes.

5.11. Data collection: Study Two

Data collection occurred over a two year time period for all groups (May 2007 – November 2008). Of the 69 Day Club groups operating across NSW and the ACT the researcher visited a total of 24 Day Club groups and one hospital-based group.

5.11.1 Completion of the Survey Questionnaires

Two-hundred OPSG surveys were completed by older adults attending social groups across NSW and the ACT. One hundred and ninety-four group members provided answers to both the OPSG survey and the DSSI 23-item scale.

5.11.2 Unstructured Focus Group Conversations

Informal unstructured conversations were used to extract information about the experiences of being a member of the group. Of the 25 sites visited, 10 sites agreed to participate in taped focus group conversations. From the ten sites, 38 people consented to interviews and participated in focus group conversations, which were recorded using a Sony digital audio-taping recorder. Group conversations involved between two and eight participants and lasted from between 10 and 45 minutes depending on the numbers participating. Some members consented to their conversations being recorded by way of contemporaneous notes. Twenty-five participants' conversations were transcribed from five of the ten visited sites that agreed to participate in taped conversations.

5.11.3 Participant Observation

Participant observation was an invaluable part of the data collection process. The data collection method included:

- Contemporaneous notes immediately following sessions
- Thematic analysis based on observed interactions within the group and with coordinators (see Section 6.7)

- Validation of themes with groups during feedback sessions (see Section 6.9).

Participant observation was used to collect information about non-verbal cues displayed by group members. The researcher developed an understanding of the importance and value of the group to some of the members and the reasons why many chose not to participate in the research although they believed the research was a valuable and useful activity. On reflection it appeared that members preferred to spend time engaging with ‘their group of friends’ rather than being interviewed. This highlighted a very important need on the part of group members to remain connected with others. For instance, members loved the games (e.g. cards, dominoes) and the laughter associated with these activities; one group of men loved to play cards even when they went on outings. The women commented that they had never seen men laugh so much. Overwhelmingly, participants believed that the games and quizzes were important and that they played a major role in keeping them cognitively active. They loved the exercise programs, and although simple in context, they believed that participating in these activities really benefited their health and well-being.

5.12 Quantitative Data Analysis

Data can be analysed both qualitatively, where the researcher uses words to describe and discuss the data, and quantitatively, using statistical techniques as indicated by Fain (2009, p. 6). Statistical Package for the Social Sciences (SPSS version 16) was used to analyse the qualitative data (descriptive) and quantitative data collected through the two questionnaires used in research study. A database was established to record responses to the combined 59 items created from the OPSG survey (35 questions with two parts to one question i.e. 36 items) and the DSSI scale (23 questions) (see Appendix 4.3 and 4.4). Data for both questionnaires were analysed descriptively and inferentially. The latter was used to identify correlations between dependent variables of the scaled measures and the independent variables from the questionnaires (see Section and 5.14.1 and 5.14.2).

The following section provides a short explanation of these components.

5.12.1. Descriptive Analysis

Descriptive designs collect data about attitudes or characteristics of individuals or groups of people, the purpose being “to describe the meaning of existing phenomena” as suggested by Fain (2009, p. 191). Descriptive studies use surveys to “collect detailed descriptions of existing variables and use the data to justify and assess current conditions and practices ...” (Elliott & Hayes, 2003, p. 297). Variables of interest can be classified as opinions, attitudes or facts but most collect demographic data such as age, gender, ethnicity, occupation and living arrangements (Elliott & Hayes, 2003, p. 298). Descriptive studies are also “usually conducted with minimal control of the study design, because subjects are examined as they exist in their natural setting” while achieving the most precise measurement possible of the variables being studied (Burns & Grove, 2005, p. 34).

Descriptive analysis was used to summarise and describe the information collected from the survey questionnaires, extracting the salient points from the results as described by Fain (2009, p. 150) and Cormack (2000, p. 365). Summary tables and graphs are used to display the analysed data. Results of the descriptive analysis are presented in Sections 5.17 to 5.19.

5.12.2. Inferential Analysis

Inferential statistical techniques used to further analyse these data were correlational and factor analysis. Results and a more detailed description of these analyses are provided in Sections 5.20 to 5.25.

5.12.2.1 Correlation

The correlation analysis was conducted, as recommended by several authors, to examine the linear relationships between two or more variables and to determine the type and degree of the relationship (Burns & Grove, 2005, p.

44) and between the characteristics of people in the groups (Kermode & Roberts, 2006, p. 286), thus providing a deeper insight into the phenomena of interest (Elliott & Hayes, 2003, p. 298).

5.12.2.2 Factor Analysis on the DSSI and OPSG Survey

Factor analysis (using principal component analysis) was employed to better understand the structure of the variables and the relationship between the variables identified from within the two survey questionnaires. Factor analysis was undertaken on the two sets of dependent variables (DV):

- (1) Importance of group to group members' measured using the OPSG survey Part Two, and
- (2) the DSSI scale.

The existence of a cluster of correlation coefficients between subsets of variables may suggest that those variables could be measuring aspects of the same underlying dimension within the data, referred to as factors. However, the conclusions of the findings are restricted to the sample collected as Field (2009, p. 637) recommended although the sample size was adequate ($n=200$) and validated by the Kaiser-Meyer-Olkin test as a measure of sampling adequacy.

5.13. Qualitative Data Analysis: Thematic Analysis

Qualitative data from the informal group conversations were analysed using interpretive hermeneutic phenomenology and theme analysis, as prescribed by Gadamer, developed from the transcribed conversations. Additionally, exemplars from a selection of the transcribed narratives were used to highlight the findings for Study Two. Further explanation of theme development and a 'Network of Themes' construction used to identify themes in Study Two is provided in Chapter 6.

5.14 Variables Being Measured

This section provides an overview of the dependent and independent variables being measured developed from within the OPSG survey and the DSSI 23-item questionnaire mentioned in Section 5.3.1.

5.14.1 Variables from within the OPSG Survey

The OPSG survey, consisting of 35 questions, was grouped for convenience into two parts with five clusters or sections for ease of analysis and discussion. Part One of the questionnaire had four clusters. These are briefly described below.

Cluster One: *Group members’ demographics* included age, gender, membership Type, DVA/Pension, pension type, Australian born, country of birth, years in Australia, postcode, years at this address, accommodation type, living status, living arrangements, occupation, years in job and years retired.

Cluster Two: *Health characteristics* included question on physical health status, emotional health status and to list any health conditions.

Cluster Three: *Service characteristics* included questions about community service use and types of support used if any.

Cluster Four: *Group characteristics* included years of membership, group, group activities they liked, other groups attended, group types, and differences in the group under study and other groups.

Five items across the four clusters from Part One of the OPSG survey were selected as the independent (predictor) variables: age, gender, living alone, physical health and emotional health.

In Part Two of the questionnaire;

Cluster Five: *Influences of group on group members*, uses 11 questions to explore the extent (or degree) to which group membership influenced different aspects of each group member's life. These were recorded as dependent variables (outcome). Constructions of these coded variables are shown in Table 5.3 below.

Table 5.3 Older Persons Support Group (OPSG) Survey Variable Construction

Variable Construction	Variable Code
To what extent is this group important to you?	Group importance
To what extent does this group provide you with social support ?	Social support
To what extent does this group provide you with emotional support ?	Emotional support
To what extent does belonging to this group keep you physically well ?	Physical wellness
To what extent does belonging to this group influence your feelings of well-being ?	Well-being
To what extent does belonging to this group affect your emotional health ?	Emotional health
To what extent does belonging to this group help you feel that others support you ?	Feeling of support from other
To what extent does being a member of this group provide you with a sense of belonging ?	Belonging
To what extent does being a member of this group raises your self-esteem ?	Self-esteem
To what extent does being a member of this group increase your self-confidence ?	Self-confidence
To what extent does being a member of this group increase your feelings of self worth ?	Self worth

5.14.1.1 Scoring the Variables in the Older Persons Support Group Survey

Categorical data includes age, gender, country of birth, and occupation within Part One of the OPSG survey. Data was coded nominally into discrete categories (e.g. males 1; females 2) ensuring that these are different and exclusive, as suggested by Fain (2009, p. 108) and Fisher & Schneider, (2007, p. 227).

Numbered categories were used to convey information about the relative importance of the responses grouped using intervals, eg. Likert self-report scale numbering one to five where number one is the ‘least’ favourable ranking and number five the ‘most’ favourable as also indicated by Fain (2009, p. 109) and Fisher & Schneider (2007, p. 228).

Responses to questions 1 to 24 of Part One of the OPSG survey were coded by the researcher and entered into SPSS 16 (see Coding Sheet Appendix 4.4). Responses to questions 25 to 35 of Part Two of the OPSG survey were collected using interval levels (Likert scale). Participants were asked to rank their opinion, using a five-point Likert scale of: ‘not at all’ (scoring 0), ‘a little’ (scoring 1), ‘a lot (scoring 2); ‘mostly’ (scoring 3) or ‘totally’ (scoring 4), to identify the extent to which being a member of the group impacted on their lives (see OPSGS Coding Sheet Appendix 4.5). These were also coded and entered into the SPSS database.

The 11 items from within cluster five became the dependent variables (DVs) (see Table 5.3). They were combined using SPSS 16 to produce one dependent variable named ‘Group Benefits’ against which the quantitative data could be correlated.

5.14.2 Variables from within the DSSI Scale

The DSSI 23-item scale consists of three sub-scales:

1. “Social Interaction” with 4 items measuring level of social interaction
2. “Satisfaction with Social Support” (subjective sub-scale) with 7 items measuring the perceived satisfaction with the behavioural and emotional support obtained from a network
3. “Instrumental Support” with 12 items measuring types of instrumental support (hands on support) received by the participants from family or friends.

The 23 question (items) DSSI scale, from which 23 dependent variables (DVs) were identified, were inferentially analysed. Several items explored group members’ experiences of their:

- Feelings that they can depend on or feel close to other family members? (explored within item 1)
- Level of Social Interaction with others (explored within items 2, 3 and 4)
- Satisfaction with Social Support and the kinds of relationships with family, friends and others (explored within items 5, 6, 7, 8, 9, 10 and 11), and
- Satisfaction with Instrumental Support asking whether others help out in a variety of ways (explored within items 12 to 23).

Responses to each of the 23 questions were recorded as variables code named from key words within each question by the researcher, for example:

- Question 1 - “Other than members of your family how many persons in your local area do you feel you can depend on or feel close to”? The variable identifier was entered into SPSS as “*dependon*”, (which will be referred to as ‘dependon’ in subsequent discussion) and for
- Question 2 – How many times during the past week did you spend time with someone who does not live with you, that is, you went to see them or they came to visit you or you went out together? The variable identifier was entered into SPSS as “*spendtime*” (which will be referred to as ‘spendtime’ in subsequent discussion).

See Table 5.4 for further details of the method of variable extraction and code naming for the DSSI scale.

**Table 5.4 Duke Social Support Index (DSSI) Scale
Variable Construction**

Variable Construction	Variable Code Word
Social Interaction sub-scale (4 items)	
1. Other than members of your family how many persons in your local area do you feel you can depend on or feel very close to?	depend on
2. How many times during the past week did you spend time with someone who does not live with you, that is, you went to see them or they came to visit you or you went out together?	spend time
3. How many times did you talk to someone (friends, relatives or others) on the telephone in the past week (either they called you, or you called them)?	talk to someone
4. About how often did you go to meetings of clubs , religious meetings, or groups that you belong to in the past week?	meetings or clubs
Satisfaction with social support sub-scale (7 items)	
5. Does it seem that your family and friend (people who are important to you) understand you ?	understand you
6. Do you feel useful to your family and friends (people important to you)?	useful
7. Do you know what is going on with family and friends ?	family business
8. When you are talking with your family and friends, do you feel you are being listened to ?	listened to
9. Do you feel you have a definite role (place) in your family and among your friends?	definite role
10. Can you talk about your deepest problems with at least some of your family and friends?	problems
11. How satisfied are you with the kinds of relationships you have with your family and friends?	relationships
Instrumental Support Subscale (12 items)	
12. Do they help out when you are sick?	help out
13. Do they shop or run errands for you?	shop or run errands
14. Do they give you gifts (presents)?	give gifts
15. Do they help you out with money ?	help with money
16. Do they fix things around the house?	fix things
17. Do they keep house for you or do household chores?	keeping house
18. Do they give you advice on business or financial matters?	advice on business
19. Do they provide companionship to you?	companionship
20. Do they listen to you ?	listen to you
21. Do they give you advice on dealing with life's problems?	advice on life's problems
22. Do they provide transport for you?	transport
23. Do they provide meals for you?	meals

5.14.2.1 Scoring the Variables in the DSSI Scale

The scoring process for the 23-items of the DSSI scale, as recommended by Koenig (2006) is to “sum up totals for all sections to obtain an overall social support score; the range being 23 to 57”. Increased values indicate higher levels of support according to Goodger et al. (1999, p. 261).

A summary of the scoring protocol provided for the DSSI scale is shown in Table 5.5 using DSSI sub-scale scores. The recommended total range of scores for the overall tool is 23 points (minimum) to 57 points (maximum). Scoring codes as interpreted by the researcher from the authors advise are provided in Appendix 4.4. “Missing” data was coded as ‘9’ and “not completed” coded as ‘8’.

Table 5.5 Study Two: Scoring for Duke Social Support Index (DSSI) Scale

Subscales	Questions	Score
“Social Interaction” with 4 items (questions 1-4)	1	0=1, 1-2=2, >2=3
	2	0=1, 1-2=2, >2=3
	3	0 or 1=1, 2-5=2, >5=3
	4	0 or 1=1, 2-5=2, >5=3
“Satisfaction” with Social Support with 7 items (questions 5-10)	Hardly Ever	1
	Some	2
	Most	3
and (question 11)	Very dissatisfied	1
	Somewhat dissatisfied	2
	Satisfied	3
“Instrumental Support” with 12 items (questions 11-23)	No	1
	Yes	2

The six items within the “Satisfaction with Social Support” (items 5, 6, 7, 8, 9 and 10) were combined in this research to produce one dependent variable (DV) named ‘Social Satisfaction’. This process was undertaken to

simplify the data for cross-tabulation analysis. Additionally, the 12 items from within the DSSI “Instrumental Support” sub-scale were combined to produce one dependent variable named ‘Instrumental Support 2’

5.15 Additional Exploration of the Data

Several questions were developed for further exploration and testing of the OPSG questionnaire and the DSSI scale using inferential analysis. Questions of interest to the current study include:

- Whether females or males were more satisfied with social support?
- Whether age defined or influenced satisfaction with social support?
- Whether those who lived alone were more likely to be satisfied with social support?
- Whether those experiencing less physical health status were more likely to be satisfied with social support?, and
- Whether those experiencing less emotional health status were more likely to be satisfied with social support?

Factor and correlation analysis were used to explore and test these questions. An overview of these analyses is provided below.

5.16 Descriptive and Inferential Analyses - Study Two

This research focused on exploring the lived experiences of older adults participating in a group. To provide a more in-depth picture of these experiences it was also useful to know some of the demographic characteristics of the participants in the study; the relationship between these characteristics; and the standardised measure of support that was used (Section 5.3.1.2). Thus, a profile of the participants and a greater understanding of the benefits they received from group membership were able to be described from analysis of the data from the Older Persons’ Support Group Survey (OPSGS) and the Duke Social Support Index (DSSI) Scale.

Descriptive statistics provided a data summary in terms of averages and percentages as suggested by Polit & Beck (2010, p. 392). The frequency of recurring responses to the defined variables of interest was the primary focus of items analysis. These are described in Chapter 4 (Section 4.3.1). The aim of this analysis was to describe participant characteristics and the discovery of group perspectives about the importance of group membership thus augmenting participant conversations which confirmed the findings generated through the quantitative and qualitative research design. The results of the descriptive analysis are provided in the following section.

5.17 Results of Descriptive Analysis of Older Persons' Support Group Survey (OPSGS)

Results of the OPSG survey variables are reported under 'cluster variable headings' which combine several of the variables. Values with decimal points between 0.1 to 0.5 were rounded down (example 28.4% became 28%) and those with decimal points 0.6 and above were rounded up to the next whole number. However, where data are presented using frequency tables the exact values are provided. Bar charts are also used to display summaries of results.

5.17.1 Cluster 1 Variables: Group Member Demographics

Group member demographics include the following items: age, sex, pension (DVA), country of birth (and time in Australia if born overseas), accommodation and living arrangements, type and duration of employment, and how long retired. A description of the findings follows.

5.17.1.1 Item 1-Sex (Respondents = 199)

Participants were asked to identify their sex. Participants' sex was established from dichotomous variables (1 = male; 2 = female); sex identifying whether a person is male or female as recommended by Oakley (1972, p. 159).

Females represented the greater proportion of the groups' total membership with 52 (26%) males and 147 (74%) were females. The sample comparison for sex is shown in Table 5.6.

**Table 5.6: Study Two: Sex Differences of Group Participants
(Respondents =199)**

	Frequency	Valid Percent
Males	52	26.0
Females	147	73.5
Missing	1	.5
Total	200	100.0

The results around sex are similar to the Australian national data (at the time the study was undertaken) reporting that women of all cultural backgrounds have greater longevity than men (Australian Institute of Health and Welfare, 2007, p. 3). The Australian census report of 2010 reported that 53% of the population over 65 years were female against 47% who were male (ABS, 2010). The finding is also “consistent with the higher life expectancy of female individuals at older age in developed countries” as reported by Rasulo, Christensen, & Tomassini (2005, p. 604). It is likely, therefore, that older females are more likely to attend groups than older males.

5.17.1.2 Item 2-Age (Respondents = 199)

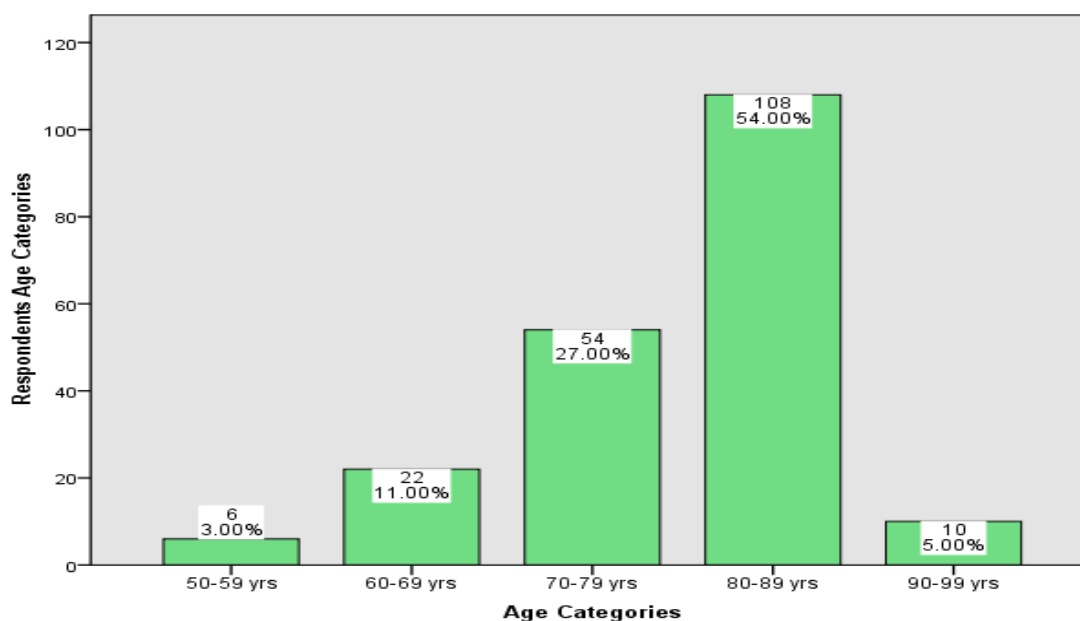
Age data was organised into 10-year categories from 50-99 years. The median age category was 70–79 years. Age comparisons are in Figure 5.1.

Of the 200 people surveyed 54% were aged between 80–89 years and 81% between 70 years and 89 years of age. Twenty-eight (14%) were between 50 – 69 years of age and ten (5%) were between 90–99 years of age.

Clearly the greatest numbers of participants were in the ‘middle-old’ to ‘oldest-old’ age group (see Chapter 2, Section 2.4.3). The ‘very old’ (80+) cohort in this current study sample is drawn from the fastest growing population group in the developed world including Australia (Centre for

Epidemiology and Research, 2008, p. 5; Australian Institute of Health and Welfare, 2007, pp. 5-6). The study group of adults aged 80+ years also has diverse backgrounds and very different needs related to health and services, compared to their younger counterparts. Their current family circumstances, living arrangements, and social and religious practices may not be the same as those who are younger (Australian Institute of Health and Welfare, 2007, p. 2).

Figure 5.1. Age Distribution of Group Attendees (Respondents = 200)



Of the study participants 77 of the 107 females fell within the 80-89 years age category compared to 30 males. Of the ten respondents aged 90+ years, eight were female (Table 5.7).

Table 5.7 Study Two: Age and Sex of Participants (Respondents = 199)

Age Category			Males	Females	Total
Age	50-59 yrs	Count	1	5	6
		% within sex	1.9%	3.4%	3.0%
	60-69 yrs	Count	6	16	22
		% within sex	11.5%	10.9%	11.0%
	70-79 yrs	Count	13	41	54
		% within sex	25.0%	27.9%	27.0%
	80-89 yrs	Count	30	77	107
		% within sex	57.7%	52.4%	54.0%
	90-99 yrs	Count	2	8	10
		% within sex	3.8%	5.4%	5.0%
Total	Count	52	147	199	
	% within sex	100.0%	100.0%	100.0%	

In June 2010 the Australian population was just under 22.5 million people, of which 3.1 million (13.5%) are aged 65 years and over (ABS, 2010). According to the 2010 Quarter census report just over half (54%) of all older people in Australia were aged 65-74 years; 33% were between 75 and 84 years of age, and 13% were aged 85 years and over (ABS, 2010). In 2010 there were 3,742 people aged 100 years and over (ABS, 2010, p. 20).

Comparing what was known about the Australian population, the study sample showed a larger proportion of those over 70 years of age (86%) and in particular those 80 years and over (54%) attending the groups. The majority were females. Additionally, the Australian national data reported that there was a significant proportion of older people actively involved in social or support groups with 66% (of 1.5 million) of those aged 65-74 years and 43% of people aged 85 and over (Australian Institute of Health and Welfare, 2007, p. 37) participating in groups.

5.17.1.3 Item 3-Country of Birth (Respondents = 199)

In the study sample three convenience categories were used for coding country of birth other than Australia, (1) Mainland Europe, (2) United Kingdom

(UK), and (3) Others. One hundred and sixty-two (81%) group members were born in Australia and thirty-seven (19%) were born overseas. One person did not complete this question.

United Kingdom was the most common countries of origin from which immigration had occurred with 24 (12%) followed by five (3%) born in European countries such as Italy and Czechoslovakia. 'Others' identified being born in Sri Lanka and Papua and New Guinea, and accounted for eight (4%) of the category "Other" countries. If not Australian born, all other participants were either in the UK, mainland Europe or 'other' category. Twenty-eight of those born overseas were female and nine, male.

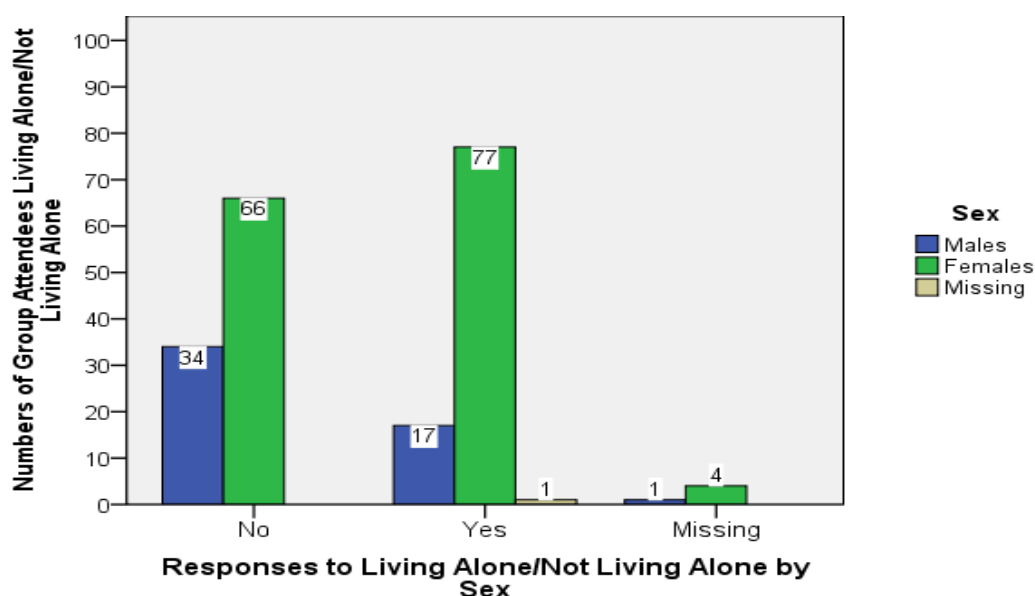
The study findings are consistent with the 2006 Australian census findings in which 35% of older people were born overseas with 39% of these coming from English-speaking countries. Where older people migrated from non-English speaking countries, the most common origins were the European countries of Italy, Greece, Germany and the Netherlands (Australian Institute of Health and Welfare, 2007, p. 4). The study sample demonstrated consistency with the national data of older people's migration from English speaking countries. The Australian Bureau of Statistics (ABS) reported that "28% of older people in NSW were born overseas and that the largest numbers were born in the United Kingdom" (ABS, 2004).

While the greater proportion of group members were born in Australia those that had migrated to Australia had done so earlier in life. Of the 37 participants who were born overseas, fifteen (7%) reported they had lived in Australia for between 11 and 50 years and 23 (11%) had lived in Australia for more than 50 years. The 2006 census reported that the proportion of overseas born people from English speaking countries was highest among the very old (85+ years) with 47% (Australian Institute of Health and Welfare, 2007, p. 4). Similarly, this study found that those participants who had migrated to Australia had done so many years ago.

5.17.1.4 Item 4-Living Situation/Type

Of the 200 older people surveyed, almost half, 95 (48%), reported that they lived alone and 100 (50%) lived with others. Five participants (2%) did not answer this question. Of those who lived with others, 81 reported living with a spouse or other family member. Eight participants identified that a family member or members lived with them. As seen in Figure 5.2, 94 of the study sample lived alone (77 women, 17 men).

**Figure 5.2 Number of Group Participants' Living Situation by Sex
(Respondents = 195)**



The Australian national data for 2006 reported that “family households were the most common living arrangement in private dwellings for older people, with 58% living with their married or de-facto partners” and 29% of older people living alone with the percentage increasing to 39% among those aged 85 years and over (Australian Institute of Health and Welfare, 2007, p. 11). Such findings are consistent with the current study.

One hundred and forty-eight (74%) study participants reported that they live in their own home. Thirty-five (17%) live in rented accommodation or a self-care unit with the remainder living in supported accommodation of some type, e.g. six (3%) lived in a hostel. No members of the group resided in a

nursing home. These data broadly reflect are consistent with the 2006 national data where 94% of older adults lived in private dwellings as members of a family or group or lone-person household, and just over 6% live in supported accommodation, e.g. guest house, aged care facility (Australian Institute of Health and Welfare, 2007, p. 11). According to the Australian Institute of Health and Welfare (2007), home ownership is a personal and social resource and long-term residence in one's own home provides people with a sense of security and continuity, which influences quality of life and provides an overall sense of well-being especially for older people (p. 14).

Sixty-three (31%) participants had lived at the same address for between one and nine years. Fifty-seven (28%) had lived at the same address for between 10– 29 years and 66 (33%) had lived at the same address for 30 years or more. Fourteen (7%) did not answer the question about length of time at current address.

5.17.1.5 Item 5-Employment

Participants were asked to state the main occupation they undertook during their working life; how long they had been in that position; and how long they had been retired. Free text space was provided for them to record this information which was thematically analysed to reveal the following response themes:

- Professional occupations examples included: nursing- both registered and enrolled nurses, teaching, medicine (20%)
- Managerial included for example: industry supervisor (6%)
- Clerical for example: secretary, telephonist (22%)
- Trade (skilled) for example: carpenter, electrician, hairdresser (13%)
- Unskilled for example: shop assistant, labourer, truck driver, taxi driver, process worker (18%), and
- Domestic services which included for example housewife/housework (18%). See Table 5.8 below.

**Table 5.8. Study Two: Employment Distribution of Study Sample
(Respondents = 193)**

Occupations	Frequency	Percent
Domestic/Housewife	36	18.0
Unskilled worker	36	18.0
Trade	25	12.5
Clerical	44	22.0
Managerial	12	6.0
Professional	40	20.0
Missing	7	3.5
Total	200	100.0

The majority of participant's occupations were domestic, clerical and professional which is in keeping with the group of mostly women who, in their earlier lives commonly undertook such duties. It has been noted that many women in the 1920's found opportunities in “women's professions”, such as nursing, teaching, social work (<http://www.entoes.com/1920-lifestyles-social-trends-american-decades/women-go-wo>) and in the 1940's women were still seen as nurturers, with those in employment also needing “to carry the burden of all housework and child-rearing” (http://www.skwirk.com.au/p-c_s-56_u-490_t-1336_c-5136/women/tas/women/austral). Mothers at that time were responsible for the daily care of the family and children as noted Oakley (1972, pp. 152-153) and Giddens (2001, p. 112-114), or had positions as teachers or nurses (Oakley, 1972, pp. 152-153).

Retirement: In response to the question on retirement:

- 17 participants were not retired
- 20 had been retired for between 1 and 9 years
- 39 had been retired for between 10 and 19 years
- 72 had been retired for between 20 and 29 years
- 19 had been retired for between 30 and 39 years, and
- 8 had been retired for more than 40 years.

Twenty-five participants did not answer the question on retirement. Only 9% (17 of the respondents) reported that they were not retired which is comparable

to 7% in a national data report (2003) for people aged 65 and over, who identified that they were not retired (Australian Institute of Health and Welfare, 2007, p. 25). Most women in the study sample highlighted that as housewives they had never retired and some men declared they were still working in a voluntary capacity for a number of different organisations e.g. Rotary, and so did not consider themselves retired.

In relation to financial matters, half of the respondents reported that they received a Department of Veterans Affairs (DVA) Pension and 64 (32%) were relatives of persons receiving a DVA Pension. Just over a quarter (26%) of the participants reported having been in a professional or managerial position during their working life. Thirty-one percent reported they had been in their stated employment for more than 40 years and 32% for between 20 and 39 years. Thirty-six percent reported that they had been retired for between 20 and 29 years.

5.17.1.6 Summary of Cluster 1 Variables

In summary, the majority of group participants in the study sample for Cluster One (demographics) were from the ‘middle’ to ‘old-age’ age group, with females dominating group membership. Over three quarters reported that they still lived in their own home and almost half (48%) lived on their own with the remaining either living with their spouse or other family member. Most of those living alone were female.

Most group members had been born in Australia but those born overseas had been a resident of Australia for most of their adult lives. Of those born overseas most were women who had migrated from English speaking countries such as the United Kingdom. A quarter of participants had held professional or managerial positions during their working life and had been in that employment for more than 40 years. While most were now retired 9% were in paid employment at the time of the study.

5.17.2 Cluster 2 Variables: Health Characteristics

Questions in Cluster Two asked participants to identify if they were in good ‘physical’ and ‘emotional’ health and to list any health conditions if present. The responses are provided by sex in Table 5.9 and Table 5.10.

Table 5.9. Participants’ Physical Health by Sex (Respondents = 199)

			Males	Females	Total
Physical health	No	Count	20	38	58
		% of Total	10.1%	19.1%	29.1%
	Yes	Count	32	109	141
		% of Total	16.1%	54.8%	70.9%
Total	Count	52	147	199	
	% of Total	26.1%	73.9%	100.0%	

Of the 29% reporting health problems the majority were female. Of the 17 participants reporting problems with emotional health, ten were female. This finding is consistent with Litwin’s (2001, p. 517) study into morale in old age where he claimed that women are at greater risk of having poorer psychological well-being and that gender is therefore predictive of morale.

Table 5.10. Participants’ Emotional Health by Sex (Respondents = 198)

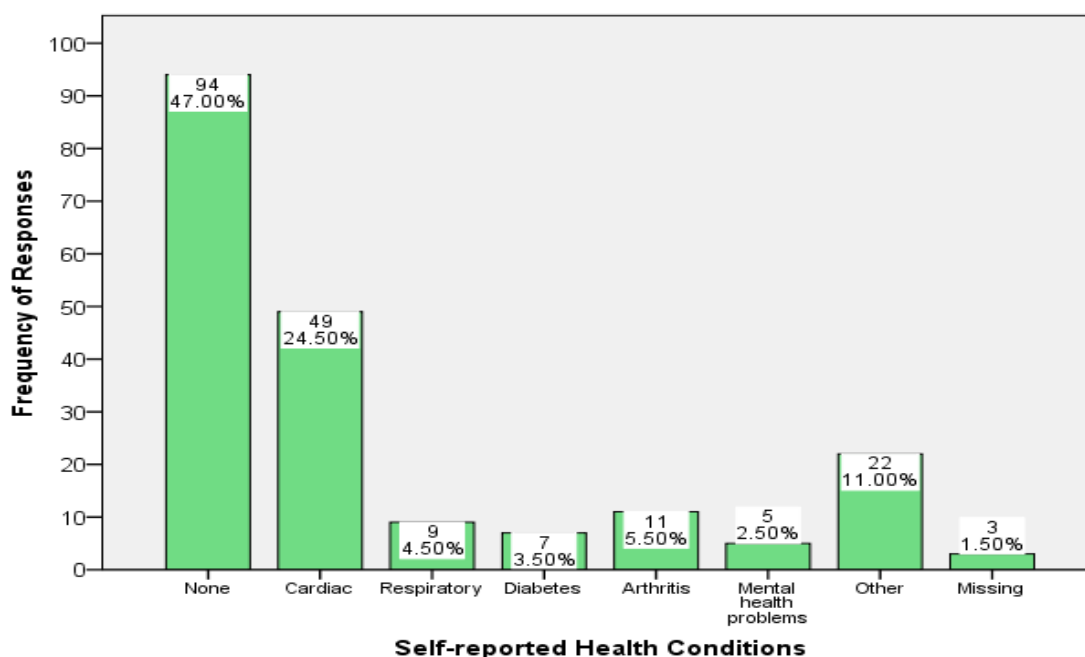
			Males	Females	Total
Good Emotional health	No	Count	7	10	17
		% of Total	3.5%	5.1%	8.6%
	Yes	Count	45	136	181
		% of Total	22.7%	68.7%	91.4%
Total	Count	52	146	198	
	% of Total	26.3%	73.7%	100.0%	

Despite listing a number of health conditions, 71% reported that they considered themselves to be in good physical health, and 181 (91%) considered themselves to be in good emotional health. This result mirrors the 2004-05 National Health Survey findings where “the majority of older Australians considered themselves to be in excellent, very good or good health” and that “many older people have a positive view of their health even

though older age may be generally associated with increasing levels of disability and illness” (Australian Government, 2008, www.aihw.gov.au, p. 293; Australian Institute of Health and Welfare, 2007, p.58).

The overwhelming majority of participants did not identify any health problems. Of those reporting health problems cardiac conditions accounting for one quarter were the most common, followed by arthritis, respiratory disease, diabetes, and ‘other’ (including kidney problems, cancer and osteoporosis (see Figure 5.3).

Figure 5.3. Self-reported Health Conditions of Group Participants (Respondents = 197)



Only 3% or five participants reported that they had a mental health problem. The Australian national data reports that 9.5% of older people had at least one long-term mental health problem (Australian Institute of Health and Welfare, 2007). While it cannot be claimed that being a member of the group has a protective element against developing mental health problems clearly, this group were more mentally healthy than in the National data. Three people (1%) did not complete this question.

5.17.2.1 Summary of Cluster 2 Variables

Overall, participants considered that they were in good physical and emotional health. Of those reporting existing health conditions, cardiac disease, arthritis and respiratory diseases were most frequently identified. This health profile is consistent with the Australian Institute of Health and Welfare (2007) Report that ranked cardiac diseases as the primary health problem among older Australians (p. 58). Arthritis was ranked by respondents as the second most common health problem similar to the national data that found, “arthritis was the most common health condition affecting 50% of older people with a profound or severe activity limitation” (Australian Institute of Health and Welfare, 2007, p. 61).

The majority of older adults are independent, and cognitively alert. Depression, although experienced by a minority of older people (Australian Institute of Health and Welfare, 2007, p. 79), was not experienced by study participants. It may be that social support is beneficial in “buffering” the effects or development of physical and or psychological health problems among this group of older adults, however, their mental health status could also be a result of other factors in their lives.

5.17.3 Cluster 3 Variables: Services Received by Group Participants

Overview: Question 19 (Cluster 3- Services Received) enquired into whether group members received community services and, if so, what those services were.

Of the 200 participants surveyed, three did not complete this question. One hundred and thirty-five (68%) reported that they did not receive any community services (see Table 5.11). Of the 197 respondents 31% (n=62) reporting service use, 47 were female and 14 male. Home or domestic services (including cleaning, shopping and at time personal care), was the most commonly recorded service type used by 51 (26%) respondents (see

Table 5.12). Those reporting use of home care services did so for domestic support such home cleaning.

**Table 5.11 Cross-tabulation of Participants Services Use by Sex
(Respondents = 197)**

Service Use			Males	Females	Missing	Total
Services	No	Count	38	97	0	135
		% of Total	19.0%	48.5%	.0%	67.5%
	Yes	Count	14	47	1	62
		% of Total	7.0%	23.5%	.5%	31.0%
	Missing	Count	0	3	0	3
		% of Total	.0%	1.5%	.0%	1.5%
Total	Count		52	147	1	200
	% of Total		26.0%	73.5%	.5%	100.0%

Only five (3%) of respondents reported using ‘meals on wheels’ and two (1%) identified receiving ‘home nursing services’ which provided specific nursing care such as dressings or other medical/nursing treatments not undertaken by home care services.

**Table 5.12. Service Types Received by Group Participants
(Respondents = 194)**

Service Type			Males	Females	Missing	Total
	None	Count	38	97	0	135
		% of Total	19.0%	48.5%	.0%	67.5%
	Homecare/cleaning/CACPs	Count	11	39	1	51
		% of Total	5.5%	19.5%	.5%	25.5%
	Meals on Wheels	Count	2	3	0	5
		% of Total	1.0%	1.5%	.0%	2.5%
	Home Nursing	Count	0	2	0	2
		% of Total	.0%	1.0%	.0%	1.0%
	Community Transport	Count	1	1	0	2
		% of Total	.5%	.5%	.0%	1.0%
	Other e.g. lawn mowing	Count	0	1	0	1
		% of Total	.0%	.5%	.0%	.5%
	missing	Count	0	4	0	4
		% of Total	.0%	2.0%	.0%	2.0%
Total	Count		52	147	1	200
	% of Total		26.0%	73.5%	.5%	100.0%

5.17.4 Cluster 4 Variables: Group Characteristic

Overview: In Cluster 4 (Group Characteristics), participants were asked to report on the length of time they had been a member of the group; whether they attended any other groups; and to record the group types where appropriate. Of the 195 responses 27 (14%) had been attending the group for less than one year. However, 104 (52%) had been a group member for between 1 and 5 years and 64 (32%) had been attending the group for between 6 and 30 years (see Table 5.13). Five participants did not respond.

Table 5.13. Membership of the Study Group in Years (Respondents = 195)

Year of Group Attendance	Frequency	Percent
<1 yr	27	13.5
1-5 yrs	104	52.0
6-10 yrs	34	17.0
11-20 yrs	21	10.5
21-30 yrs	9	4.5
missing	5	2.5
	Total	100.0

A little over half (56%) of participants attended another type of group in addition to the group surveyed. Of the 111 attending another group, 82 were female. Participants were not required to report how long they had been a member of any other group. Three people (2%) did not respond to the question on other ‘group types’.

Of those reporting attendance at different or other group types, the most frequently reported included, Legacy, Probus, Senior Citizens and church groups. In the category of ‘other’ groups, volunteer and exercise groups were mentioned. However, 43% of group participants did not attend any other group, and of those, 32% had been attending the group being surveyed for more than five years. Despite the majority of respondents being over 80 years old, their information differed from the Australian Institute of Health and Welfare (2007) report which stated that “over 1.5 million community-dwelling people 65 years and over (61%) were actively involved in a social or support

group in the past 12 months before the 2006 General Social Survey (GSS) but that this involvement ‘decreased with each subsequent age group’ with 66% of 65-74 year olds involved in groups compared with 43% for those 85 years and over” (p. 36-37).

5.17.4.1 Summary of Cluster 3 and 4 Variables

It appears that the participants in this study have little reliance on “instrumental support” (hands on support) offered by community services. Participants however, appreciate the “emotional support” and the friendships and companionship gained by attending some type of group because more than half (56%) of the respondents attended at least one other group.

5.17.5 Cluster 5 Variable: Influences of the Group on Group Members

Overview: Part 2 of the OPSG survey contained 11 variables constructed from Questions 25 to 35 (see Appendix 4.1) and explained earlier in Table 5.3. These were named Cluster Five variables, relating to the extent to which the group:

1. Is important to them?
2. Provides social support?
3. Provides emotional support?
4. Keeps you physically well?
5. Influences feelings of well-being?
6. Affects emotional health?
7. Helps feel that others support you?
8. Provides a sense of belonging?
9. Raises self-esteem?
10. Increases self-confidence?, and
11. Increases feelings of self-worth?

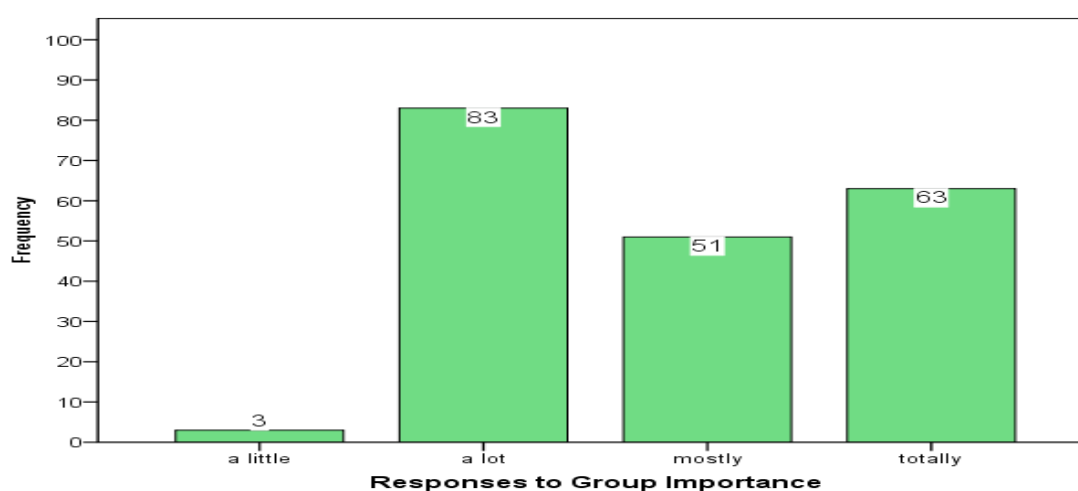
Participants were asked to rank their opinion, using a five-point Likert scale of: ‘not at all’ (scoring 0), ‘a little’ (scoring 1), ‘a lot (scoring 2); ‘mostly’

(scoring 3) or ‘totally’ (scoring 4), to identify the extent to which being a member of the group impacted on their lives. Results related to each of the 11 variables are described below and, and the majority of participants rated this aspect highly. A summary of the findings related to Cluster 5 variables is provided in Section 5.17.5.1.

1. *To what extent is the group important to you? (Variable: Group importance)*

Results: Figure 5.4 provides participants responses on the extent to which the group is important to them.

Figure 5.4. Participants Response to Group Importance (Respondents = 200)



A summary of the responses of group importance by sex is provided in Table 5.14. Almost all participants, (98%) claimed the group was important to them. Of these, 42% or 83 participants reported that group membership as having ‘a lot’ of importance. More than half (57%) or 114 identified that the group was ‘mostly’ or ‘totally’ important to them, 85 were female. Three people regarded group membership as only ‘a little’ important to them.

Table 5.14 Group Importance by Sex (Respondents = 199)

			Sex		Total
			Males	Females	
Group importance	a little	Count	2	1	3
		% of Total	1.0%	.5%	1.5%
	a lot	Count	21	61	82
		% of Total	10.6%	30.7%	41.2%
	mostly	Count	19	32	51
		% of Total	9.5%	16.1%	25.6%
	totally	Count	10	53	63
		% of Total	5.0%	26.6%	31.7%
Total		Count	52	147	199
		% of Total	26.1%	73.9%	100.0%

Munn-Giddings & McVicar (2006) noted similar findings in studies concerning the value of mutual-aid groups which, based on reciprocal peer support, offer a valuable type of resource in the community (p. 26). Furthermore, Maier & Klumb (2005), suggested "that time spent with friends affords a survival advantage among older adults above and beyond the effects of other leisure activities" (p. 31). Eighty-five of the respondents who reported that group participation was 'mostly' or 'totally' important were women of whom 61 reported that importance amounted to 'a lot'.

Table 5.15 reveals that whether they lived alone or with 'others' the group was equally important to respondents. Those who did not live alone reported that the group was very important to them. Sixty-four respondents who did not live alone reported that the group was 'a lot' to 'mostly' important, and 34 reported that group membership was 'totally' important to them. These findings are congruent with Lee & Ishii-Kuntz's study findings, as noted by Litwin (2001), who explained that friendship interactions are made by choice whereas family interactions are governed by norms and obligations (p. 522). In other words, choice of friends is important but family relationships can be different and yet remain stable.

Table 5.15 Group Importance and Living Situations (Respondents = 195)

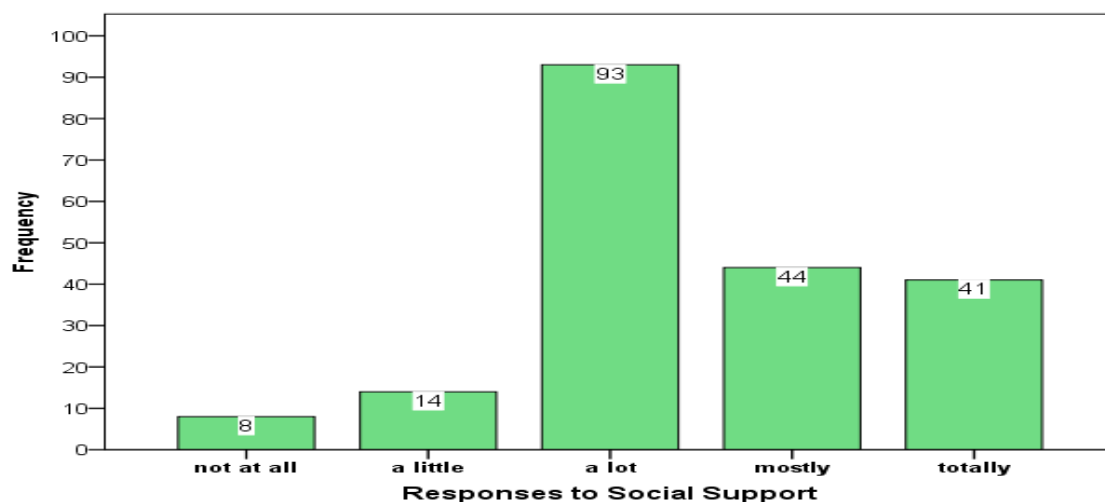
Living Situation		Group Importance				Total
		a little	a lot	mostly	totally	
Alone	No	2	37	27	34	100
	Yes	1	43	23	28	95
	Missing	0	3	1	1	5
Total		3	83	51	63	200

2. *To what extent does the group provide you with social support?*
(Variable: Social support)

Results: The group provided “social support” to 178 (89%) of males and female participants with 93 (46%). Respondents claimed that group membership offered them more than ‘a lot’ of support (72 being female) and 85 (43%) identified that being part of the group provided them with ‘most’ or ‘total’ social support (see Figure 5.5) with 62 of those being female. Eight participants stated that the group did not provide them with social support.

Clearly, participation in the groups provides members with a large social support network where they feel supported by other members in an environment that offers sustained and reciprocal companionship. In support of this finding, Maier & Klumb (2005) in their study noted that several authors had suggested that “participation provides social contacts and thereby fulfills a phylogenetically determined need for affiliation” (p. 31). Maier & Klumb (2005) also found that support and the effects of social participation did not depend on social activities but could be achieved through the mere presence of others (p. 37).

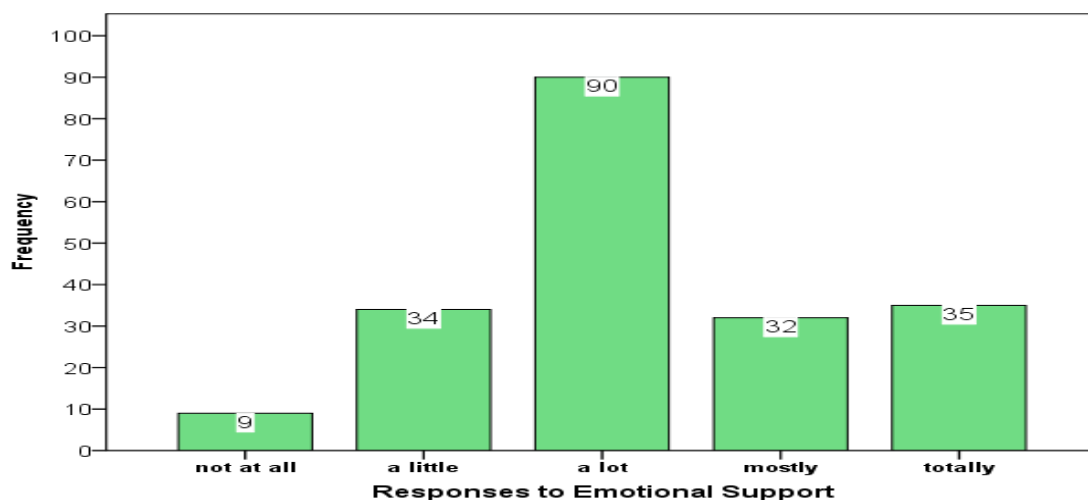
**Figure 5.5. Participants’ Response to Influence on Social Support
(Respondents = 200)**



3. *To what extent does the group provide you with emotional support?*
(Variable: Emotional support)

Results: Participants’ responses to the extent that the group provided emotional support to them are provided in Figure 5.6. Over three quarters (79%) of participants identified that the group provided “emotional support” to them ranging from ‘a lot’ to ‘totally’. Almost half, 90 (45%) reported that group membership provided them with ‘a lot’ of emotional support. A little over one third (34%) reported that the group provided them with emotional support either ‘mostly’ or ‘totally’. Of the 147 women surveyed, 116 reported they felt emotionally supported more than “a little” of the time with 40 out of the 52 males recording the same response. Nine participants recorded a “not at all” response to emotional support.

**Figure 5.6. Participants’ Response to Influence of Emotional Support
(Respondents = 200)**

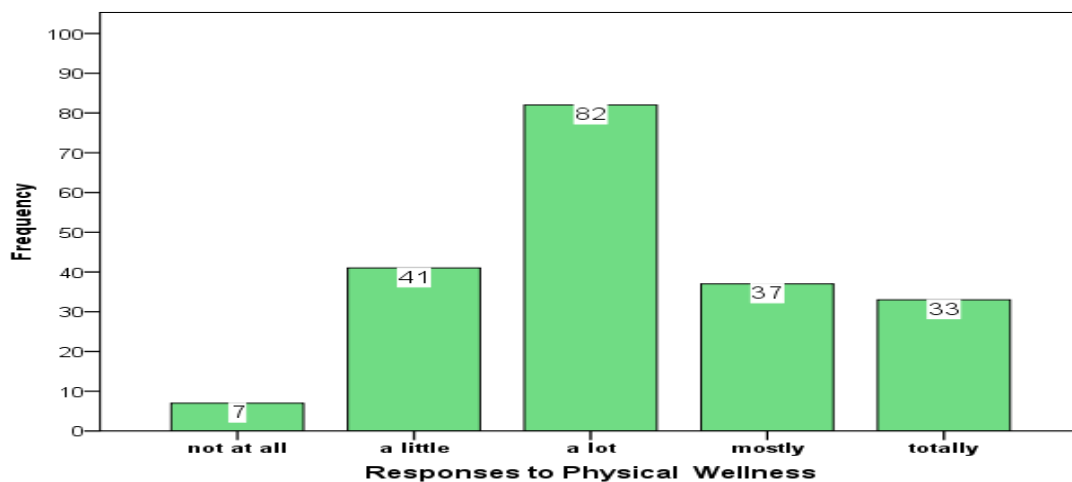


Being part of the group provided participants with emotional support and was important to participants’ sense of well-being. This finding is reflected in the literature and in particular a study by Griffiths, Horsfall, Moore, Lane, Kroon, & Langdon (2007) which highlighted that there were links between improved emotional or psychological health and community participation and a social network system.

4. To what extent does the group keep you physically well? (Variable: Physical wellness)

Results: Just over three quarters (76%), of the participants reported that the group had an effect on their physical health in a positive way. Almost half (41%, or 82 participants) identified that the group played a part in maintaining their physical health ‘a lot’ and 35% highlighted that the group impacted on their physical health ‘mostly’ or ‘totally’. These distributions of responses are displayed in Figure 5.7. One hundred and fourteen women expressed ‘a lot’ to ‘totally’ that the group kept them physically healthy.

**Figure 5.7. Participants’ Response to Influence on Physical Wellness
(Respondents = 200)**



In keeping with the study findings, Uchino (2006) referring to other authors, has identified that there are reliable links between social support and better health outcomes (p. 377). However, the mechanisms by which this is achieved was one of the primary features of Uchino’s (2006) own study into the physiological processes linking social support and disease outcomes

*5. To what extent does the group influence your feeling of well-being?
(Variable: Well-being)*

Results: All respondents felt that the group influenced their well-being to some extent. Figure 5.8 provides the distribution of responses to the extent that group membership influenced participants feeling of well-being. A large number, 89% (or 179), of participants reported that attending the group had a positive impact on their feelings of “well-being” with 147 of those being women. Almost half 48% (or 97) highlighted that belonging to the group effected their sense of well-being ‘a lot’, 76 of those being women and 21 were men. Forty-one percent (or 82) recorded that being part of the group ‘mostly’ or ‘totally’ influenced their feeling of well-being.

**Figure 5.8. Participants’ Response to Influence on Well-being
(Respondents = 200)**

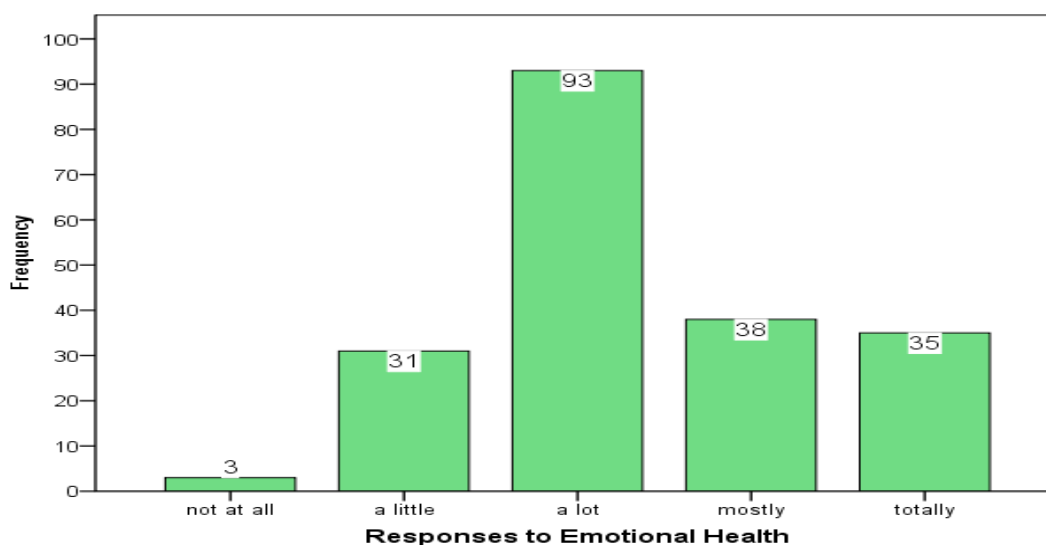


This finding is similar to the finding that group participation had on participants’ physical health. Engaging older people in meaningful leisure occupations can provide quality of life which enhances feelings of well-being.

6. *To what extent does the group affect your emotional health? (Variable: Emotional health)*

Results: Well over three-quarters (83%) of participants highlighted that belonging to the group positively affected their “emotional health”. Almost a quarter (46%) reported the group affected their emotional health ‘a lot’ and 36% (n=73) expressed that the group ‘mostly’ or ‘totally’ affected their emotional health. The distribution of responses to the question on the extent that the group affected participant’s emotional health is provided in Figure 5.9. Females (n=122) surveyed reported that the extent to which the group affected their emotional health ranged from ‘a lot’ to ‘totally’.

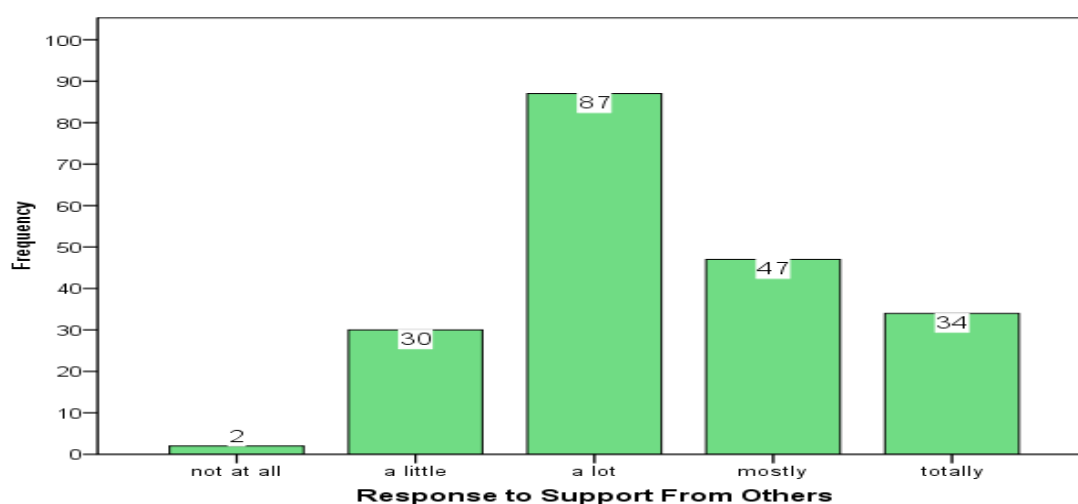
**Figure 5.9. Participants’ Response to Influence on Emotional Health
(Respondents = 200)**



7. *To what extent does belonging to the group help you feel that others support you? (Variable: Feeling of support from others)*

Results: Having people you can rely on and feeling “supported” by others in the group was reported by 84% (or 168) of participants with the distribution of these responses shown in Figure 5.10.

**Figure 5.10. Participants’ Response to Feeling of Support from Others
(Respondents = 200)**



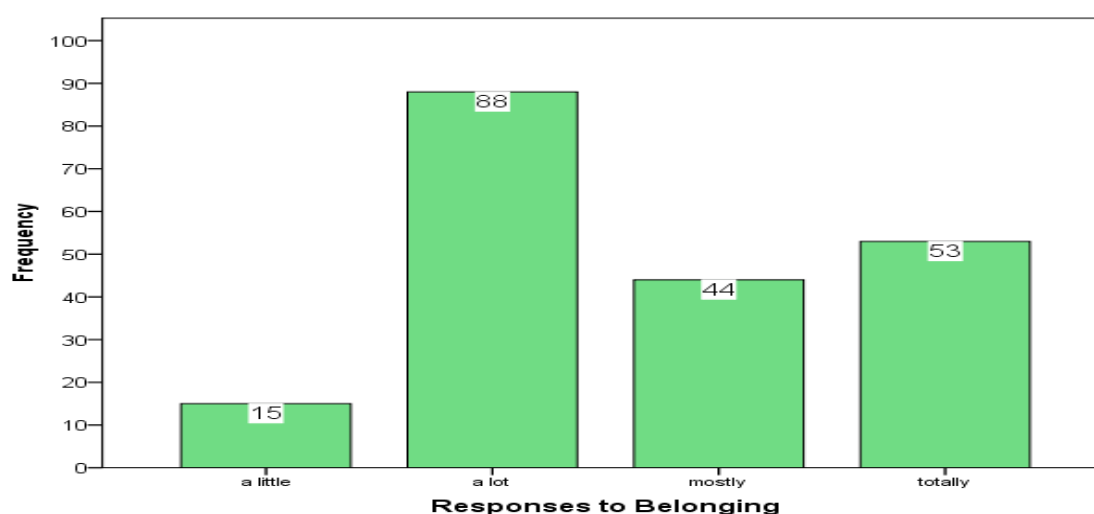
Feeling supported by other members of the group ‘a lot’ was identified by 43% (or 87), and 41% (or 81) of participants felt ‘mostly’ or ‘totally’

supported by other group members of which 54 were women and 26 men. There was mutual appreciation for one another and reciprocal feelings of friendship and connectedness among almost all group members.

8. *To what extent does belonging to the group provide you with a sense of belonging? (Variable: Belonging)*

Results: For most participants (92%) the group provided more than ‘a little’ “sense of belonging” with 135 females reporting this level of response compared to 49 men. “A sense of belonging” was recorded by 44% (or 88) of participants, as ‘a lot’, 69 of which were women, and 49% (n=97) conveyed that belonging to the group provided them with ‘most’ or a ‘total’ “sense of belonging”. The overall response rate to this question is displayed in Figure 5.11.

Figure 5.11. Participants’ Response to Influence on Belonging (Respondents = 200)

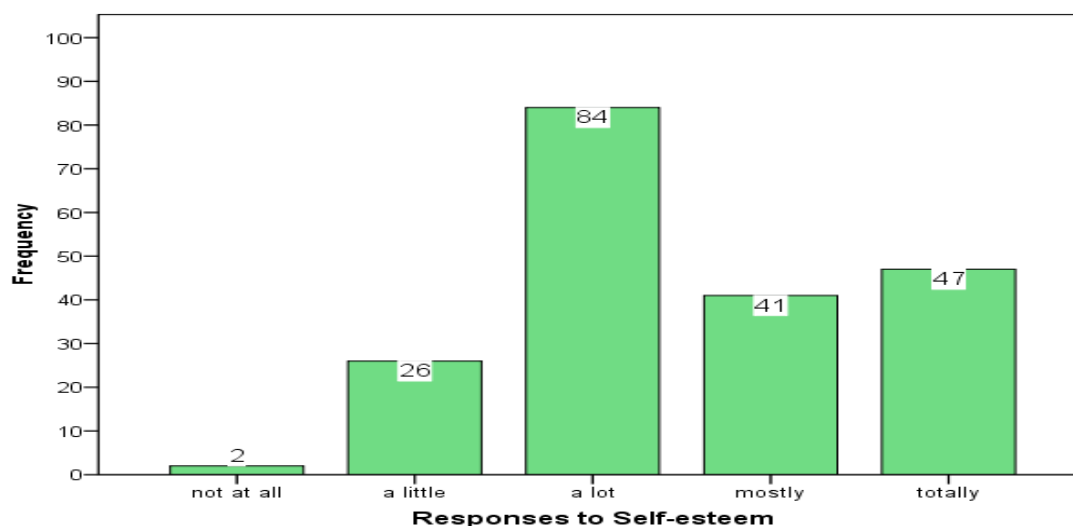


9. *To what extent does belonging to the group raise your self-esteem? (Variable: Self-esteem)*

Results: Figure 5.12 highlights the significance of group membership and its effect on self-esteem. Belonging to the group resulted in an increased sense of “self-esteem” for 86% (or 172) of group members. Eighty-four (or 42%) of participants reported that being part of the group raised their self-esteem ‘a lot’, and 88 recorded that group membership ‘mostly or

'totally' influenced their sense of "self-esteem". Litwin (2001) noted the work of authors Lee & Shehan who maintain that friendship interaction is positively related to self-esteem whereas relationships with family or kin are not (p. 522).

**Figure 5.12. Participants' Response to Influence on Self-esteem
(Respondents = 200)**

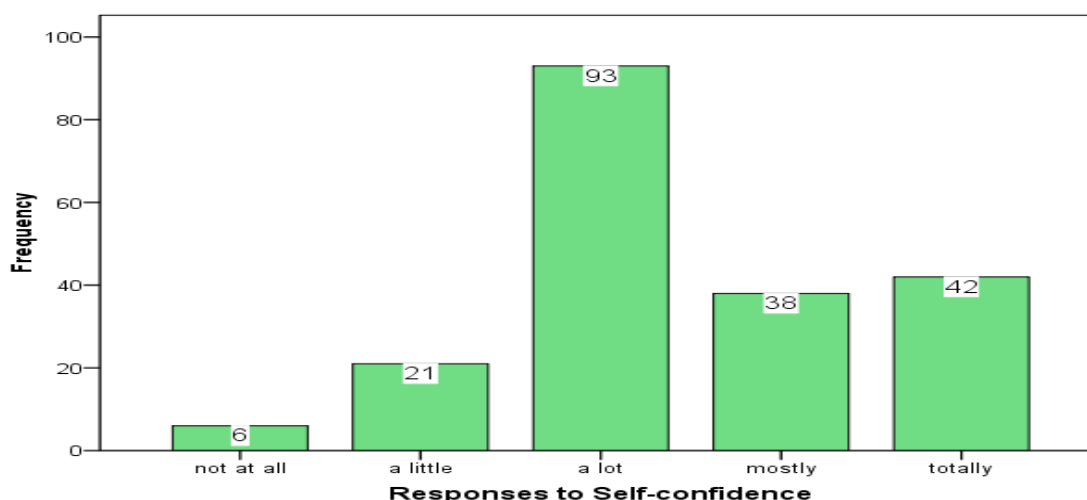


Of the 172 responses to being asked the extent to which the group raises self-esteem 'a lot', 'mostly' and 'totally', 126 were women and 45 were men.

10. To what extent does belonging to the group increase your self-confidence? (Variable: Self-confidence)

Results: Consistent with the findings related to the previous variable of self-esteem, 86% (173) of both male and female participants reported that belonging to the group increased their "self-confidence" 'a little' and above. Forty-six percent (or 93) of participants recorded that being part of the group improved their "self-confidence" 'a lot', with 40% (or 80) highlighting that it had this effect 'mostly' or 'totally' (see Figure 5.13). One hundred and twenty-eight women reported that the group influenced their feelings of "self-confidence" more than 'a little'.

**Figure 5.13. Participants’ Response to Influences on Self-confidence
(Respondents = 200)**

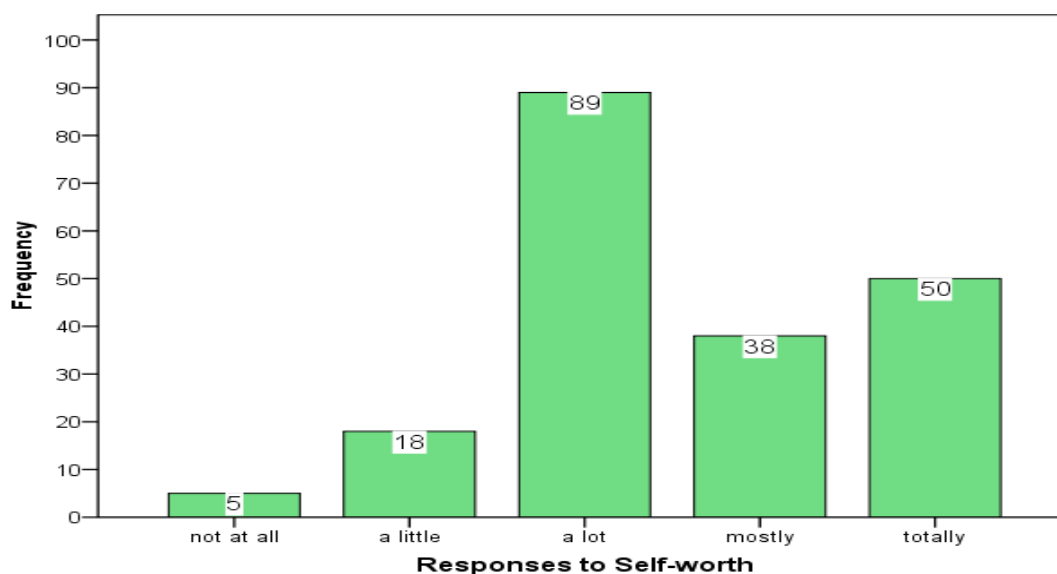


Eighty-six participants attended this group only. Of the 111 attending other groups as well as this one 95 participants recorded that the group provided them with feelings of “self-confidence” ‘a lot’ to ‘totally’, and more importantly, 76 of the 86 who did not attend any other group, experienced similar increased “self-confidence”.

11. To what extent does belonging to the group increase your feeling of self-worth? (Variable: Self-worth)

Results: Belonging to the group increased participants’ feelings of “self-worth” for 177 (88%) participants. For 89 (44%) participants being a part of the group increased their “sense of self-worth” ‘a lot’ and 44% (or 88) reported that it increased it ‘mostly or totally’ (see Figure 5.14) with 130 of those being female participants.

**Figure 5.14. Participants’ Response to Influence on Self-worth
(Respondents = 200)**



5.17.5.1. Summary of Findings for Cluster 5 Variables

Responses to Cluster 5 variables (Group Influences of Group Members) indicated that the perceived benefits of group membership were many and included significant influences on key aspects of emotional and physical health which impacted on their feelings of well-being.

Table 5.16 provides a summary of the frequency with which participants responded to Cluster 5 questions and the data indicated that almost all participants believed that group membership affected them in a number of ways. Responses ranged from maximum (‘a little’ to ‘totally’) to minimum (‘not at all’).

Table 5.16. Frequencies of Group Influence on Specific Variables for Older Persons Support Group Survey–Study Two

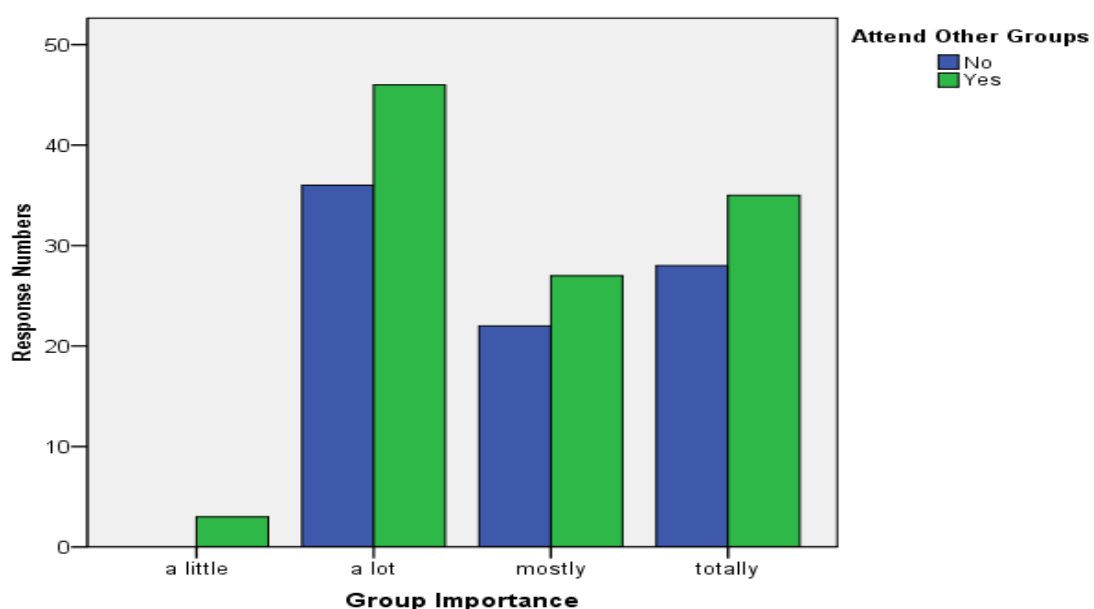
VARIABLE	Maximum frequency	Minimum frequency
Groups importance	100.0%	0.0%
Influence well-being	100.0%	0.0%
Sense of belonging	100.0%	0.0%
Raise self-esteem	99.0%	1.0%
Support from others	99.0%	1.0%
Emotional health	98.5%	1.5%
Increase self-worth	97.5%	2.5%
Increase self-confidence	97.0%	3.0%
Physical health	96.5%	3.5%
Social support	96.0%	4.0%
Emotional support	95.5%	4.5%

Two hundred (100%) older adults in the study reported that the group was important to them, even if it was only ‘a little’. Membership in these groups appeared to be more important to those who also attend other groups suggesting that these groups are indeed special to them in many ways. In the majority of cases, those who attended other groups recorded the highest responses to all 11 items that asked ‘To what extent the group impacted on their lives?’ Belonging to the group influences their feeling of well-being and gives them a sense of belonging at least ‘a little’ to ‘totally’. Over 95% of respondents reported that, to some degree, belonging to the group affects their emotional and physical health and, provides them with a sense of emotional and social support. Additionally, 84% (n=168) report they felt supported by others in the group ‘more than a little’.

From the results, of the cross tabulation shown in Figure 5.15 it is clear that the group plays a major role in members’ social networks and participants feel well supported by their peers. The group is important to them in many ways and participants believe that being part of the group positively affects their health, both physically and emotionally, and thus their “sense of well-being”. As well

as social support, the group provides them with emotional support and a “sense of belonging”. Additionally, being part of the group increases their sense of self-worth, self-confidence and self-esteem and they feel supported by their peers, friends and companions that they trusted and respected. Thus, the group is an integral part of a constellation of characteristics that has influenced group members’ overall physical and psychological health and sense of general well-being.

Figure 5.15. Importance of Group Membership Cross-tabulated with Group Attendance (Respondents = 197)



These findings are consistent with those reported by others such as Mendes de Leon, Glass and Berkman (2003) in their study on social engagement of older people and Maier & Klumb's (2005) study on social participation and survival in old age. Both study findings suggest that being socially engaged influences positive health outcomes and as stated by Maier & Klumb (2005, p. 640) “is a worthy goal in and of itself”.

5.18 Descriptive Analysis of Items from the Duke Social Support Index (DSSI) 23-item Scale

The DSSI was used to augment the phenomenological methods employed for the study (see p. 11) and to expand on data collected using the OPSG survey.

The DSSI 23-item is comprised of 23 questions and is divided into three sub-scales: ‘Social Interaction’, measuring the number and type of the social network (Questions 1-4), ‘Satisfaction with Social Support’, measuring the perceived satisfaction with the behavioural and emotional support obtained from this network (Questions 5-11) and ‘Instrumental Support’ measuring the types of instrumental support (e.g. hands on support) received by the participants from family or friends (Questions 12- 23).

Responses to each of the 23 questions were recorded under 23 coded items/variables created from key words within each question, for example, Question 1 - “Other than members of your family how many persons in your local area do you feel you can depend on or feel close to”? The variable code or identifier was entered into SPSS as “dependon” (see Section 5.14.2). For reporting purposes the three sub-scales were divided into three Clusters: ‘Social Interaction’, ‘Satisfaction with Social Support’ and ‘Instrumental Support’.

Six of the 200 participants did not complete the DSSI scale choosing only to be interviewed, leaving 194 group participants from across NSW and the ACT who answered the DSSI survey. The following information has been extracted from the responses to the 23 questions of the DSSI scale using frequency analysis are reported under the sub-scale headings.

5.18.1 Cluster 1. Sub-scale: Social Interaction

Overview: The capacity of older people to be involved in family, community and social life is an important factor that impacts on quality of life

(AIHW, 2007, p. 35). This subscale investigated participants’ social involvement with family and friends, and their participation in ongoing activities, for example, attending other group meetings.

The first subscale ‘social interaction’, contains four questions (1- 4) generating four variables and four sets of responses. Scoring protocol for this set of questions as provided by the author is shown below and in Section 5.14.2.1:

- Questions one and two are scored/coded as 0=1, 1–2=2, >2=3;
- Questions three and four were scored/coded as 0 or 1=1, 2–5=2, >5=3.

5.18.1.1 Cluster 1, Variable 1-Depend On

Results: As mentioned in Section 5.3, the first question in this section required participants to report on the number of persons in their local area that they felt they could “depend on” or feel close to people other than members of their own family?

One hundred and eighty of the 194 respondents reported that they could “depend on” one or more people in their local area, other than their family during the course of a week (see Table 5.17). Only 14 (7%) reported that they could “not” “depend on” anyone nor did they feel close to anyone in their local community. Clearly, a significant proportion of respondents had a small social network of people that they felt they could depend upon and who were part of their social support network.

Table 5.17 Results of Responses to Variable 1 - “Depondon” (n=194)

Coding	Frequency	Percent
0	14	7.2
1-2	62	32.0
>2	118	60.8
Total		100.0

5.18.1.2 Cluster 1, Variable 2-Spend Time with Someone

Results: The second question asked about “time spent with someone” who did not live with them over the course of the past week. All respondents reported spending time with at least one person during the week. One hundred and seventy-four participants reported that they spent time with others who did not live with them ‘more than once’ during the course of the week (see Table 5.18).

Table 5.18 Result of Responses to Variable 2 - “Spendtime” (n=194

Coding	Frequency	Percent
1	20	10.0
1-2	78	39.0
> 2	96	48.0
Total	194	97.0

It would appear that this group of older people are not socially isolated and spend time with others on a weekly basis. This finding is consistent with the ABS (2006) data that reported 96% of older people living in the community had contact at least once a week with family or friends who lived elsewhere (AIHW, 2007, p. 35).

5.18.1.3 Cluster 1, Variable 3-Talk to Someone

Results: Question three asked participants to record how many times they “talked to someone” (friend or relatives) on the telephone in the past week; that is, whether they called someone or someone called them. As shown in Table 5.19, all respondents talked to someone during the week with 174 recording that they communicated with someone on the telephone ‘two or more times’ in the course of the week. Seventy-three reported that they “talked to someone” ‘more than five’ times a week.

**Table 5.19 Result of Responses to Variable 3 - “Talktosomeone”
(n=194)**

Coding	Frequency	Percent
1	20	10.0
2-5	101	50.5
> 5	73	36.5
Total	194	100.0

From these results it can be concluded that this group of older adults not only have a significant social support network that involves physical contact with others residing in their local area, but that they have an extended social network accessed by telephone and attendance at other social forums, e.g. clubs and meetings. According to the Australian Institute of Health and Welfare (2007, p. 40), older people are making more use of personal computers and other forms of technology (e.g. telephones) to expand their source of communication, gather information, carry out business and access services.

5.18.1.4 Cluster 1, Variable 4-Go to Meetings or Clubs

Results: Question four asked participants to identify how often they attended groups, clubs or religious “meetings” during the past week. One hundred and two reported that they attended groups, clubs or religious meetings ‘two to five times’ a week and 14 recorded they attended such forums ‘more than five times’ a week. Seventy-eight attended no other forums (other than this group) or only attended once a week (see Table 5.20).

**Table 5.20 Result of Responses to Variable 4 - “Meetings or Clubs”
(n=194)**

Coding	Frequency	Valid Percent
1	78	39.0
2 -5	102	51.0
> 5	14	7.0
Total	194	100.0

These results are consistent with the Australian Institute of Health and Welfare (2007) report which stated that “the most common type of social activity (for older people) was visiting friends, or being visited by friends for indoor (61%) or outdoor (58%) activities” and that “similar proportions of older men and women participated in these social activities” (p. 36).

5.18.2 Cluster 2. Sub-scale: Satisfaction with Social Support

Overview: Data are recorded below under the coded variables for the seven questions that make up the second sub-scale of ‘satisfaction with social support’. Scoring for this section of the scale questions five to 10 is arranged on a three point Likert-type scale under; ‘hardly ever’ = 1, ‘some’ = 2 and ‘most’ = 3. Scoring for item eleven is ‘very dissatisfied’ = 1, ‘somewhat satisfied’ = 2, ‘satisfied’ = 3 (see Appendix 4.3). The results are as follows:

5.18.2.1 Cluster 2, Variable 5-Understand You

Results: In response to question five, 139 participants reported that they believe they are “understood” by people that are important to them such as family and friends ‘most of the time’, but almost a quarter (n=47) believe that they are understood only ‘some of the time’. A small number (n=7) report they are ‘hardly ever’ “understood” by family and friends and one participant did not answer this question. The majority feel that they are “understood” by significant others as shown in Table 5.21.

Table 5.21 Results of Responses to Variable 5 - “Understand You” (n=193)

Coding	Frequency	Percent
Hardly ever	7	3.5
Some of the time	47	24.4
Most of the time	139	72.0
Total	193	100.0

5.18.2.2 Cluster 2, Variable 6-Useful to Your Family and Friends

Results: In question six, participants were asked about their perception of whether they felt “useful” to family and friends (those people most important to them). One hundred and thirty-five reported that they feel they are “useful” to family and friends ‘most of the time’. Fifty identified they were only “useful” ‘some of the time’ and eight recorded they ‘hardly ever’ feel useful to those that are important to them (Table 5.22). One participant did not answer this question.

Table 5.22 Result of Responses to Variable 6 - “Useful” (n=193)

Coding	Frequency	Percent
Hardly ever	8	4.0
Some of the time	50	25.0
Most of the time	135	69.5
Total	193	100.0

5.18.2.3 Cluster 2, Variable 7-Going On with Family Business

Results: In question seven, participants were requested to give details on whether they knew what was “going on” with family and friends. One hundred and thirty reported that they believe they know what is “going on” within their family and among their friends ‘most of the time’ (see Table 5.23). Fifty-five declared they know what is “going on” ‘some of the time’ and only seven of the 194 participants conveyed that they ‘hardly ever’ know what is “going on” in the family.

Table 5.23 Results of Responses to Variable 7 “- “Family Business” (n=192)

Coding	Frequency	Percent
Hardly ever	7	3.6
Some of the time	55	28.6
Most of the time	130	67.7
Total	192	100.0

5.18.2.4 Cluster 2, Variable 8-Feel You Are Being Listened To

Results: Question eight asked participants to record the degree to which they felt they are “listened to” when they are talking with family or friends (see Table 5.24). One hundred and twenty (or 62%) reported that they feel “listened to” ‘most of the time’ and 66 (or 34%) feel they are “listened to” ‘some of the time’. Seven (or 4%) feel they are ‘hardly ever’ “listened to”. One person did not answer this question.

Table 5.24 Results of Responses to Variable 8 - “Listened To” (n=193)

Coding	Frequency	Percent
Hardly ever	7	3.6
Some of the time	66	34.2
Most of the time	120	62.2
Total	193	100.0

5.18.2.5 Cluster 2, Variable 9-Definite Role

Results: The frequency at which participants feel that they have a “definite role” to play among their family and friends was asked in question nine. One hundred and forty-one (or 73%) participants identified that they feel they have a “definite role” among family and friends ‘most of the time’. Forty-three (or 22%), reported this only happens ‘some of the time’ and eight (or 4%) responses recorded that this occurs ‘hardly ever’ (Table 5.23). Two people did not answer this question.

Table 5.25 Results of Responses to Variable 9 - “Definite Role” (n=192)

Coding	Frequency	Percent
Hardly ever	8	4.2
Some of the time	43	22.4
Most of the time	141	73.4
Total	192	100.0

The results related to these nine questions of the DSSI scale are similar to findings reported in the literature which suggests that:

Older adults are active contributors to family and community life. Almost half of people aged 65-74 years (48%) provide unpaid assistance to someone outside their household, one-third (33%) provide volunteer services through an organisation, 29% are actively involved in community organisations and two-thirds in social support groups of various kinds. People aged 65-74 years provide 11 % of carers and 13% of all primary carers who assist people of all ages with disability” (Australian Institute of Health and Welfare, 2007, p. viii)

thus reinforcing that older adults have a definite role and contribute significantly to the support of others and the community.

5.18.2.6 Cluster 2, Variable 10-Talk about Your Deepest Problems

Results: Question ten explored how often participants talks about their “deepest problems” with some of their friends or family. One hundred and twenty (or 62%) reported that they feel they could talk about their “deepest problems” with some family and friends ‘most of the time’ and 60 (or 31%) conveyed that this occurs ‘some of the time’. Thirteen (or 7%) reported they ‘hardly ever’ talk about their “deepest problems” with family or friends (Table 5.25). One participant did not answer this question.

Table 5.26 Results of Responses to Variable 10 - “Problems” (n=193)

Coding	Frequency	Percent
Hardly ever	13	6.7
Some of the time	60	31.1
Most of the time	120	62.2
Total	193	100.0

5.18.2.7 Cluster 2, Variable 11-Satisfied with Relationships

Results: The level of satisfaction with the kinds of “relationships” participants have with family and friends was explored in question eleven with responses provided in Table 5.27. One hundred and fifty-seven reported that they are ‘satisfied’ with such “relationships”. Twenty-two (or 11%) participants conveyed that they are ‘somewhat dissatisfied’ with their “relationship” with family and friends. Fourteen (or 7%) reported they are ‘very dissatisfied’. One participant did not answer the question.

Table 5.27 Result of Responses to Variable 11 - “Relationships” (n=193)

Coding	Frequency	Percent
Very dissatisfied	14	7.3
Somewhat dissatisfied	22	11.4
Satisfied	157	81.3
Total	193	100.0

5.18.3 Cluster 3: Sub-scale: Instrumental Support – Variables 12 to 23

Overview: There were twelve questions to this sub-scale which required a ‘no’ answer for a coded score of one point; or a ‘yes’ answer for a coded score of two points. The questions investigate whether family or friend’s help in a number of ways (see Appendix 4.3). Table 5.28 provides a summary of the questions; records the variable; the numbers of responses to each

question; and missing data. The table is colour-coded with pink showing the cluster variables; and yellow showing the greatest number of responses to the question asked. This is followed by an overview of the sub-scale results created from the responses.

**Table 5.28. Response Scores to Instrumental Support Sub-scale 3:
Items 12-23 of the DSSI Scale**

Question	Support item investigated	Variable	Yes	No	Missing data
Q. 12- Item 12	Whether family and friends help when they are 'sick'?	Help Out	n=175	n=15	n=4
Q.13 – Item 13	Whether family or friends 'shop or do errands'?	Shop/ Errands	n=152	n=39	n=3
Q.14- Item 14	Whether they received 'gifts' or 'presents' from family or friends?	Give Gifts	n=174	n=16	n=4
Q.15- Item 15	Whether family or friends 'help out with money'?	Help with Money	n=44	n= 143	n=7
Q.16- Item 16	Whether family or friends 'fix things' around the house for them?	Fix Things	n=116	n=73	n=5
Q.17 – Item 17	Whether family or friends 'keep house' or 'do chores' for them?	Keeping House	n=53	n= 135	n= 6
Q.18 – Item 18	Whether family or friends 'give advice on business or financial matters'?	Advise on Business	n=89	n=101	n=4
Q.19- Item 19	Whether family or friends provide 'companionship'?	Companionship	n=160	n=28	n=6
Q.20 – Item 20	Whether they feel family or friends 'listen to them'?	Listen to You	n=172	n=18	n=4
Q.21 – Item 21	Whether family or friends 'give advice' on dealing with life's problems?	Advise on Life's Problems	n=127	n=60	n=7
Q.22 – Item 22	Whether family or friends 'provide transport'?	Transport	n=111	n=77	n=6
Q.23 – Item 23	Whether family or friends 'provide meals' for them?	Meals	n=59	n=128	n=7

Results: This sub-scale examines whether or not family or friends provide group participants with "instrumental support" (or hands on support). The responses indicate that the majority of participants receive some type of instrumental support from either family or friends.

Participants reported that family and friends do 'help out' when participants were unwell or sick (n=175), and do 'shop or 'do errands' (n=152), 'fix things' if required (n=116) and 'provide transport' (n=111) for them. However, whether family or friends 'keep house' or 'do chores' for them was examined in question 17 where it was reported by 72% (n=135) of the respondents that this does not occur, and only 28% (n=53) of respondents identifying that such forms of support does occur.

Meals are not provided to 128 (68%) of respondents by either family or friends with only a quarter (n=59) or 32% reporting that they have some meals provided to them. This finding is consistent with OPSG survey results regarding the use of community services where 68% reported that they do not use community supports. These results suggest that the study sample do not have significant physical incapacities and therefore do not require family, friends or community services to undertake domestic activities in their home such as cleaning or cooking.

In relation to question 15, a little more than three quarters (77%) of participants recorded that they are not 'helped out with money' by family or friends. In fact, most respondents found this question amusing, affirming that "they" are the ones that help their families with money. In support of this claim, the AIHW (2007) report that 24% of all older Australians provide direct or indirect financial support for adult children or other relatives living outside the household (p. viii).

Importantly, participants' responses suggest that they believe they are listened to by family and friends and that family and friends provide companionship, bestow gifts and provide advice to them related to life's problems and, to some extent, on business or financial matters, if required.

5.19 Summary of the DSSI Scale Descriptive Results

The DSSI scale measures social interaction, social satisfaction as perceived by the respondents in relation to emotional and social support as described by Pachana et al. (2008, p. 667), and (in the 23-item scale) whether family or friends provide hands on support, defined in the literature as "instrumental support".

In the current study respondents believe that they have a network of social support and good "social interaction" with 92% reporting that they can depend on (Q1) one or more persons in the local area in which they live who were not family. However, 7% report that they do not have any one they can depend on. Forty-eight percent of participants report that they spend time (Q2) with two or more people and 87% indicated they talked to two or more people on the telephone during the course of the past week (Q3). All participants expressed that they had attended at least one group (which included the group that they were attending at the time the research study took place); with 58% identifying that they had attended two or more meetings or groups over the course of that week (Q4). Thirty-nine percent attend only this group during the course of the week. The responses shown in Table 5.29 (below) indicate that, overall, the majority of respondents experienced some form of social interaction with at least one to two people either directly or indirectly during the course of a week. All respondents engaged with at least one other person or participated in a group weekly. Table 5.29 provides a summary of the results for the sub-scale "social interaction".

The tables that follow (Tables 5.29; 5.30 and 5.31) provide an overview of the participant's responses to the DSSI scale. Interestingly their responses meld closely with the strong findings in the phenomenological interpretation of what participants were experiencing in terms of social support and meaningful relationships.

**Table 5.29. Summary Table of DSSI Results for
Sub-scale: Social Interaction, Questions 1 – 4**

Question	Responses	
Q1 Depend on	14	respondents reported they can depend on 0 person per week
	62	respondents reported they can depend on 1 to 2 people per week
	118	respondents reported they can depend on more than 2 people per week
Q2 Spend time	20	respondents reported spending time with 0 to 1 person per week
	78	respondents reported spending time with 1 to 2 people per week
	96	respondents reported spending time with more than 2 people per week
Q3 Talking to someone	20	respondents reported talking to 0 to 1 person per week
	101	respondents reported talking to 1 to 2 persons per week
	73	respondents reported talking to more than 2 people per week
Q4 Going to meetings	78	respondents reported going to 0 to 1 meeting or club per week
	102	respondents reported going to 1 to 2 meetings or clubs per week
	14	respondents reported going to more than 2 meetings or clubs per week

In terms of “satisfaction” with social support this group of participants felt that they were understood by family and friends, felt useful, knew what was going on within their family, felt that they were listened to; reported being satisfied with the relationships they had with family and friends; and felt they could confide in them with regard to their deepest problems. The participants thought they were able to receive instrumental support (hands on support) from their family and friends. However, as indicated from participants’ responses to the OPSG survey questions on whether participants received community services, 68% (n=135) did not require such support and were independent; however, they knew that assistance is available if they need it.

The following Tables 5.30 and 5.31 provide a summary of the overall social support responses for the two subscales; “satisfaction with support” (questions 5 to 11) and “instrumental support” (questions 12 to 23). Again these results augment the phenomenological findings in relation to respondent’s satisfaction with, and utilisation of, social support and networks.

**Table 5.30. Summary Table of DSSI Results for
Sub-scale: Satisfaction, Questions 5 – 11**

Question	Variable	Number of Respondents	Hardly ever	Some of the time	Most of the time
Q5	Understand you	n=193	7	47	139
Q6	Useful to family & friends	n=193	8	50	135
Q7	Know what's going on with family business	n=192	7	55	130
Q8	Feel you are being listened to	n=193	7	66	120
Q9	Define role	n=192	8	43	141
Q10	Talk about you deepest problems	n=193	13	60	120
Question	Variable	Number of Respondents	Very dissatisfied	Somewhat dissatisfied	Satisfied
Q11	Satisfaction with relationships	n=193	14	22	157

Table 5.31 (below) provides a summary of the “yes” and “no” responses to questions 12 to 23 (Table 5.28).

**Table 5.31. Summary Table of DSSI Results for
Sub-scale: Instrumental Support, Questions 12 – 23**

Questions	Q12	Q13	Q14	Q15	Q16	Q17	Q18	Q19	Q20	Q21	Q22	Q23
Response code	Participants responses to the above questions											
No	15	39	16	143	73	135	101	28	18	60	77	128
Yes	175	152	174	44	116	53	89	160	172	127	111	59
No of Participants	190	191	190	187	189	188	190	188	190	187	188	187

In relation to feeling supported, participants believed they received advantages and benefits from membership of those local community groups. Therefore, it is highly likely that the support networks the participants report

they can 'depend on' come from other group members whom they met on a weekly basis at these group meetings.

While the DSSI results are interesting, they are not the only source of data relied upon in this study.

5.20. Inferential Analyses of Data

Anecdotally, as described in Chapter One, group membership for older people impart many positive outcomes for participants. These were explored using descriptive analysis and described earlier in this chapter. However, the extent of their significance and the factors that influenced the outcomes remained unclear, so these were investigated further through the use of inferential analyses to enable inferences to be made about the population as suggested by Polit & Beck (2010, p. 392) from the sample data (Fain, 2009, p. 158; Polit & Beck, 2006, p. 362), and to make comparisons and explore differences or associations between sets of data (Kermode & Roberts, 2006b, p. 286).

Firstly, this section provides a short description of the inferential analyses used, and secondly, the results of analyses undertaken on questionnaire items (the dependent variables) from within the DSSI scale, the sub-scales: Social Interaction, Satisfaction with Social Support and Instrumental Support, and the Group Benefits Scale from within Part Two of the OPSG survey. These methods explored the relationship of these dependent variables with several independent variables described in Section 5.14.1.

5.21 Exploration of the Data

Several questions were developed by the researcher for further exploration and testing of the OPSG questionnaire and the DSSI scale using inferential analysis. Questions of include:

- Whether females or males are more satisfied with social support?
- Whether age defined or influenced satisfaction with social support?
- Whether those who live alone are more likely to be satisfied with social support?
- Whether those experiencing less physical health status are more likely to be satisfied with social support?, and
- Whether those experiencing less emotional health status are more likely to be satisfied with social support?

Factor and correlation analysis were used to explore and test these questions. An overview of the analyses is provided below.

5.21.1 Factor Analysis

Exploratory factor analysis (EFA) assumes no prior hypothesis about the dimensions of a set of variables and the most widely used factor extraction method is principal component analysis (PCA) (Polit & Beck, 2008, p. 487).

Factor analysis was used to examine the structure of the scale as indicated by Schneider (2003a, p. 385). PCA was also used to identify related variables and group them together under a common construct as suggested by Polit & Beck, (2008, p. 463) combining variables that are collinear (Field, 2009, p. 628) thus reducing multicollinearity. According to Field (2009) PCA is a ‘psychometrically sound procedure’ (p. 638).

Factor analysis was performed on Part Two of the OPSG survey to reduce data into possible sub-scales, as proposed by Munro (2001, p. 308) or to create a single construct where items measuring the same dimension are loaded on the same factor (Elliot, 2007, p. 215). Authors such as Powers et al. (2004) and Goodge et al. (1999) report on the factor structure of the 11-item DSSI scale, which has two sub-scales however, Koenig et al, (1993) described the structure of the 23-item DSSI scale as having been developed from the

original 35-item scale (p. 62). In this research study, factor analyses were conducted on:

1. Part Two of the OPSG questionnaire (questions 25 to 35) (named the ‘Group Benefit Scale’),
2. Satisfaction with Social Support sub-scale, from within the DSSI scale (questions 5 to 11), and
3. Instrumental Support sub-scale from within the DSSI scale (questions 12 to 23).

5.21.2 Correlation Analysis

Correlation analysis is the measure of the linear relationship between two variables (Field, 2009, p. 167) and is referred to as bivariate correlation (p. 175). Correlation analysis was used to examine the relationships between the characteristics of the people in the group as recommended by Kermode & Roberts (2006b, p. 286).

5.22 Analysis of the OPSG Survey with Other Variables of Interest

Factor analysis using oblique rotations was performed on the 11 questions of Part Two of the OPSG survey. Kaiser’s measure of sampling adequacy was used to quantify the correlations among items. “Cronhbach’s alpha coefficients were used to estimate the inter-item reliability for each factor and all items” as reported by Powers et al. (2004, p. 73). The percentage of variance was used to assess the suitability of the factor analyses which was also recommended by Powers et al. (2004, p. 73). The results of the analysis of items (variables) selected within both surveys are provided below.

5.22.1 Results of the OPSG Survey – ‘Group Benefits Scale’

Part Two of the OPSG survey (questions 25 to 35) was named the “Group Benefit Scale”. Using factor analysis, all 11 variables of the Group Benefit Scale were entered into SPSS 16. Analysis of this data produced an 11 x11 correlation matrix with a sample size of 200 respondents. The correlation matrix revealed no values below 0.3 or greater than 0.9.

Principal components analysis (PCA) with oblique rotation was used to determine the factor structure of the 11 Group Benefit support items. The eigenvalue was 7.602. One factor was extracted accounting for 69% of the variance. The Kaiser-Myer-Oliklin (KMO) (.936) and Bartlett's test of Sphericity ($F(193) 1.36, p > .001$) both indicated the factorability of the correlation matrix. Cronbach alpha was .954 on the 11 items indicating high reliability. Table 5.32 contains the factor structure and descriptive statistics for this component.

Table 5.32 Summary of Exploratory Factor Analysis OPSGS – Group Benefit Scale Items 25 to 35.

Analysis Summary	Factor 1: Group Benefits
Eigenvalue	7.602
% of variance	69%
α	.954

Independent *t*-tests were performed to compare the Group Benefit Scale with sex, age, living alone, less physical health and less emotional health. The *t* test revealed that there was:

- no sex/gender difference ($t(197) = .045, p > 0.05$)
- no age difference ($t(195) = .680, p > 0.05$)
- no living alone difference ($t(193) = 1.130, p > 0.05$)
- no difference on group benefit for those with poor versus good physical health ($t(198) = 1.780, p > 0.05$) or poor versus good emotional health ($t(197) = 1.073, p > 0.05$).

5.23 Analyses of DSSI Scale with Other Variables of Interest

The following provides results of correlation analyses for the three sub-scales of the DSSI 23-item scale: Satisfaction with Social Interaction, Satisfaction with Social Support subjective sub-scales and Instrumental Support objective sub-scale with the IDVs gender, living alone, physical and emotional health.

5.23.1 Results of the 23 item DSSI Scale: Three Sub-scales

1. Satisfaction with social Interaction sub-scale (items 1 to 4)

5.23.1.1 Social Interaction Sub-scale: Item 1

Item one in the DSSI sub-scale ‘Social Interaction’ explored participants’ experiences of whether - “other than members of your family how many persons in your local area do you feel you can ‘depend on’ or feel very close to?” This item was examined in relation to:

- Males and females being more satisfied with social support,
- Those living alone being more likely to be satisfied with social support, and
- Those experiencing less physical/emotional health status being more likely to be satisfied with social support/receiving instrumental.

Correlational analysis of the ‘dependon’ (dependent) variable with independent variables of interest (males, females, living alone, health status) highlighted that living alone is negatively correlated with not having many persons in their local area who they could depend on and feel close to (-.142). Although this represents a small number (n=14 of n=194) of participants it is important to identify this group so as to recognise any needs that they might have for support.

Chi-square (χ^2) analysis was performed on the in-group relationships on the following four nominal variables. The first to be examined was:

- ‘gender’ by the DV dependon developed from Question 1 of the DSSI scale and named as the variable of interest for the SPSS data base.

This analysis found no significant difference ($\chi^2(2) = .386, p > .05$).

While no statistically significant difference was found, ten older females and four males in the group had no one whom they could depend on.

The second variable was:

- ‘living alone’ by the DV dependon. This result indicated no statistically significant difference ($\chi^2(2) = .919, p > .05$) even though seven older

participants were living alone and identified that there was no one else whom they could depend on. Another six who were not living alone identified that they also had no one to depend on.

The third and fourth variables were:

- ‘emotional health’ and ‘physical health’ by the DV ‘dependon’ which showed that a difference was found ($\chi^2(1) = .000, p > .05$) between being in less physical health and having someone they could depend on. It is worth noting that 58 participants with almost equal numbers of males and females reported being in poor physical and 17 (seven males and ten females) reported being in poor emotional health.

Only one person who had emotional health issues reported not having anyone they could depend on during the course of the week (see Table 5.33). When cross tabulation with the DV ‘dependon’ and ‘emotional health’ was undertaken, sixteen of the seventeen respondents (from the sample of $n=193$) or 94%, who reported not being in good emotional health, had up to two or more people they could depend on during the course of a week. Tables 5.33 and 5.34 provide details of cross tabulation results for emotional and physical health.

Table 5.33 Result of Cross-tabulation of the DV ‘dependon’ with Emotional Health (n=193)

			Depend on			Total
			0	1 - 2	> 2	
Emotional Health	No	Count	1	5	11	17
		% within emotional health	5.9%	29.4%	64.7%	100.0%
	Yes	Count	13	57	106	176
		% within emotional health	7.4%	32.4%	60.2%	100.0%
Total		Count	14	62	117	193
		% within emotional health	7.3%	32.1%	60.8%	100.0%

Four physically unwell respondents had no one they could ‘dependon’ as shown in Table 5.34. Additionally, thirty-eight (or 66%) of the 58

respondents who reported not being in good physical health acknowledged that they could ‘dependon’ more than two person during the week with 93% acknowledging that they could ‘dependon’ at least one person during the week who were not family

Table 5.34 Result of Cross-tabulation of the DV ‘depondon’ with Physical Health (n=194)

			Depend on			Total
			0	1 - 2	> 2	
Physical Health	No	Count	4	16	38	58
		% within physical health	6.9%	27.6%	65.5%	100.0%
	Yes	Count	10	46	80	136
		% within physical health	7.4%	33.8%	58.8%	100.0%
Total		Count	14	62	118	194
		% within physical health	7.2%	32.0%	60.8%	100.0%

5.23.1.2 Social Interaction Sub-scale: Items 2, 3 and 4

Items two, three and four of the Social Interaction sub-scale asked about:

- “Time spent with someone” who did not live with the participants over the course of the past week,
- How many times they “talked to someone” (friend or relatives) on the telephone in the past week; that is, whether they called someone or someone called them, and
- How often participants attended groups, clubs or religious “meetings” during the past week.

One hundred and seventy-one participants reported that they ‘spent time’ with others who did not live with them, ‘more than once’ during the course of the week. Analyses of these data suggest that older people are not socially isolated and that they spend time with others on a weekly basis.

One hundred and seventy-three reported that they conversed with someone on the telephone ‘two or more times’ in the course of the week.

Seventy-three reported that they "talked to someone" 'more than five' times a week. It can be concluded that this group of older adults not only had a significant social support network that involved physical contact with others residing in their local area, but that they had an extended social network accessed by telephone and attendance at other social forums, e.g. clubs and meetings.

One hundred and two participants reported that they attended groups, clubs or religious meetings 'two to five times' a week and 14 recorded they attended these forums 'more than five times' a week. Seventy-five attended no other forums or only attended once a week. From this information the groups that they were attending were indeed an important part of their social network system and a significant resource for them in terms of social interaction which included spending time with others, and talking to others.

2. Satisfaction with social support sub-scale

5.23.1.3 Satisfaction with Social Support Sub-scale: Items 5 to 10

Factor analysis of this sub-scale for items five to ten shows that all variables load onto one factor. KMO was .824 and Bartlett's test of Sphericity ($F(15) 306.55, p > .001$). The strength of the relationship was 32%, with a Cronbach's alpha of .79 indicating reasonably good or an acceptable internal reliability. This result is in keeping with the recommended level of .70 as noted by Goodger et al. (1998, p. 263).

Independent t tests were performed on satisfaction with social support by age, gender, living alone, physical health and emotional health. T tests allow the researcher to test and explore the differences between two or more variables as noted by Fisher & Schneider (2007, p. 241). Thus, the following analysis examined the relationship between the five IDVs of age, gender/sex, living alone, physical and emotional health and the DV 'Satisfaction'. The following data provide t test results for:

- “Age” by Satisfaction – identified no significant difference ($t(186) = .382, p > .05$) for social satisfaction by age.
- “Sex” by Satisfaction – identified no significant difference ($t(188) = .173, p > .05$) for social satisfaction by gender.
- “Alone” by Satisfaction – identified no significant difference ($t(184) = 1.410, p > .05$) for group members’ social satisfaction if living alone.
- “Physical Health” by Satisfaction – identified no significant difference ($t(198) = .601, p > .05$) for group members’ social satisfaction by physical health.
- “Emotional Health” by Satisfaction – identified no difference ($t(197) = .105, p < .05$) for group members’ satisfaction with social support by emotional health.

3. *Finding related to the support group members’ satisfaction with the kinds of relationships with family and friends (Item 11)*

**5.23.1.4 Satisfaction with Social Support Sub-scale:
Item 11**

From descriptive analysis 157 (or 78%) of the participants reported that they were ‘satisfied’ with “relationships” with family and friends. Twenty-two (11%) participants identified that they were ‘somewhat dissatisfied’ with their “relationship” with family and friends. Eleven (7%) reported they were ‘very dissatisfied’.

4. *Findings Related to the Instrumental Support Sub-scale (Items 12 to 23)*

5.23.1 5 Instrumental Support Sub-scale: Items 12 to 23

Principal components analysis (PCA) with oblique rotation was used to determine the factor structure of the 12 instrumental support items. The Kaiser-Meyer-Olkin (.772) indicated adequate sampling size for factor analysis, and Bartlett’s test of Sphericity ($F(66) = 432.90, p < .001$) both indicated the factorability of the correlation matrix.

A factor analysis of this sub-scale revealed that there was only one factor highlighting that the items were homogenous and accounted for 50% of the variance of support. There were three factors with Eigenvalues greater than unity, each of these explained more than 5% of the variance, and together they explained approximately 52% of the variance. A Scree Plot suggested the presence of three factors. The pattern matrix is presented in Table 5.35, together with the intercorrelations among these factors, means, standard deviations, and Cronbach's Alpha. Items clustering on the same components were named:

1. Factors of 'Daily Living';
2. Factors of 'Empathy' and
3. Factors related to 'Advice and Fix Things'.

Table 5.35 Pattern Matrix of DSSI Scale Items 12 - 23

Variables of interest	Component		
	Daily Living Needs	Empathy	Fix Things
Keep house	.72		
Help money	.69		
Provide meals	.70		
Provide transport	.60		
Listen to you		.76	
Companionship		.69	
Help out		.67	
Give gifts		.56	
Shop and do errands		.44	
Business advise			-.75
Advice life problems			-.66
Fixing things			-.61

Component	1	2	3
1	1.000		
2	.168	1.000	
3	-.241	-.254	1.000

Internal reliability using Cronbach’s Alpha was .67 identifying Factor 1 named by the researcher as “Daily Living Needs”, .71 for Factor 2, named “Empathy”, and .58 for Factor 3 named “Fixing Things”. Table 5.36 provides a summary of the results.

Table 5.36 Summary of Exploratory Factor Analysis for DSSI Scale Items 12 to 23

Analyses Summary	Daily Living Needs	Empathy	Fix Things
Eigenvalue	3.455	1.644	1.078
% of variance	28.79	13.70	8.99
α	.67	.71	.58

5.24 Correlational Analysis of the DSSI Sub-scale: Instrumental Support

Within the sub-scale of Instrumental Support, analyses considered correlations were at 0.01 level of significance (2-tailed) with correlations over .400.

Responses to variable ‘helpout’ (items 12) and variable ‘shop/errands’ (item 13) related to whether others shop and run errands for you and help out when you are sick. These were positively correlated (.726) indicating a reasonably high level of correlation. It is therefore likely that when support group members are sick that family and friends will shop and run errands on their behalf.

Responses to the variable ‘give gifts’ (items 14) and variable ‘help with money’ (item 15) related to giving gifts (presents) and help out with money. These were positively correlated (.535) indicating a medium level of correlation. It may be that when support group members are sick, family and friends help out by providing monetary and other support. This was an unexpected finding as older adults in the study reported that they are more likely to provide financial and other gifts for their adult children than to receive.

Items 19 (variable ‘companionship’) and 20 (variable ‘listen to you’) were questions that asked – Do family and friends listen to you and provide companionship? These were positively correlated (.470) indicating a medium level of correlation. This finding indicates that participants consider the availability of companionship and someone who will listen to them as being available sometimes rather than always.

Independent *t* tests were utilised to explore whether:

1. Females/males are more satisfied with social support, and whether
2. Those living alone are more likely to be receiving instrumental support.

No difference between males and females was revealed on the scores for satisfaction, with their level of social support ($t(197) = 1.43, p = .153$), or between those people living alone or not alone ($t(193) = .69, p = .494$). Independent *t* tests were used to further explore whether those older participants experiencing less physical/emotional health status are more likely to be satisfied with social support/receiving instrumental support. From the descriptive analysis, the majority of respondents (91.5%) reported that they experience good emotional health and 71% reported good physical health. An independent samples *t* test revealed no significant difference between those with high versus low levels of physical health on their perception of instrumental support available to them ($t(178) = .94, p = .349$) nor on levels of emotional health ($t(177) = p = .74$).

5.25 Summary of Results from Inferential Analyses

Inferential analysis was essentially exploratory in methodology and methods. The principal dependent variables of interest in the study were the respondents subjective ranking of the extent to which group attendance and membership is important to group participants as measured by the 11-items (DVs) extracted from the OPSG survey. Responses measured the extent to which the group provide or influence different life constructs. Cronbach’s alpha at .954 indicates excellent internal reliability.

T tests demonstrated no significant difference in the relationship of any of the dependent variables to the independent variables analysed. There was no association to age, whether male or female, or whether group members were living alone or having less physical or emotional health to the value or importance group members placed on group membership.

Conclusions from the data are that the 11 variables contained in Questions 25 to 35 of the OPSG survey all have a significant influence on group member's experiences and that being a member of the group is important and that group membership provides them with significant benefits. Being part of the group influences them 'feeling good' about themselves by raising their self-esteem, increasing their self-confidence and self-worth and providing a sense of belonging. The group provided members with different items or features of support that were both instrumental and expressive. Factor analysis combined all 11 items of the OPSG survey into one factor representing the 'Group Benefit Scale'.

Factor analysis performed on the 12 items of the DSSI sub-scale Instrumental Support produced three factors confirming that group members had access to several forms of instrumental support provided by family and friends. Such support was not only 'instrumental' in nature meeting many of their "daily living needs" where support was provided through physical means such as "fixing things" and "helping out", but also 'expressive' in terms of displaying "empathy" where others provide companionship, communication, comfort and understanding through regular verbal and physical contact.

5.26 Validation

The researcher visited four of the surveyed groups to ensure content validity and to confirm that the researcher's interpretation of what was shared by participants was valid, and to seek clarification about data interpretation.

One specific aspect, which was discussed further with participants, was whether attending the group assisted them in maintaining their independence

at home for longer? This had not been explored by the researcher during conversations nor were such questions asked in either questionnaire. From the responses about “instrumental support” in the DSSI sub-scale, it was assumed that this indeed was the case as family and friends were available to most respondents to provide different components of both expressive and instrumental support. Some of the participants felt that this was possibly true for them, but could not speak for others although they suspected that this may have been the case. Whether group participation influences members’ capacity to remain in their own home longer is an area that should be considered for future research and therefore will be addressed again in the section on recommendations for future study.

5.27 Conclusion

The literature review for study two (Chapter 2 Section 2.3.2) provides a description and evaluation of research by authors such as Antonucci (2001); Beckley M (2006); Munn-Giddings & McVicar (2006); Tomaka, Thompson, & Palacios (2006) and Reblin & Uchino (2008) demonstrating a relationship between quality and quantity of social interaction and improved outcomes for people with a variety of physical and mental health problems. As noted in those studies, this research study also identifies a strong association between social participation and positive feelings of subjective wellness. Results of quantitative analysis from this research also highlights that beneficial effects of social participation can be achieved through the mere presence of others such as peers and established friendships as suggested by Maier & Klumb (2005, p. 37), and engaging in social interaction. As reported by Maier and Klumb (2005) “spending time with them (other group members) is rewarding in itself, and affirms the worth of the persons involved” (p. 37).

Results indicate that, the social context contributes to the health and well-being of this group of older adults. Peer support and connectiveness with others may possibly contribute to older group members’ longevity because of the accumulative effect of connecting with ‘others’ on a weekly basis (Maier & Klumb, 2005, p. 38). Also, group membership may also contribute to

members' independence and their capacity to remain in their own home as they have formed a local support group outside of the group meetings that they can call upon if required and which includes family and friends and other group members. Clearly the benefits and effects they receive from these weekly gatherings last much longer than the one day when the groups meet.

5.28 Reflection on Chapter 5

This Chapter describes the methodology and methods, quantitative and qualitative, utilised to conduct the second study. Key components of the research process are presented and discussed and include ethics approval, a description of the study participants, the recruitment process, and the consent protocol including information for participants. Data collection methods for Study Two are described in detail along with procedures used in data analyses.

Results are based on an analysis of data from the OPSG survey questionnaire and responses to the DSSI 23-item scale. The chapter records, where appropriate, numerical data that describes the differences between variables that were collected, attributes of individuals, and general information about group membership as indicated by Elliott & Hayes (2003, p. 298). Missing data are also identified. Data for the study sample were collected with minimal control over the study subjects, or the study environment, consistent with the principles of descriptive data collection as recommended by Burns & Grove, (2005, p. 34). The study sample was facilitated under the same principles i.e. all groups had similar activities and programs (such as exercises, quizzes, sing-a-longs) and met on a weekly basis. Importantly, the data were collected in the groups' 'natural setting' or where each group regularly came together in similar facilities, such as church halls.

CHAPTER 6

STUDY TWO: QUALITATIVE FINDINGS

This Chapter presents detailed information on the development and construction of themes derived from analysis of narratives recorded from focus group conversations with study participants, field notes and observational records collected by the researcher during Study Two.

In this chapter the findings from Study Two are compared and discussed with the findings from Study One.

6.1 Introduction

Study Two employed the same qualitative research paradigm of hermeneutic interpretive phenomenology as was undertaken for Study One (described in Chapter Three). Within this paradigm is the belief that people relate to their worlds as concerned human beings, an ontological position that "seeks to understand the conditions whereby human beings can understand their existence and thus the nature and meaning of being" (O'Brien, 2003, p. 194).

This Chapter describes the manner by which themes were developed from a collection of group member's taped conversations and transcribed narratives collected during Study Two. The findings derived from this collection of data are presented including comments recorded in field notes. Exemplars from participants were used to support the thematic analysis or study findings developed from interpretation of the text and comparisons of findings.

6.2 Data Analysis

Forty-eight group members, both male and female, from 10 of the 25 group sites visited across NSW agreed to be interviewed. Thirty-eight of them from ten sites agreed to participate in audio-taped conversations. Ten participants chose not to have their conversations tape-recorded but agreed to have conversations captured by way of the researcher's notes or simply talked to the researcher informally. Twenty-five members' taped conversations, from five of the 10 sites that agreed to taped interviews, were transcribed. Generally speaking, these sites represented the far north coast, and south coast of NSW, and inner, western and south western Sydney. ACT group members did not participate in formal focus group conversations but they did complete written surveys.

Conversations (or interviewing) ceased when information being collected reached saturation point or when no new information was being generated by further data collection, as indicated by Polit & Beck (2008, p. 71). Saturation had been achieved before the final set of conversations had been recorded, but the researcher did not wish to discourage any group member who was eager to tell their story and consequently take part in the research study.

The twenty-five participants' transcribed conversations were analysed manually by the researcher. All transcript pages were numbered sequentially (eg. A-1, A-2; B-1, B-2), for each group of participants' transcripts, as suggested by Taylor (2006c, p. 462). One copy of each set of group participant's conversations was kept untouched for reference. The conversations were a mix of short and long timeframes, some members eager to give an historical account of how they came to be involved with the group, others keen to articulate their satisfaction and delight at having the opportunity to be a part of the group. Particular group characteristics such as information on non-verbal cues shown by the group members were also recorded and become an invaluable part of the data collected.

The researcher gained knowledge of the importance and value of the group to many of the members, and the reasons why many chose not to participate in the research although they believed the research was a valuable and useful activity. The researcher identified that because group members only met once a week they preferred to spend time engaging with ‘their group of friends’ than being interviewed. This could be interpreted, suggested Shand (1994), as an example of Husserl’s philosophy of time when he professed:

that every real experience is one that endures, and
this duration takes place within the stream of an endless
filled continuum of durations which forms an infinite
unity; every present moment of experience – every
now – is fringed by a before and after as limits (p. 245).

6.3 The Hermeneutic Phenomenological Process

Upon entering the investigation for Study Two the researcher again declared her “pre-understanding” of group membership. Findings derived from Study One became the new understandings for Study One, and the “pre-understandings” for Study Two. As with Study One, narratives from the second study were collected using focus group conversations. The transcribed conversations generated the development of the second “hermeneutic text”. Analysis of the hermeneutic text uncovered themes which were consistent with findings from Study One. However, additional findings were revealed from interpretation of the narratives thus the researcher entered “the hermeneutic circle” of the second study. New understandings were unearthed adding to the “fusion of horizons”, complementing those that were uncovered during Study One.

6.4 Theme Development

As in Study One, in Study Two the researcher utilised the ideas of the philosopher Gadamer to undertake the inquiry as described in Section 3.4.1. Consistent with hermeneutic phenomenology the three main steps for analyses

were maintained: naive reading, structural analysis and interpretation of the whole text. However, for Study Two, themes were developed using the principles of thematic network analyses as described by Attride-Stirling (2001) which "seek to unearth the themes salient in the text at different levels, and thematic networks aim to facilitate the structure and depiction of these themes" (p. 387). This process was chosen because it "shares the key features of hermeneutic analysis" suggested by Attride-Stirling (2001, p. 338), where the understanding of the lived experience is sought from within the collection of narratives that create the hermeneutic text. This is achieved through a series of analytic steps as indicated by Carpenter (2003, p. 63) acknowledging the "interrelationship between epistemology (interpretation) and ontology (interpreter)" as noted by Geanellos (2000, p. 112).

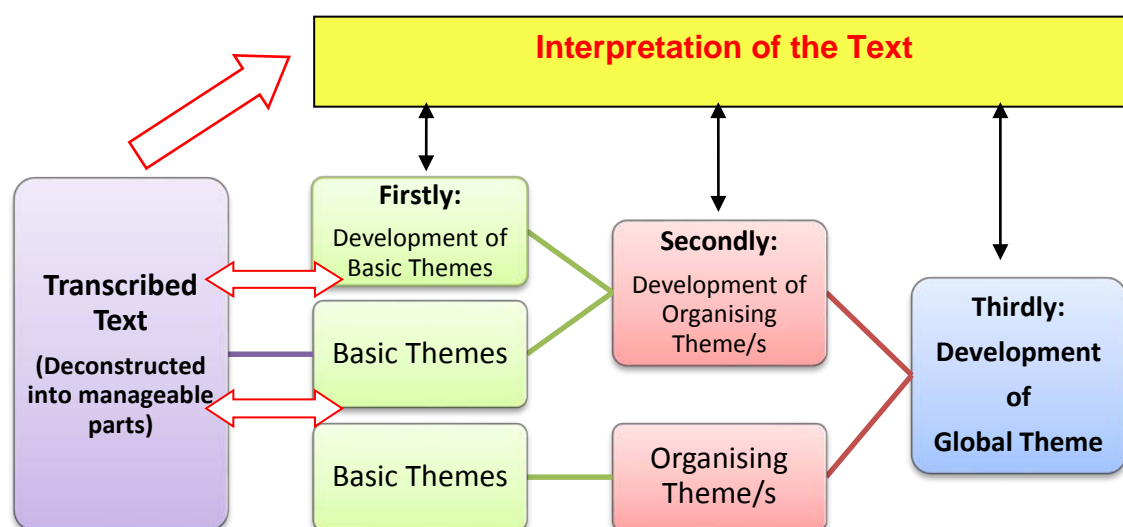
What a thematic network offers is a web-like configuration "as an organising principle and a representational means", making clear the procedures that may be employed in going from text to interpretation (Attride-Stirling, 2001, p. 388). Attride-Stirling (2001) suggested that Thematic Network Analysis is a technique that reveals each step in the analysis process aiding in the organisation of the analysis and its presentation providing "a sensitive, insightful and rich exploration of a text's" meaning (p. 386).

According to Attride-Stirling (2001, p. 388), Thematic Network Analyses:

1. put in order and draw out the lowest-order ideas evident in the text which are referred to as Basic Themes;
2. group the basic themes together to condense them into more abstract beliefs known as Organising themes; and
3. generate super-ordinate theme/s encapsulating the most basic metaphors in the text as a whole, which is referred to as the Global Theme/s.

These features are then represented as a network or structure showing the main themes at each of the three levels of development. Figure 6.1 illustrates this process. This procedure provides a method for dissecting the text into manageable parts in order to find meaning and understanding. These levels of development are presented below.

Figure 6.1: Configuration of Thematic Network Analysis



This model shows the Thematic Network Structure used to deconstruct the transcribed hermeneutic text

6.4.1 Basic Themes

Basic Themes are the most fundamental or lowest-order themes derived from the text which contribute to the development of a central or over-arching ‘global theme’. “Basic Themes are simply premises characteristic of the data and on their own say very little about the text or group of texts as a whole” (Attride-Stirling, 2001, p. 389). There is no finite number of Basic Themes that may be identified from the deconstructed text.

6.4.2 Organising Themes

The Organising Themes are the middle-order themes that group the Basic Themes together into clusters of similar concepts or ideas. The clusters summarise the primary assumptions of a group of Basic Themes, revealing meaning within the text and unifying the significance of the broader theme upon which the super-ordinate theme is based providing meaning to the text as a whole (Attride-Stirling, 2001, p. 389).

6.4.3 Global Themes

The Global Themes constitute the central theme or overarching theme that encompasses the principal metaphor in the data as a whole. Global Themes group sets of Organising Themes, "that together present an argument, or position or assertion about a given issue or reality" (Attride-Stirling, 2001, p. 389). They summarise the clusters and lower-order themes abstracted from the data providing understanding and meaning, telling us in simple terms what the whole texts are about (Attride-Stirling, 2001, p. 389). The Global theme is the core of the thematic network and there may be more than one thematic network created from the analysis of the text (Attride-Stirling, 2001, p. 489).

6.5 Construction of the Thematic Network From the Text

In this study the Thematic Network Analyses, as suggested by Attride-Stirling (2001), has three main stages. The three stages are:

1. The reduction or breakdown of the text, which includes;
 - a. devising a coding framework to dissect the text
 - b. identifying themes from coded text segments, and
 - c. constructing the Theme Network;
 - i. selection of Basic Themes
 - ii. organisation of Basic Themes into Organising Themes
 - iii. establishment of the Global Theme.
2. The exploration of the text, which includes;
 - a. Description and exploration of the Thematic network, and
 - b. Summarising the Thematic Network, and
3. The intergration of the exploration which includes interpretation of the whole text (p. 399).

6.5.1 Stage 1: The reduction or breakdown of the text

a) The coding framework:

A coding framework was developed from salient issues that were identified from within the text and from the literature reviewed. Consistent with the analytic process described above, significant statements were extracted from the transcribed. The segments of text such as quotations, single words, sentences and passages of text, were placed in a data management file (Windows for Word 2007 computer word processing document) and prominent items from within the texts identified (see Table 6.1 for an example of this process).

Table 6.1 Example of Text Dissection and Coding

Example: Segment of Text Transcript of Participants' Statements	Items Discussed and Coding Items
P1: Well I like it [the group] for companionship and actually I don't regard it as a club I regard it as my family. It feels like a family. We all know each other and know what each one has had, illnesses don't we?	<ul style="list-style-type: none">• Companionship• My family; Feels like a family• Know about each other
P2: It's the fellowshipand the people themselves, and the volunteers, they all get to know you, it's fun and it just sort of keeps you going all the time.	<ul style="list-style-type: none">• Fellowship, friendship• Fun• Engagement• Keeps them motivated

b) Identifying themes from the coded text

An example of the development of the Thematic Network is provided in Table 6.2, along with a description of the process. Using the coding framework (Column 1) segments of text or quotations were attached to coded items (Column 3). Records of the various issues that had been discussed and identified from within the text and during conversations with participants were tracked and recorded (Column 2).

Table 6.2 Example of Themes Development

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6
Codes created from literature	Issues discussed	Themes identified as Basic Themes from the Text	Basic Themes identified	Organising Themes created	Global Theme established
Humanness Solidarity	Contact Friendship Care Companion-ship Physical Protection from abandonment	Companionship Conversation Sociability All speak to each other Shown respect as well as give respect to each other You feel they really care, actually care, personally Really care for us	Caring Feeling needed Physical contact Conversation Empathy Compassion Attachment Feeling valued	Immersed in Humanness	SUPPORT (Expressive or emotional support and other types of support e.g. appraisal)
Needs being met Family Group Trust	Protection Comfort Attachment Belonging Caring	Companionship My family Feels like a family Support when sick Family group Regard it as family	Family Friends Watchfulness Safety Reassurance Feeling needed	Finding Family	Support
Pleasure Reciprocity Network	Happiness Fun Laughter Social contact Beneficial	Great day out I like the social side I like the fun Like the conversation Volunteers are wonderful Transport is wonderful All so happy Great time	Happiness Pleasure Encouragement Motivation Meeting needs Feeling good	Finding Meaning and Joy	Support

c) Construction of the Thematic Network

Themes emerged from the specific quotes that contained themes common or popular across all group conversations, which were of specific interest to the study, thus the themes that were more common were given preference. These became the Basic Themes (Column 4) which were then

interpreted and classified into Organising Themes (Column 5) where the underlying issues were made explicit thereby naming the Organising Themes. The Organising Themes were reduced and The Global Theme (Column 6) unified the Organising Themes and the Thematic Network was complete.

6.5.2 Stage 2: Exploration of the Text: Study Two Findings

Deconstructing the text provided additional meaning to the Global Theme of Support. As with the first study the most significant findings revealed from within the hermeneutic text of the second study was the concept or idea of support. The three sub-themes (or Organising Themes) from Study One were Finding Friendship, Essence of Life and Learning to Adapt.

- I. Finding Friendship had four sub-themes or Basic themes which included companionship, trust, respect and bonding.
- II. Essence of Life, also had four sub-themes or Basic Themes of acceptance and being needed, understanding, and achieving, and
- III. Learning to Adapt, had three sub-themes or Basic Themes that highlighted confidence, disclosure and giving.

These themes were clearly evident throughout conversations with participants and interpreted from within the transcribed text of the second study and consistent with the findings of the first study. However, a number of new themes or elements were identified and interpreted by the researcher from within the second study text that provided additional meaning to group membership and the importance of peer support (see Table 6.2).

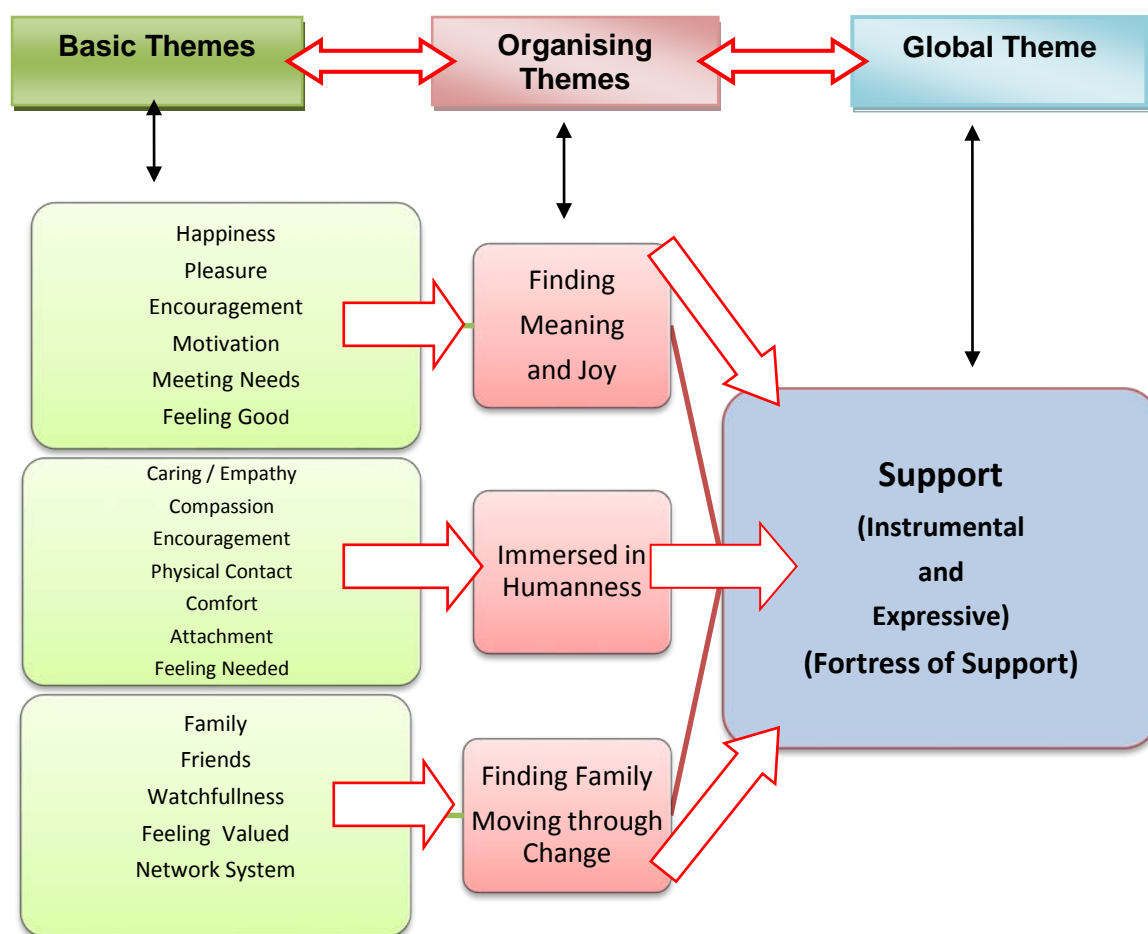
The Basic Themes created from within the second study texts were clustered into Organising Themes. The Organising themes were interpreted as:

- I. Finding Meaning and Joy with sub-themes or Basic Themes of happiness, pleasure, encouragement, motivation, meeting needs and feeling good,
- II. Immersed in Humanness with sub-themes or Basic Themes of caring, companionship, empathy, compassion, physical contact, comfort, attachment and feeling needed,

- III. Finding Family and Moving through Change with sub-themes of family, friends, network system watchfulness (safety) and feeling valued.

Figure 6.2 provides a diagrammatic model of the Thematic Network developed from analyses of Study Two.

Figure 6.2: Model of Thematic Network Development for Study Two



This model shows how the different stages of themes were created from the hermeneutic text

6.5.3 Stage 3: Integration of Exploration

Integration of the exploration included interpretation of the whole text. In this stage of analysis the key conceptual findings are summarised for each thematic network created and pooled together to make a cohesive story (Attride-Stirling, 2001, p. 402). Therefore, the principal themes and patterns that emerged in the analysis must be related back to the research question (Attride-Stirling, 2001). An explanation of the findings follow and are related back to the research question. A selection of participants' verbatim conversations are used as evidence to support the findings and illustrate the researcher's interpretation and thematic construction as suggested by Polit & Beck (2008, p. 71).

6.6 Study Two Findings

As in Study One the central or Global Theme interpreted from the conversations with participants was *Support*. Like the first study, the second study provided a focus for three additional common or Organising Themes with a collection of Basic Themes that supported the development of the Global Theme. Again the frequency of the occurrence of particular elements within the text, and the repetition of salient points as noted by Streubert-Speziale (2003a, p. 25), determined the importance of the Basic and Organising Themes. As suggested by Streubert-Speziale (2003a, p. 25). the repetitive nature of the data being collected was the point at which saturation was decided.

6.6.1 Finding Meaning and Joy

The genuine support felt by so many group members interviewed allowed them to see themselves as part of a whole connected with others which is so important in encouraging feelings of self-worth and self-esteem. This was interpreted by the theme '*Finding Meaning and Joy*' and correlated well with the theme from Study One of 'Essence of Life'. Group membership, engendered happiness and aroused much pleasure, joy and laughter. For some members, the group offered encouragement and motivation to achieve

different things (like coping with loss and grief or managing illness and pain) and made them feel valued and better able to manage their pain. These beliefs support the utilitarian philosopher J.S. Mill's (1806-1873) "Greatest Happiness Principle" which holds that actions that promote happiness are good and that "by happiness is intended pleasure, and the absence of pain" (Mills, 1998, p. 55). This philosophical theory was somewhat highlighted through the comments of one lady who claimed that:

"[She] used to stay home and listen to music. But now I really look forward to Wednesday. I find it doesn't matter how I feel I will make every endeavour to come. No matter how I feel, I might as well sit here in pain as sit at home in pain".

Furthermore, Mills (1998) proclaimed "that some kinds of pleasure are more desirable and more valuable than others" (p. 56), that "pleasures should be distinguishable not only in terms of quantity but with reference to their quality" (Harrison-Barbet, 2001, p. 199; Mills, 1998, p. 59) and "be as rich as possible in enjoyments" (Mills, 1998, p. 59). According to Harrison-Barbet (2001) Mill's also noted that happiness is made up of many elements (p. 201) which was apparent in many of the participants' comments and having observed them together as a group.

Importantly, the group appeared to bestow a health promotion way of thinking as one lady declared that:

"It [the group] was a lifeline"

And added that the group:

"[It] gives you the energy to come out".

Better mental health and emotional well-being was reported by many of the group members. One question asked by the researcher was: *"By coming to the group, does that help you in any way?"*

The eager response of one lady (who had stated previously that she had had a significant cardiac condition) was:

"Oh yes [I am] peaceful, bright and happy"

and laughingly added:

"You know I don't get depressed or anything" [as a result of attending the group].

Physical and mental activity is important and the literature review undertaken suggests that such activities contribute to one's overall feelings of well-being. One group in the present study had a significant number of men who loved to play cards. The women reported that they had never seen men laugh so much. Members believed that the games and quizzes were important and that they played a major role keeping their minds alert and cognitively active. The mental stimulation generated by a variety of board games, cards, indoor bowls, bingo, entertainment and information sessions was equally important to so many members and was captured in a statement expressed by one lady as:

"Quiz is good, keeps the mind active, tests your brain".

And supported by another participant who expressed a similar sentiment when she stated that playing cards:

"Keeps [her] brain active".

Such statements from participants were repeated with many of the same elements being reinforced such as peer support and the influence group membership had on some members' health illustrated by the statement from one lady who said:

"[It] Helps with emotional health".

The importance of the routine exercise program was also valued and many members were aware of the benefits of maintaining physical activity and believed that the exercises influenced their health and well-being in a positive way.

As with Study One overwhelming gratitude and admiration was expressed for the volunteers and organisers of the group programs. One lady stated in regard to the volunteers:

“No money, no nothing, just give their time week after week and always thinking and trying to do what they can do to make us happy...”

6.6.2 Immersed in Humanness

Humanness is the quality of being human. It is an ontological position dealing with the nature of Being described by Heidegger as “being-in-the-world”. Peterson (2001) stated that to be human is to sense beauty and feel joy and sorrow and to participate in the world around us. Benner & Wrubel (1989) writes in “Primacy of Caring” that an “aspect of humanness is that things matter to us. We have the capacity to care, and our caring causes us to be involved in and defined by our concerns” (p. 42).

Humanness is acquired over time achieved by adapting to the society in which we exist (Peterson, 2001) and connecting with others, such as our peers and, to seek a variety of components among those being comfort, support, empathy, compassion and friendship. This theme had similar concepts to the theme of ‘Finding Friendship’ identified in Study One. The eminent English poet Joseph Addison (1672-1719) wrote, “Friendship improves happiness, and abates misery, by doubling our joys, and dividing our grief” (Addison, 1672-1719 [www.famousquotes](http://www.famousquotes.com) and authors.com).

Peer support, as suggested by Caplan (1974, p. 30), “provides social – emotional supports of regular friendly interaction with those in similar situations who understand one’s predicaments and share one’s concerns”. Peer support

for some group members was not only about conversation and social engagement. The group provided a means of caring, comfort, empathy, attachment and physical contact with others, "being-with-others", an example of *'Immersed in Humanness'* expressed sincerely by one lady that:

"Friday is a special day for [her] [she gets] lots of cuddles"

And another reinforced this feeling by stating:

"We have a joke and a laugh with the volunteers. They're all really friendly".

Members were comfortable disclosing important issues to each other, and there were no secrets as stated by one lady who declared that:

"We all know each other and know what each one has had [illnesses]".

The importance of Companionship was a prominent and a re-occurring statement summarised by one lady's comment:

".....Companionship ...it's just lovely to wait for Wednesday to come!"

The concept of compassion and empathy was highlighted by another lady who claimed that:

There's no gossip, only interest if you've been absent everyone's enquiring how you feel. I had lots of calls when I've been in hospital from different members".

This statement emphasises the protective and human element present among members and how they looked out for each other and protected each other. This was also an important 'safety-net' for the members who lived alone knowing that someone will be 'looking out for them' and a comfort knowing that someone cares about them. Within this theme there is a strong reflection of

what Durkheim (1964).referred to as "mechanical solidarity" and more specifically the *collective or common conscience* where ..."The totality of beliefs and sentiments common to average citizens of the same society form a determinate system which has its own life"(p. 79).

6.6.3 Finding Family and Moving Through Change

Family can be considered as providing warmth, tenderness and understanding among its members. The Organising Theme of '*Finding Family and Moving Through Change*' comprised Basic Themes such as: like family, family group, showing respect as well as giving respect, having a watchful element in terms of 'looking out for each other' and acting as a network system assisting each of them in times of need. This family network theme had similar features as 'Leaning to Adapt' identified in study one. An example of these themes was captured by a lady who had been attending regularly every Monday for five or six years following the death of her husband. After attending for a couple of weeks she found that she liked it and stated that:

"I like the people, I like the people that organise it and I like the volunteers".....

She went on to add that since that time:

"I look forward to it [the group] every Monday".

This was reinforced by many members who stated that whatever day they came to the group was important and that no appointments or activities were allowed to interfere with whatever day they attended.

When asked what their experiences were of the group and what was important about the group, participants' responses, may be summarised by quoting one lady who stated:

"Well I like it for the companionship and actually I don't regard

it as a club I regard it as a family. It feels like a family."

Another female member stated that:

"You get respect".

6.7 Observational and Field Notes

In qualitative studies the collection of unstructured observational data is an alternative (Polit & Beck, 2006, p. 302) but also an important supplement to self-report data. Data collection was undertaken in the participants' naturalistic setting. Observational notes documented objective conversations and descriptions of different aspects of group behaviour and group dynamics of the study sample (Polit & Beck, 2006, pp. 303-304). This additional supporting data collected at various times during visits to the group meetings captured the participants' interactions with each other and enabled further immersion into the data collected. These data were primarily collected from participants who chose not to complete the questionnaires nor have their conversations recorded yet their contribution to this study was important. Interestingly, Vaillant (2007) refers to Socrates who wrote: "I enjoy talking to older people. They have gone before us on a road by which we, too, many have to travel, and I think we do well to learn from them what it is like" (Plato's Republic cited in Vaillant, 2007, p. 181).

Consent was obtained from this group of participants who were agreeable to have comments and statements used as data. This valuable data highlighted and reinforced many of the findings from the questionnaires. Comments that participants recorded in the "free-text" area of the questionnaire were also collected and used in the data analysis. Examples of some of the comments from the variety of sources stated are provided below.

The question put to members of the group in general terms was:

"What does the group mean to you and how important is it to you?"

One male group member stated that the group was important to him because:

"Likes the socialisation and meeting people.

Feels he is helping the [other] people."

One lady remarked:

"The group keeps [her] young."

Another lady who when asked: What would happen if the group did not exist? Responded with –

"We couldn't possibly describe it ... this is our life".

another said:

"I would be bored!"

One female respondent, when asked: Why the group was important to her, responded with:

"[It is an] outlet, without it I do not know what I would do!

[Provides] Friendship

[You] get information from visitors".

For some members, group membership had almost a medicinal or therapeutic like quality. One lady supported that belief when she emphasised that [the group] was:

"A tonic for her".

Another lady stated that:

"This group gives me a reason to get out of bed".

The power of interaction and conversation were consistent with findings from the first study by statements such as:

"Communicating with others is so important."

Many of the participants reported the happiness they experienced by coming to the group every week and that they looked forward to it so much and hated the Christmas holiday break when the groups did not meet. Many reported:

"[They] never laughed so much until they came to the groups".

This was evidence of a particular vitality that was derived from others in the group on those days that members met. Vitality, according to van Dongen (2001, p. 400), is an important source which involves humour and is related to intimacy, and in the words of Joseph Addison (1672-1719) "true happiness arises, in the first place, from the enjoyment of one's self, and in the next from the friendship and conversation of a few select companions" (Addison, 1672-1719 [www.famousquotes](http://www.famousquotes.com) and authors.com).

6.8 Discussion

The Global Theme for Study Two remained as "Support" but Basic and Organising Themes for Study Two gave the Global Theme added meaning and so was named by the researcher as the "Fortress of Support" because it encompassed elements of 'expressive', 'appraisal', 'instrumental' and 'informational' support and because of the protective factors that group membership appeared to provide to members. Attachment, trust and reciprocity as suggested by Putnam (2000) are clearly evident providing strong and beneficial support.

The benefits of group membership that emerged were many but prominent among the numerous elements were that the group was influential in:

- i. Preserving and protecting (Organising Theme) group members' physical and mental health were highlighted within the Basic Themes of engaging in exercise programmes, maintaining mental

- stimulation, having human contact and being involved in conversations with peers.
- ii. Providing (Organising Theme) a pleasurable and happy environment where the importance of group membership was emphasised through the Basic Themes of friendship, fun, and being part of a family (attachment), and
- iii. Promoting (Organising Theme) positive feelings of well-being with meaning provided by the Basic Themes related to the capacity of the group to raise self-esteem, self-confidence and self-worth amongst each other.

6.9 Validation

Data were collected until saturation was achieved as suggested by Fain, (2009, p. 206). Sampling was purposive where older people were selected who had lived the experience of group membership and were willing to participate in the study as recommended by Fain (2009, p. 206). The sample size represented the total number of groups that meet across NSW and of different regions across the state, eg. rural, far north and south coast, the Sydney metropolitan area and the central north and south coast districts and the ACT. The researcher visited the groups involved in the study conducting face to face interviews, undertaking participant observation and recording field notes of those experiences. This allowed the researcher to observe and record environmental aspects of the group and confirm this with interview data and compare and contrast this with quantitative data analysed from the two questionnaires.

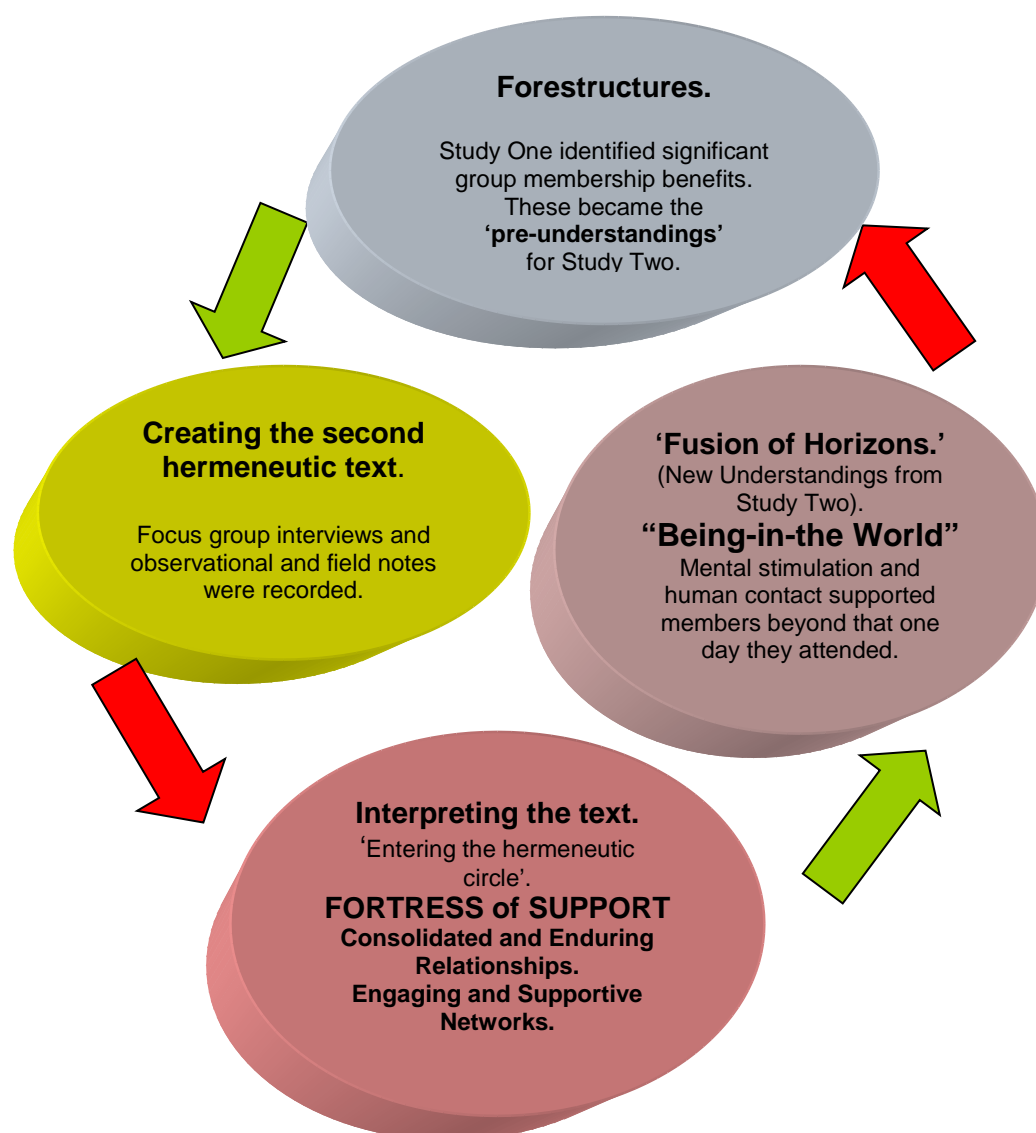
6.10 Conclusion

The selection of exemplars presented were tape recorded and documented by the researcher during group conversations (interviews) with participants and collected as field notes. These statements reflected the literature reviewed where studies reported that group involvement improved [participants'] quality of life, decreased loneliness and [their] perceived impact

of [their] disease (Reblin & Uchino, 2008; Mendes de Leon, Glass, & Berkman, 2003). More importantly these narratives strengthened and reinforced the findings from the two questionnaires suggesting that group membership played a major role in contributing to group members' sense of self, and well-being and health, and that being a member of a group was a key ingredient that contributed to their capacity to create, engage in and maintain a meaningful social and productive life.

Qualitative findings from Study Two have many parallels with the themes from Study One such as friendship, companionship and supporting each other during life's journey. However, there are additional constructs and concepts related to the meaning of group membership identified in the second study. Study Two also identified common features around support but appeared to generate powerful features around bonding, and the development of enduring relationships that offered experiences of humanness, interconnectiveness and consolidation of a social world that they have each contributed to. This "social engagement" encompasses 'social care' (both instrumental and emotional/expressive) 'social networking' and 'social integration'. The group provided an appealing and therapeutic atmosphere that acted as a form of alternative therapy for some of the group member's physical ailments. The group had become a "fortress of support", a treasury of elements which gave them a reason for "being-in-the-world", providing a forum for fun, mental and physical stimulation, and human contact which sustained them throughout the week. Figure 6.3 provides a revised model of group membership experiences incorporating the themes from Study Two.

Figure 6.3. Model of Support Experiences for Study Two



Collective Model of Support generated from Study One and Study Two findings reflecting hermeneutic interpretive processes of thematic analysis

6.11 Reflections on Chapter 6

This Chapter has provided the findings generated from interpretation of conversation through the use of narratives recorded during Study Two of the research project. Overall, no difference was found between the findings of the two studies. Groups in Study One and Study Two met for the same reasons (of socialisation and the need to be with peers) and members reported the

same outcomes of finding companionship and friendship, being part of conversations and communication, and feeling supported socially and emotionally. Being a member of a group combated loneliness and according to participants, significantly influenced physical health and feelings of well-being.

CHAPTER 7

INTEGRATED DISCUSSION

The chapter begins with an overview of the research study. Discussion of the findings from the preliminary study along with the results of the descriptive and inferential analyses conducted for Study Two are provided in this chapter.

The overall findings are highlighted emphasising the philosophical underpinnings that were used to develop the research study. Additionally, a reflection of the social concepts described in the literature review are re-examined in the context of the research study's qualitative findings and quantitative results along with the limitations, strengths and weaknesses of the research study.

7.1 Overview

There was limited literature identifiable on research into firstly, the experiences and secondly, the benefits of group membership and social support networks for older adults living in the community where group membership was unrelated to any health problems. This belief was supported by a number of authors including Harris, Nutbeam, Sainsbury, King & Whitecross (1999) who found little work published on interventions in the health literature (p. 149) and later by Fiori, Antonucci, & Cortina (2006) who found "little research on the influence of network types on well-being" for older people (p. 25).

The researcher, as explained in Chapter One, had only anecdotal evidence on the benefits of group membership for older adults and therefore required empirical evidence to support this claim. Thus, a research study was developed to address this knowledge deficit consisting of a preliminary study

and a main study. Study One engaged older adults in conversation and employed hermeneutic interpretive phenomenology for data analysis of those conversations. The main study design used a mixed method incorporating two paradigms: qualitative, again employing hermeneutic interpretive phenomenology for data analysis of participant’s conversations, and quantitative, using descriptive and inferential analysis to examine the data generated from participants’ responses to two questionnaires.

The purpose of the research study was to investigate the benefits of group participation in terms of the personal and social benefits, the influence this may have on their feelings of well-being and therefore possible health benefits as perceived by the participants, for older adults living in the community across NSW. The research question: “What are the experiences of older people participating in groups and what are the benefits of group membership?” aimed to:

- explore and interpret their experiences,
- increase the understanding of the meaning of ‘being’ for older adults participating in groups,
- reveal the personal and social experiences of well older people engaging in peer support groups and social network systems, and
- quantify the depth and extent of those experiences.

An additional aim was to provide evidence that would allow health professionals, particularly nurses, to expand their knowledge and develop a greater appreciation about older adults and the importance of social groups and socialisation, and to identify appropriate network systems needed to support older people, particularly while living in their own home.

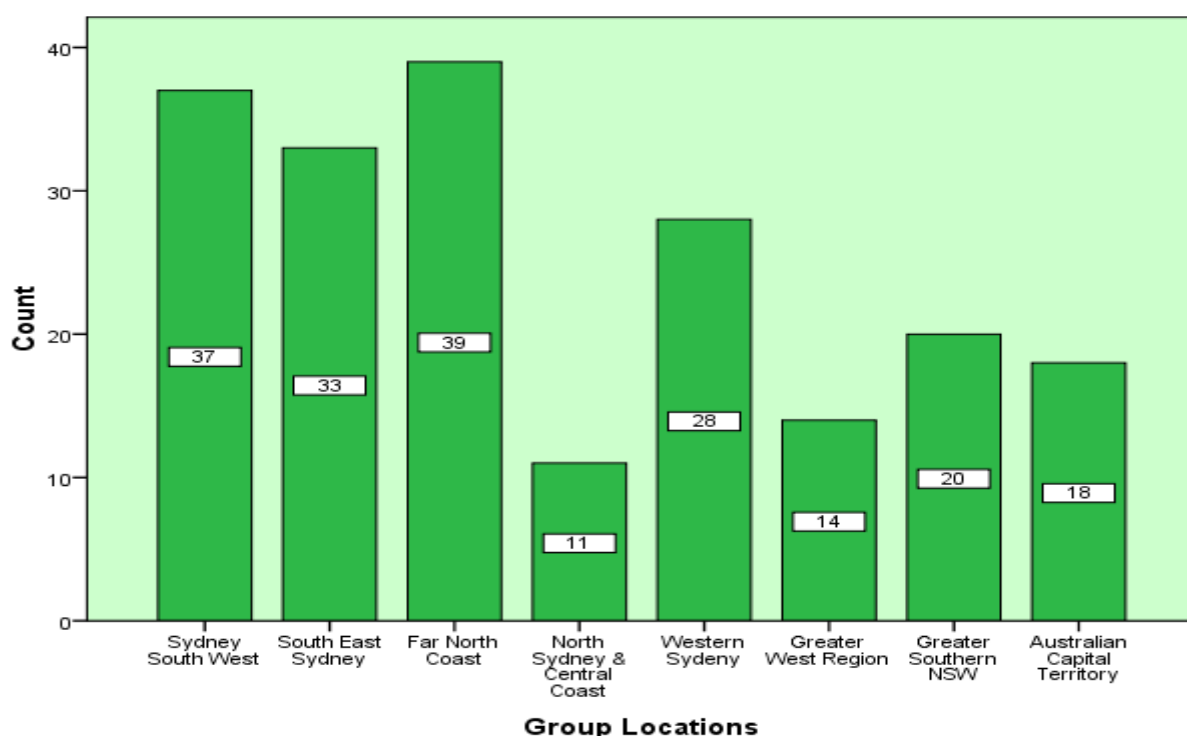
7.2 Discussion

Study One was conducted using focus group conversations involving a small number of participants (n=6). Study Two of the research engaged a larger number (n=200) of participants and employed mixed methods using both qualitative and quantitative data collection methods and appropriate data

analyses. These two research methods were selected to enhance data collection capacity, to generate additional information about group membership and to provide a more holistic and deeper understanding of the phenomena under study. Sampling was purposive, and participants were self-selecting from groups of older people meeting across NSW and the ACT. However, there was an attempt to collect data from a representative sample of participants from groups meeting across different regions of NSW, including the north coast and far north coast, the south coast and far south coast, the inner, western and south western Sydney metropolitan areas, and a rural and regional location.

Data for Study Two came from focus group conversations, and the completion of two questionnaires collected from participants attending social support groups across NSW and the ACT (See Figure 7.1). Two survey questionnaires were used in the research study (along with participant focus group conversations) to gain an understanding of these phenomena. The Older Persons Support Group Survey (OPSGS) collected items that allowed for the construction of a profile of those attending the particular groups surveyed and measured participants' perceptions of the extent to which group membership affected them. The self-report component of the OPSG survey (Questions 25 to 35) captured participants' opinions of the importance of group membership and allowed them the opportunity to express the extent or degree to which group membership influenced different characteristics related to their health and feelings of well-being.

Figure 7.1. Number of Study Participants Across NSW and ACT



The second questionnaire, the 23-item Duke Social Support Index (DSSI) allowed participants to report levels of satisfaction within three key sub-scales related to social support, satisfaction with support and whether they had access to instrumental support. The 23-item DSSI scale measures the perceived satisfaction with the level of support and whether instrumental support was part of that network. This instrument (DSSI) was used to ensure rigor of the quantitatively derived data. Data from the completion of these questionnaires were analysed descriptively and inferentially utilising SPSS Version 16. Therefore, new knowledge was generated from the descriptive and inferential analysis of quantitative data collected in Study Two. However, it is important to emphasise that the qualitative paradigm and associated research methods as used in Study One remain the primary data source for Study Two and the focus for the overall research study.

7.2.1 Demographic Profile of Study Two Participants – Survey Components

Cluster One of the OPSG survey collected demographic data and provide a profile of group attendees. Of those surveyed the majority of group

attendees were born in Australia, aged between 70 and 89 years, and living independently in their own homes either alone or with a spouse or other family member. The greatest proportions of those surveyed were female (n=147).

As reported by the Australian Institute of Health and Welfare (2007), men and women attend informal social activities (visiting or socialising with friends; both indoor and outdoor activities) in similar proportions until aged 85 years and over where male participation declines as opposed to that of females (Australian Institute of Health and Welfare, 2007, p. 36). There are also similar participation rates in social or support groups by both men and women but this is reported to decline by 85 years and over particularly for women and is possibly related to increased disability and widowhood (Australian Institute of Health and Welfare, 2007, p. 37). However, such reports are not consistent with my findings from study sample with females as the dominant group members in all age categories.

In the study sample, responses to the question on employment (Question 13) indicated there was a relatively equal distribution of participants in each occupation represented except for managerial positions (n=12) which were lower. This is possibly because management positions have become a significant part of the today's workforce and career pathways, which were not as prominent in the workforce during the period that most of the study participants would have been employed. Furthermore, Oakley (1972) reported that males had higher paid positions that had higher prestige (p. 153). In support of this, and according to the 2006 census, there was an even distribution of mature-age persons across all major occupational groups, "with the exception of the larger proportion in the higher skilled occupations category of managers and administrators (where mature-age persons constituted 52% of the total employment) and the smaller proportions in the lower skilled occupations of elementary clerical, sales and service workers (26% of the total employment, ABS 2006)" (Australian Institute of Health and Welfare, 2007, p. 23). Oakley (1972) reported that there had been a significant increase in the number of women employed in office and secretarial positions since the Second World War and that such positions were seen as fitting "with the

traditional female role”(p. 153). This is what Giddens (2001) referred to as “occupational gender segregation” based on what is designated as ‘male’ and ‘female’ work (p. 391). However, there is evidence that the distribution of occupations has since changed significantly to the sample population in terms of generational management opportunities and positions in Australian society particularly for women.

According to the AIHW (2007, p. viii) there were 266,100 Department of Veterans’ Affairs (DVA) income support beneficiaries aged 65 and over representing 10% of all older Australians and 27% of those 85 years and over in receipt of DVA income support. DVA pension recipients were well represented in this study probably because the groups (excluding the hospital group) operated under the patronage of the ex-service organisation (the Returned and Services League) and the Department of Veterans’ Affairs.

7.2.2 Cluster Two, Three and Four of the OPSG Survey

Cluster two explored health characteristics of group attendees. From the study of group attendees, almost three-quarters reported being in good physical health and 91% reported being in good emotional health despite many recording health conditions, the most common being cardiac. These findings are similar to those found in the 2004-05 National Health Survey findings (self-assessment) where “the majority of older Australians considered themselves to be in excellent, very good or good health” and that “many older people have a positive view of their health even though older age may be generally associated with increasing levels of disability and illness” (Australian Government, 2008, www.aihw.gov.au, p. 293; Australian Institute of Health and Welfare, 2007, p.58). Furthermore, studies by Uchino (2006) identified that there was “strong evidence linking social support to aspects of cardiovascular function that may confer lower risk for disease” and “that social support is associated with lower testing of blood pressure primarily in older adults” (p. 379). It is understood that this occurs because social support decreases deleterious cardiovascular changes during stress (Uchino, 2006, p. 380).

Results of Cluster Three on community service use indicated that almost three-quarters of those surveyed did not require community services or 'instrumental support' (as reported in Question 19 of the OPSG survey) despite a number recording health conditions. Moreover, from responses to Question One of the DSSI scale more than half of the study sample reported that they could depend on a family member or a close friend in the local area, to assist them should they require help.

Cluster Four enquired about the degrees of social interaction group attendees were engaged in. Of the 200 members surveyed 111 reported attending at least one other group during a week. One hundred and thirty-eight had been attending the current group for between one and ten years.

The Australian Institute of Health and Welfare (2007) stated that "over 1.5 million community-dwelling people 65 years and over (61%) were actively involved in a social or support group in the past 12 months before the 2006 General Social Survey (GSS) but that this involvement "decreased with each subsequent age group" with 66% of 65-74 year olds involved in groups compared with 43% for those 85 years and over (p. 36-37). However, this finding was not consistent with the findings of this study where the majority of group attendees were over 80 years of age.

7.2.3 Cluster Five of the OPSG Survey

The principal dependent variables of interest in Study Two were the respondents' subjective ranking of the extent to which group attendance and membership was important to group participants as measured by the 11-items (DVs) extracted from the OPSG survey in Cluster Five. Responses measured the extent to which the group provided or influenced different life constructs.

From the completed self-report section of the OPSG survey (Questions 25 to 35) it appeared that group participation had multiple benefits. The group was very important to the vast majority of group members offering a significant source of social and "emotional support", and a "sense of belonging". Over

three-quarters of the members had been attending the group for more than ten years. Importantly, participants reported in Questions 33, 34 and 35 of the OPSG survey that being a member of the group was strongly associated with feelings of "self-esteem", "self-confidence" and "self-worth". Although a small proportion of group members reported a number of health problems, almost all highlighted that group participation positively affected their physical and emotional health and increased their "feeling of well-being". It could be suggested that being part of the group influenced members' physical health by providing them with an exercise program that they believed was worthwhile. In support of this belief, Baker, Atlantis and Fiatarone Sing (2007, p. 375) claimed that "various modalities of exercise have been demonstrated to improve physical function and quality of life in older adults". Uchino (2006) also noted that health behaviours such as exercise can have beneficial effects on feelings of stress (p. 378). Moreover, a number of studies (Reblin & Uchino, 2008; Beckley, 2007; & Tomaka et al., 2006) investigated the benefits of social interaction to better health outcomes for people with a variety of health conditions. Their studies, for some participants, showed little changes in the course of the disease process, but they did identify positive changes in patient attitudes to their health status and to quality of life as a result of social and community participation and peer support. Thus it could be assumed that group membership in this study cohort is having similar effects on attitudes to health.

From the data analysed the researcher concluded that the 11 variables contained in Questions 25 to 35 of the OPSG survey indicated important outcomes which all had a significant positive influence on group member's experiences. Being a member of the group was important and group membership provided them with significant benefits. Being part of the group influenced them in terms of 'feeling good' about themselves by raising their self-esteem, increasing their self-confidence and self-worth and providing a sense of belonging. The group provided members with different items or features of support that were both instrumental and expressive. Factor analysis combined all 11 items of the OPSG survey into one factor

representing the ‘Group Benefit Scale’. Cronbach’s alpha was .954 indicating excellent internal reliability.

7.2.4 Duke Social Support Index Scale

The DSSI scale measured social interaction, social satisfaction as perceived by the respondents in relation to emotional and social support as reported by Pachana et al. (2008, p. 667), and whether family or friends provided hands on support, defined in the literature as “instrumental support”.

There was no significant difference found on the benefit of group membership by age, gender, living alone, or having poor physical or emotional health. Therefore, the results indicate that the values older people put on being part of a social support network and a member of a peer support group have no relationship to how old they are, whether they are male or female, or living alone or with others.

Group members believed that they had a ‘social network’ that supported them. Responses to Question One of the DSSI scale indicated that 90% of attendees had someone in the local community they could ‘depend on’. However, 14 (7%) attendees indicated that they did not have anyone they could depend on. All attendees spent time with at least one person during the course of the week, 87% spent time with more than one person and 48% with two or more people in the course of a week.

People in poor health often feel physically isolated and have limited social supports and a smaller network of people upon those whom they can rely. However, those who reported being in poor physical and emotional health reported that they did have people they could ‘depend on’ possibly as an *outcome* of group participation. People they could ‘depend on’ were family but may possibly be other group members for as Thorlindsson (2011) reports “individuals that live in a community that is poor in social capital may benefit from their involvement in networks that produce social capital” (p. 22). Furthermore, Cohen & Wills (1985) reported “that people who have more social

companionship have more access to instrumental assistance and esteem support" (p. 313). Additionally, Putnam (2000) reported that being engaged in a group resulted in other members helping out when someone was sick or that other group members had extended help to someone outside of the group making those people feel that there was someone they could depend on and that they were not alone (p. 149). This may be what Putnam (2000) referred to as "civic virtue" which he said was most powerful when embedded in a dense network of reciprocal social relationships which thus produces social capital (p, 19).

Giddens (2001) wrote that the transfer of information and communication is crucial to any society (p. 461). So the fact that all respondents reported attending at least one group (which included the group that they were attending at the time the research study took place) with 58% identifying that they had attended two or more meetings or groups over the course of that week, was important and highlighted their eagerness for social engagement. Additionally, 48% percent of participants reported that they spent time with two or more people during the course of a week which according to Giddens (2001, p. 463) is referred to as face to face interaction. Results of responses to communication questions indicated that 87% talked to two or more people on the telephone during the course of the past week which is referred to as mediated interaction moving beyond face to face interaction (Giddens, 2001) and again, a most important element in social engagement and support.

In terms of social "satisfaction", explored in Questions 5 to 10 of the DSSI scale, this group of participants felt that they were understood by family and friends, felt useful, knew what was going on within their family, felt that they were listened to; reported being satisfied with the relationships they had with family and friends; and felt they could confide in them with regard to their deepest problems. Koenig et al. (1993) noted that subjective support measures the quality of support received by respondents and that it "is perhaps the most important dimension of social support as far as health outcomes are

concerned" (p. 68). This sub-scale recorded a Cronbach's alpha of .79 well within the recommended score of .70 as reported by Goodger et al. (1999).

The participants thought they were able to receive instrumental support (hands on support) from their family and friends. However, as indicated from participants' responses to the OPSG survey Questions 19 on whether participants received community services, 68% (135) did not require such support and were independent; nevertheless, they knew that assistance was available if they needed it which was explored in Questions 12-23 of the DSSI scale. Importantly, they described being satisfied with the level of social networking they had access to and the support they received.

Inferential results of the study responses highlight that neither age nor gender are significant to the extent that group participation is important. However, analyses did suggest that being in less physical health influences the number of people group members can 'depend on', an outcome possibly related to having been a member of the group and the civic virtue embedded in the social network. This finding is consistent with other authors' findings, such as Powers, Goodger & Byles (2004), who confirmed a positive association between social support and mental and physical health demonstrating also that quality rather than quantity of social contacts has strong associations with subjective well-being.

T tests demonstrated no significant difference in the relationship of any of the dependent variables to the independent variables analysed. In other words, there was no association to age, whether male or female, or whether group members were living alone or experiencing less physical or emotional health to the value or importance group members placed on group membership.

Factor analysis performed on the 23 items of the DSSI sub-scale Instrumental Support produced three factors confirming that group members had access to several forms of instrumental support provided by family and friends. Such support was not only 'instrumental' in nature meeting many of

their "daily living needs" where support was provided through physical means such as "fixing things" and "helping out", but also 'expressive' means displaying "empathy" where others provided companionship, communication, comfort and understanding through regular verbal and physical contact.

7.2.5 The Thematic Analyses

The qualitative core of this research was underpinned by hermeneutic interpretive phenomenology, and as suggested by Taylor (2006b), "informed by phenomenological thought" (p. 339). Important elements of phenomenology (as developed by Heidegger) are notions of inter-subjectivity and the idea of the 'lifeworld' (*Lebenswelt*) (Holloway & Wheeler, 2002) which was originally recorded by Husserl (Gadamer, 1994, p. 31). In inter-subjectivity a number of subjectivities exist which are shared by a community and the individuals that share that common world (Holloway & Wheeler, 2002, p. 174). Hermeneutics is a theory of the interpretation of meaning (Holloway & Wheeler, 2002, p. 175). Hermeneutic philosophers claim that human sciences are not concerned with *explaining* behaviour instead their aim is to *understand* – motives, intentions, choices of ourselves and other people (Harrison-Barbet, 2001, p. 415). Gadamer (1975) expanded this concept emphasising "the rootedness of human beings in history and cultural contexts" (Harrison-Barbet, 2001, p. 415) and Holloway & Wheeler, (2002) reflects on Heidegger's (1962) claim that:

nothing can be encountered without reference to the person's background understanding, and every encounter entails an interpretation based on the person's background, in its "historicality". The framework of interpretation that we use is the foreconception in which we grasp something in advance (p. 175).

Gadamer (1975) also suggested that human beings' experience of the world is connected with language (Holloway & Wheeler, 2002, p. 175; Gadamer, 1994, p. 43). Furthermore, Capra (1997) wrote that:

the uniqueness of being human lies in our ability to continually weave the linguistic network in which we are embedded. To be human is to exist in language. In language we coordinate our behaviour, and together in language we bring forth our world (p. 282).

Thus hermeneutic phenomenology, which is “the theory of interpretation” (Holloway & Wheeler, 2002, p. 175), uses language as the medium for interpretation and understanding, and as used in this research study, has offered an expanded and deeper understanding of the experiences of older adults participating in groups and their desire to be with their peers in a social way through recording conversations and interpretation of their beliefs and opinions.

The methodology and analysis of qualitative data exercised under the prescription of Gadamer, provided a means of uncovering the essence of human experience in a significant sample size of older adults thus transcending the “horizon”. This transcendence was made possible by language, the ‘technical tool’ by which we understand (Gadamer, 1994, p. 26). Gadamer emphasised that:

We cannot extricate ourselves from language to come into direct contact with the ‘reality’ that language is in some sense about. But through an interpreter’s ‘dialogue’ with a text, painting or other cultural product he can both separate it from its horizons (the author’s personal experiences, or the cultural context of the work) and transcend his own horizons (cited in Harrison-Barbet, 2001, p. 416).

Therefore, “Being that can be understood is language” (Gadamer, 1975, p. xxii) and “this is the fundamental axiom of hermeneutics” stated Gadamer, (1994, p. 43). As the dialogue (with study participants) progressed a ‘fusion of

horizons' was achieved, which Gadamer (1975) argues, is an approximation to the ideal meaning attained, as suggested by Harrison-Barbet (2001, p. 417). The described essential elements 'or essence' of the experiences of group members was captured in narratives and transcribed to interpret meaning grouped into themes. Thematic Networks were used as the analytic tool for qualitative research as described by Attride-Stirling (2001) for theme development and a structure of interpretation as this process supports hermeneutic analysis. These themes were interpreted by the researcher and the 'fusion of horizon' was attained from 'a prior' knowledge and 'new knowledge' interpreted from the text created from focus group narratives during Study One and reinforced during Study Two.

The revealed meanings from the narratives, endorsed from the creation of the text, concluded that these older people had become completely immersed in their world (the groups). Within this context older people (participating in these groups) have the capacity to respond and react to the situations and relationships with others that they meet or are attached to in their world (Grbich, 2007, p. 90). The psychological and intellectual experiences that have eventuated and the interconnectedness of individuals in "being-in-the-world" all provide a focus for 'being' as stated by Grbich (2007, p. 90) and for group members the phenomenology, or 'the lived experience', had shown itself in unconcealment as what 'is' for them as suggested by Heidegger (Gadamer, 1994, p.98). Equally, group membership from a social perspective, demonstrated a level of solidarity reflecting the theory recorded by Durkheim (1964), and of Putnam's (2000) definition of social capital where trust and reciprocity are evident.

Study One used a qualitative paradigm and revealed the meaning of group membership created from transcribed conversations with a small number of group participants. The findings from Study One identified that the '*support*' each member received was a major feature and benefit of group membership. Support encompassed multiple dimensions and concepts interpreted as caring, friendship and companionship. There were reoccurring comments and statements that were categorised into Organising Themes of:

- i. Finding Friendship,
- ii. Essence of Life, and
- iii. Learning to Adapt.

The text offered examples of the participants' *essence of life*, which was expressed as feelings of being needed and a strong sense of belonging. The text also offered examples of *learning to adapt*, expressed by the participants as the ability to gain confidence in themselves and share with each other in such a way as to meet each other's needs, and *finding friendship*, where companionship, trust and reciprocity, respect and bonding occurred.

Study Two used both qualitative and quantitative paradigms and revealed a greater understanding of the meaning of group membership created from additional transcribed conversations, participant observation and descriptive and statistical data analyses from a larger sample of study participants.

The qualitative findings from the second study supported the qualitative findings of the first study but were enhanced with further constructs and concepts that broadened the meaning of group membership which were recorded as three Organising Themes of:

- i. “Finding Meaning and Joy” with six sub-themes or Basic Themes of pleasure, happiness, encouragement, motivation, meeting their needs and feeling good about themselves,
- ii. “Immersed in Humanness” meaning that group members cared about each other, which helped them care for themselves. The six Basic Themes were caring, companionship, physical contact, comfort, attachment and feeling needed, and
- iii. “Finding Family” had five Basic Themes related to family, friends, watchfulness, feeling valued and providing a supportive network system.

Additional qualitative findings from Study Two suggest that group membership offer elements of both ‘instrumental and expressive support’ (as described in the literature) where both their physical and emotional needs are

being met. However, the ‘expressive support’ received is very significant.

Members expressed experiences of:

- Great *happiness* with weekly episodes of joy and fun accompanied by lengthy periods of laughter
- Positive *feelings of health and well-being* allowing members to maintain vigour, integrity and promote independence and optimal functioning.

Importantly, group membership provides participants with an engaging and supportive network and creates an opportunity for the consolidation of very strong and enduring relationships which become a “fortress of support”. These characteristics provide:

- A source of comfort to endure periods of loss, grief and sadness,
- A capacity to engage and manage change and ageing in a positive way, and
- An environment that promotes feelings of self-confidence, self-esteem and empowered feelings of self-worth.

The group motivates the older members through an all encompassing and friendly atmosphere that projects positive feelings among each other assisted by positive attitudes projected by volunteer workers and group coordinators. In essence, being a member of the group preserves mental and physical health, promotes positive feelings of well-being that influences self-confidence and protects and provides support to each other through difficult times. This interrelationship is presented diagrammatically in Figure 7.2: “Importance of Group Membership Model”.

Figure 7.2. Importance of Group Membership Model



Model based on findings from Study One and Study Two created from interpretation and understanding of the hermeneutic text

Clearly, the social support members receive from their peers positively affects each group member's emotional well-being (through a network of relationships and contact with others), which in turn positively affects their general health (through motivation and engagement) and attitudes to current life situations (through reassurance and attachment). They value the sense of friendship, accept each other wholly, and understand each other's life situations and circumstances. Being a member of the group acts as a 'lifeline' (as reported by one lady), something the majority of group members feel greatly enhances their lives and supports and sustains them for more than that one day of weekly group attendance.

The findings from this research identified that older adults do benefit substantially from coming together with peers and that this has a profound

effect on their sense of general physical health and psychosocial welfare and, more specifically on feelings of psychological well-being. Being part of a supportive network provides group members with a reason for “being-in-the-world”. The meaning of “being” for this study cohort had multiple meanings and resulted in several distinctive characteristics. Exemplars provided by the researcher highlighted participants expression of support that have been expressive, affectionate and informative and in some cases instrumental. Attachment, trust, and reciprocity, as suggested by Putnam (2000), are clearly evident promoting strong and beneficial support. Furthermore, the groups and group participation was a resource and a source of social capital brought about by their social connections to each other.

7.3 Reflections on the Study

Social network systems for older people, from this research show that group membership and the resulting interpersonal relationships contain objective characteristics of age, gender, residential type and status, years attending a group and frequency of contact, but more importantly the study reveals subjective understandings around the social support received from group membership related to content and quality of those social relationships. It could be argued that the “groups” have become a place, ‘temporal and spatial’ location, where the older person has the “capacity to respond and react to situations and to relationships with others that they confront, meet or are attached to in their worlds” as suggested by Grbich (2007, p. 90). This could be what Heidegger revealed as ‘real’ by way of “man’s *practical* engagement in the world” (Harrison-Baret, 2001, p. 355).

7.4 The Group as a Concept of Social Support

“The groups”, could be what Antonucci (2001) refers to as, “a structural concept”. She suggested, that they are shaped by a number of factors such as personal (age, gender, personality, member participation) and situational (role, expectations, resources, facilitation, program content and implementation) factors “that influence the support relations experienced by the individual” (Antonucci, 2001, p. 430) or group members. Antonucci (2001) has described

this as a "convoy model" where people (group members) form the convoy and the convoy (the group) "provides a protective, secure base or cushion that allows the individual to learn about and experience the world" (p. 430). "These personal and situational factors, and social relations, in turn, affect that individual's health and well-being both contemporaneously and longitudinally" (Antonucci, 2001, p. 430). This is because "the protective base provided by convoy members" (Antonucci, 2001) (group members) offers support and acknowledgement of health-related issues and life events allowing optimal growth and development for that period of their lifecycle (p. 430). The groups also provide a "buffering model" as described by Cohen & Wills (1985) because members can 'buffer' each other from stressful life events (p. 310). As a number of other studies have reported, this subjective or perceived "expressive support" can be far more influential than objective support or "instrumental support" in affecting the health and well-being of older people. What is most unique about the model described by Antonucci (2001) and its reflection of group membership is:

the conceptualisation of the individual as part of a dynamic network that moves through time, space, and the life course surrounding, embracing, and supporting the individual through the multiple experiences of life. The individual changes, grows, and develops. The situation within which that individual exists changes; it may become more or less complex and it may involve more or less people. The interaction between the individual and the situation changes in response to both the individual's changes and the situational changes. The convoy reflects this dynamic aspect of social relations. As the individual ages, people are added to the convoy, subtracted from the convoy, move in and out the convoy in response to both internal and external events. Under optimal conditions, this dynamic aspect of the convoy allows it to meet and be responsive to the changing needs of the individual

(Antonucci, 2001, p. 431).

Being a member of the groups provided a network of supportive relationships that, as suggested by Antonucci (2001), appears to have bestowed “a sense of security” aligned with positive feelings about themselves and the world in which they continued to engage (p. 439). It could be suggested that being a member of the group facilitated a pathway toward ageing well. Rowe and Kahn (1998, cited in Bowling & Iliffe, 2006) in their model of successful ageing, suggested that ageing successfully is not defined only as longevity, but as absence or avoidance of stress, maintenance of physical and cognitive functioning and active engagement with life (p. 608).

7.5 The Group as a Concept of Social Capital

Social capital, expressed by Bourdieu (1993) as the collection or combination of actual or potential resources, is relevant to older people and to successful ageing (Cannuscio, Block & Kawachi, 2003, p. 395). Access to social capital in the form of group participation can assist older people to maintain independent and fulfilling lives. This research has shown that the benefits of group participation are truly embedded in the constructs of social capital where trust and reciprocity (Putnam, 2000) is in abundance, “lubricating social life” (Putnam, 2000, p. 21) and where the groups themselves have become “the main site of the accumulation and transmission of that kind of capital” (Bourdieu, 1993, p. 33). However, additional constructs have been revealed in the themes described in Chapter 3 and 6 and in Section 7.4.1 and 7.4.2 of this chapter adding to the meaning of group participation by older adults. Prominent among these are happiness and joy, feeling good about themselves (with positive feelings of self-esteem, self-confidence and self-worth) and feeling needed and valued by others.

An important feature of social capital, claimed by McKenzie, et al. (2002), is “that it is a property of groups rather than individuals” (p. 280) as does Putnam (2000) who referred to social capital as the connections among people (p. 19) a feature of social life – networks, norms, and trust - that enabled participants to act together (Ziersch et al., 2009; McKenzie et al.,

2002, p. 280; Putnam, 2000). Clearly individuals and all the characteristics that each person may bring to the group are what make groups effective in providing social support, a network of relationships and productive social capital.

7.6 Strengths of the Research

Todres and Holloway (2010) claim that "the strength of a phenomenological approach is that it provides both philosophical and methodological support in attempting to capture and express the meaning of significant human experiences in a rigorous manner" (p. 185).

This research used a combination of data collection techniques and qualitative and quantitative research methods emphasising the phenomenological approach. This study included a reasonably large number of older adults and collected data based on more than one observation or measurement tool as suggested by Kermode & Roberts (2006c, p. 235). The study utilised the longer version of the DSSI (23-items) as opposed to the shorter version (11-items). The 23-item scale, unlike the 11-items, enquires about 'instrumental support' which was important for this study which sought to investigate instrumental support but more importantly emotional support and the influence of these constructs on older persons' feelings of social support and their social support networks.

As noted by Goodger et al. (1999) the DSSI provided "the opportunity to use a measure of social support, which has been assessed specifically with older people instead of single-item measures or scales that have limited psychometric evidence" (p. 260). Moreover, the study yielded reliable and valid information as the data collected were not only from participants' self-reported measures but included the validated (Goodger et al., 1999; Keonig et al., 1993) performance scale (DSSI) and taped and transcribed narratives of the lived experiences, reported, associated with group membership from group members, and some observational field data. Group participants were eager to share their thoughts and feelings of what group membership meant for them.

The qualitative narratives collected in Study One provided valuable data that supported the continuing operation of the hospital social support groups, provided evidence for the establishment of a second hospital social support group, and reinforced that need and benefits of group participation by older people as a health promoting initiative. Additionally, data collected in Study One informed the development of Study Two which engaged both qualitative and quantitative paradigms. Integrating both qualitative and quantitative data offsets the shortcomings of each approach enhancing the validity of the conclusions and, according to Polit & Beck (2008, p. 196), converges on the truth.

The study did not seek to correlate the health outcomes with group participation as many previous studies had done. However, it did reinforce the aim of phenomenology, which Munhall noted, and Crotty (1996) suggested, was to improve the social fabric of human life (Munhall, 2007, p. 27). The findings of this study support other findings in relation to improved health outcomes and social engagement with others such as those reported by Powers et al. (2004) that “older adults, higher social support has been associated with better physical and mental health and reduced mortality” (p. 71). The DSSI as used here, captured elements of the strength of social networks, satisfaction with network support and the scope of instrumental support available through the network. Also, according to Powers et al., (2004) “the DSSI is an appropriate tool for determining social support because of its brevity, validity and use with older people” (p. 74). In addition however, the OPSG survey captured participants’ own opinions of the extent to which group participation influenced different elements of their life by way of a self-report measure and revealed concealed meaning about the benefits of group membership and engagement with peers. The findings have significant implications for clinical practice and are described more fully in the concluding chapter, Section 8.3 .

7.7 Limitations of the Research

The first study was a preliminary study using a qualitative design involving only six participants selected from one study site. Although the sample size was small ($n=6$) it did have male and female representation and was appropriate for the chosen methodology of interpretative hermeneutic phenomenology.

Study Two employed a mixed method design and engaged a statistically acceptable larger sample of older adults ($n=200$) from across a larger number of study sites ($n=25$). However, there were 69 Day Clubs established at the time of the study with 44 of those not included in the study. Therefore, it is not known if engaging group members from those additional sites may have provided different study findings. Moreover, it should be noted that the study was undertaken in only one Australian state, New South Wales and one Australian Territory, the ACT. The extent to which the findings could be reflective of groups meeting elsewhere is uncertain. However, it is likely that similar findings would be experienced by similar cohorts of older people in other Australian states and territories and even abroad given the strength of the study's positive findings.

Subjects in both studies were self-selecting ie. they chose to participate in the study, and all who participated in the study either chose to complete the questionnaires and participate in group interviews. However, there was a small number of participants who failed to answer all the questions resulting in reduced response rate and thus reducing the statistical representativeness of the sample group. An additional limitation was that the majority of respondents were white and of Anglo-European origin with the greater percent being Australian born. There were no non-English speaking group members even though five (2%) had been born in Europe. All could read and write English, but this could have been a potential limitation as both questionnaires used by the researcher were only produced in English.

Another limitation of the study was that the DSSI scale, used in Study Two, according to Pachana et al. (2008, p. 669) was not able to record negative aspects of social support. Additionally, a limited range of values is obtainable in the satisfaction section of that scale which scores a maximum response of 'most of the time' and it does not capture degrees or level of emotional support. However, the section of the OPSG survey (Q's 25 -35) allows respondents to rank the level of influence on emotional and physical health that group membership provides from a negative to a positive opinion.

A more comprehensive tool may be able to measure social support which would be useful to explore the scope and depth of what social support means to older people and what other forms of social support are needed by them to enhance their physical and mental functioning and maintain independence.

This study did not investigate the extent to which group membership may influence the capacity for some older adults to remain in their own home, although it is clear from this research, that psychological and physical well-being influences one's capacity to function optimally. Further evidence related to the hypothesis around group participation and the influences this may have on one's capacity to remain in one's home longer, would be helpful. However, this may be a likely factor given the very old age range of the majority of participants, and the fact that the majority lived alone requiring very little if any community service or instrumental support. In addition, the study did not explore the role that spirituality and religious beliefs may play in influencing older participants' health and well-being. These items may be explored in future studies which are recommended in Section 8.2 of the concluding chapter.

7.8 Reflection on Chapter 7

This research has explored the meaning that older adults derive from being members of a group. Gaining a greater understanding of their experiences was important and has provided greater insight into their (group

members') "being in the world". Constructs such as friendship, companionship, togetherness, humanness... have been created from the concept (phenomenon) of group participation as noted by Polit & Beck (2006, p. 32) and may contribute to the meaning of social capital. This research study found, and as stated by Antonucci (2001, p. 431), that the social networks of older people consist mainly, though not exclusively, of close family and friends and that the closest relationships are most importantly linked to well-being. In this study, friends were most commonly other members of the group. The research also demonstrates satisfaction with the social networks and the social relationships established through group participation. This association provides a better subjective quality of life by enhancing members' self-rated psychological and physical health status.

Putnam (2000) argued that social engagement had seen turbulent times and in some circumstances had become a thing of the past. However, he reinforced that although types of social engagement have shifted with time, there is no substitute for "place-based, face-to-face, enduring social networks" (p. 411) especially for the elderly. Group membership and group participation is a perfect example of Putnam's philosophy on civic engagement. Groups that provide social support and a social network may also be a way to promote social capital especially among older adults. Putnam (2000) requested that methods that create social ties need to be rekindled, stating "we need to address both the supply of opportunities for civic engagement and the demand for those opportunities (p. 403). Reflecting on this assumption "the group" was for their member's a type of social capital, the resource that provided them with "the glue" (McKenzie et al., 2002) that held them together both physically and psychologically.

CHAPTER 8

CONCLUSIONS AND RECOMMENDATIONS

The is the concluding chapter of the Thesis. This chapter offers conclusions that can be drawn from the research findings presenting the implications these may have for nursing practice.

Recommendations further studies are also offered.

8.1 Introduction

The latter part of the 20th century has seen a shift in thinking about health and well-being to more fully recognising the impact of bio-psychosocial factors on these important states (Capra, 1997; Barker & Buchanan Barker, 2007). Antonucci (2001) has suggested that the emergence of social relations as an important area of study, has provided evidence about the influence of psychological factors on physical and mental health and the contribution that social relations has on the health and well-being of the elderly (p. 427). The reductionist model (as discussed in Chapter 1) has not been able to acknowledge the interrelatedness and interconnectedness between body and mind and social factors (Barker & Buchanan Barker, 2007, p. 101; Stewart, 2004, p. 276-277; Capra, 1997) of people across all ages, thus a social philosophical approach is essential if we are to appreciate the complexity of ageing and develop a better understanding of the support mechanisms required to assist older adults to age successfully and reduce the impact of ageing on health and social services (Bowling and Dieppe, 2005).

It has been suggested by Keleher and Berni (2004, p. 3) that:

....Understanding health is based on the position that health practitioners from any discipline require the development of knowledge and understanding not just about health but also its underlying determinants. ...

Understanding health is built upon broad notions of health that recognise the range of social, economic, and environmental factors that contribute to health and that understanding health in terms of people's capacity to have access to the resources they need to be healthy, and to adapt, respond to, or control the challenges and changes in the environments that surround them (p. 4).

Ageing is associated with many challenges and changes, both physically and mentally, and the degree and quality of social relationships help older people to “prepare for, cope with, and recover from many of the exigencies of life that are associated” with these changes (Antonucci, 2001, p. 427). Antonucci (2001) refers to a number of studies, undertaken by researchers both in the United States and elsewhere, that have documented the “association between social relations and numerous aspects of physical and mental health including depression, cancer, heart disease, experiences of pain, recovery from major health events, and the occurrence of dementia” (p. 428). Neither of these authors considered the lived experiences of the study subjects.

This then has been the essence of the current study, to explore the experience and the importance of social relations among older adults, but in particular the part that group membership and peer support plays in this process. Theoretical knowledge and empirical evidence on the topic have been developed revealing new understanding and meaning about the phenomenon that had been concealed. This concluding chapter provides some recommendations related to the implications arising from the findings and how best to utilise the knowledge derived from the research.

8.2 Recommendations for Further Research

A body of knowledge on the benefits of group participation has been developed as a result of this research. However, additional epistemological

elements could be included as a result of further investigations into support groups. Powers et al. (2004) noted a positive relationship between social support and physical and mental health in their study. Similar findings have been noted in this study where feelings of well-being were associated to the social support received from group membership. The extent to which group participation contributes to optimising physical and occupational functioning related to activities of daily living should be further explored.

The study also engaged a convenient audience of older adults able to participate in group meetings. Future studies may need to explore the benefits older people believe they would experience if they were able to attend such support groups and what could be undertaken to support them in their disability.

Other studies could involve groups attended by older people with specific health conditions and could be compared with support groups attended by younger adults. Additional studies could include those specific to non-English speaking background older adults and the findings compared to the older adults in this study that were primarily from an English speaking background. Further studies should aim to include even larger numbers of older adults with representatives from rural and remote regions of Australia. Addressing all of these issues would allow for a greater capacity to make generalisations about the findings with other similar social support groups.

8.3 Implications for Nurses and Clinical Practice

The reductionist or medical model continues to dominate healthcare delivery (Giddens, 2001) and while at times it is necessary for the treatment of disease and good mental and physical functioning, the bio-psychosocial model must also be considered as it encompasses life satisfaction, social functioning and social participation (Bowling and Dieppe, 2005, p. 1550), which are important determinants of health and well-being particularly for older people. Nursing philosophy and nursing art constitutes the care of human beings in their totality (their body, mind and spirit) and "understanding unique individuals

and their meanings and interactions with others and the environment” (Barker & Buchannan Barker, 2007; Lopez and Willis, 2004, p. 726). These concepts are foundational to nursing practice and contribute to nursing’s theoretical framework. Thus, holistic care and rejection of reductionism is at the centre of our professional practice (Barker & Buchannan Barker, 2007, p. 101; Carpenter, 2003, p. 65). The challenge for nurses as stated by Neno et al., (2007) is “to provide therapeutic, stimulating care that looks to maintain psychological as well as physical well-being, regardless of the care setting the older person is in” (p. 8-9). It is important therefore that nurses, have both an understanding of the health and disease process (including physical, emotional, social, and spiritual) and the interaction of the these elements, and a range of treatment options and therapeutic interventions (Neno et al., 2007, p. 8) that compliment individuals’ conditions and presentations. “Gaining a deeper understanding of human experience can become actualized in the human care that is an outcome research” (Munhall, 2007, p. 217). Munhall (2007) claimed that “human understanding facilitates human care” and that “understanding has direct care applications”: it provides for care that is more fully informed , timely and sensitive, providing more appropriate nursing responses (p. 222). In terms of the study findings and implications for nursing practice and holistic care, consideration is given to several factors such as:

- i. Nurses acknowledging the lived experiences of older people for whom they care
- ii. Nurses undertaking comprehensive assessments that include older people’s social support systems and networks
- iii. Nurses needing to include older adults’ social support needs when planning discharges from hospital or other health care services
- iv. Nurses using support groups as health promotion and illness prevention initiatives
- v. Nurses conducting groups as part of inpatients’ and community teams’ recovery and rehabilitaion models of nursing care, and
- vi. Nurses influencing and being a part of policy development and service planning for older people.

These factors are explained in greater detail below.

8.3.1 Nurses Acknowledging the Lived Experiences of Older People for Whom They Care

Because phenomenological inquiry requires the integrated whole to be explored, states Carpenter (2003, p. 65), it is appropriate for studies of phenomena that are important to nursing practice. Phenomenology is one approach that attempts to resolve the mind-body split theory because it attempts “to describe the lived experiences, without making previous assumptions about the objective reality of those experiences” (Holloway & Wheeler, 2002, p. 172). Additionally, an essential belief of Heidegger (1962) “was that the relation of the individual to his (sic) *lifeworld* should be the focus of phenomenological inquiry” as subjective experiences are linked with social, cultural and political contexts (Lopez and Willis, 2004, p. 729). This is an existential phenomenological concept called ‘situated freedom’ and although individuals are free to make choices, these choices are governed by specific conditions of their daily lives, stated Lopez and Willis (2004, p. 729). The perceived world of participants and meaning about participants’ ‘being-in-the-world’ and how these meanings influence the choices they make have been captured in participants’ narratives, and the interpretation of these narratives, suggested Lopez and Willis (2004, p. 729), are foundational to interpretive phenomenology. It is therefore imperative for nurses to understand the importance of patients’ lived experiences and to consider such life events when assessing older people and developing individual care plans and person-centred nursing interventions.

8.3.2 Nurses Undertaking Comprehensive Assessments that Include Older Peoples Social Support Systems and Networks

Assessments are important for identifying baseline information from which desired outcomes can be measured (Glendinning, Clarke, Hare, Kotchetkova, Maddison, & Newbronner, 2006, p. 10). Cannuscio et al. (2003)

recommended that clinicians harness the benefits of social capital and incorporate it into their routine clinical assessments and care and that clinicians should prescribe more active involvement of patients in their communities.(p. 399). In support of this philosophy Litwin & Shiovitz-Ezra (2006), highlighted that “gerontological practitioners should address older adults’ social networks in their assessments of clients” (p. 735) and “that adding a network focus to the care of elderly clients could significantly enrich the repertoire of helping skills that are at the disposal” of all practitioners (p. 742).

This research has offered knowledge around the benefits of group participation which appear to have provided older people with the capacity to better cope with different events in their lives within a network of peer support. Wenger and Tucker (2002) suggested that the use of an instrument that identifies social support networks in which older people may be engaged, is an important part of the assessment information that should be collected and used to influence care programs for older people.

8.3.3 Nurses Need to Include Social Supports When Planning Discharges from Hospital or Other Health Care Services

Nurses need to consider social networks and social support systems utilised by the older patient, or when there are deficits in their network of supports, when undertaking a comprehensive psycho-social assessment, particularly for patients living in the community and who wish to remain so. Such issues need to also be considered when planning discharge from services, because the value of social relationships, as stressed by Rasulo et al., (2005), are important even at very old ages. Such assessment methods and discharge practices should form part of the routine documentation and be written into hospital and nursing policy.

8.3.4 Nurses Using Support Groups as Health Promotion and Illness Prevention Initiatives

Health promotion and illness prevention are key components of contemporary nursing practice (particularly mental health nursing care) along with principles attached to rehabilitation and recovery models of care. Outcomes requested and valued by older people are related to preventing deterioration in health, well-being and quality of life (Glendinning et al., 2006, p. 4). Access to social support and social contact with others is an important outcome desired by older adults. Groups can provide such contact and are a beneficial form of health promotion and illness prevention that should be encouraged across all health care service settings for all ages. Sainsbury (2000) notes that principles of public health have been adopted more recently in Australia creating a better conceptualisation of mental health promotion, one that recognises not only the importance of prevention but emphasises promoting positive mental health.

Promoting better health for the population has been encouraged in a variety of health domains and across a range of health service settings “through a combination of social and environmental conditions” (ACHS, 2010, p. 355). Establishing support groups for older adults, as an extension of older person’s services, is an activity that can promote better health and feelings of well-being and contribute to recovery and rehabilitation.

Findings from this study demonstrated that social participation with peers in groups, with a supportive and enriched atmosphere; generated a constellation of significant factors that influenced overall feelings of better health, well-being and optimal physical and psychological functioning.

8.3.5 Nurses Conducting Groups as Part of Inpatients’ and Community Teams’ Recovery and Rehabilitation Model of Nursing Care

Providing group support for patients has long been a part of the clinical setting in mental health nursing. According to Baker & Buchanan-Baker (2007, p. 159) group-based support has a key role to play in helping people to prepare and undertake life's journey. These authors suggest that being part of a group provides members with the opportunity to:

- a. Share experiences
- b. Obtain natural human support from peers
- c. View problems from different perspectives
- d. Enjoy the experience of being the helper rather than the one that is being helped
- e. Explore and share different ideas for resolving problems of living
- f. Learn from the experiences of others, and
- g. Gain an opportunity to ‘stand back’ from problems and review them from a different perspective (Baker & Buchanan-Baker, 2007, pp. 159-160).

Nurses can take a leading role in facilitating groups that support a recovery model of care. Through interpersonal associations, and the close relationships that are formed, stated Luffman (2009), people learn from each other which has “important implications for self-reliance, self-identity and social well-being” (p. 347). Thus nurses must provide a therapeutic environment, and an attitude that supports this process.

8.3.6 Nurses Influencing Policy Development and Service Planning

Australia’s population is rapidly ageing and health care services need to consider different aspects of care and service delivery to meet this unprecedented demand. Nurses make up a major part of healthcare delivery and service provision and dominate the aged care sector as care providers.

Older adults wish to remain active and functional and "have social contact and company, including opportunities to contribute as well as receive" (Glendinning et al., 2006, p. vi). Thus, nurses need to develop initiatives that have outcome-focused activities, and participate in policy development that monitors and evaluates such initiatives.

Social networks, such as group participation, serve as a target of purposive social intervention (Litwin & Shiovitz-Ezra, 2006, p. 735) which should be encouraged and implemented by nurses and health services particularly for the elderly as part of the services they provide to older adults. Barker and Buchannan-Barker (2007) have suggested that the most vital function of care

is to provide the conditions under which the person might begin to reconnect with 'others', establishing the kind of relationships that might provide the basis for friendship, natural social support and a sense of belonging and membership to some community of others (p. 126).

Such activities should be supported, well funded and written into organisational policy, thus meeting many of the requirements suggested by government directives. Additionally, authors such as Harris, Sainsbury & Nutbeam (1999) and Marmot (2005) suggest that social inclusion and addressing psychosocial needs are important issues for public policy as they reflect the social determinants of health and thus influence physical and mental health status.

8.4 Conclusion

Psychosocial and sociological perspectives, as suggested by Davies & Ryan (2007), help broaden our understanding when thinking about potential strategies for working with older people to provide effective support during major periods of transition and with health needs (p. 23). This research

highlights the benefits that social participation and group membership with peers has as a health promoting initiative for older adults, and that the multidimensional outcomes of such programs could be used as an alternate model of health care and illness prevention and during periods of rehabilitation and recovery. An understanding of these aspects will assist clinicians and service coordinators and providers to improve their understanding of what constitutes successful ageing. More specifically, this research highlights, as suggested Finfgeld-Connett (2005), that “nurses should reconsider social support as a nursing intervention” and research ways “to bolster existing networks or investigate ways to promote the development of new ones” (p. 7). Thus, nurses are advised to encourage patients to use and enhance personal support networks. Such an outcome would also be consistent with Godfrey and Denby’s (2004), suggestion that “intimate relationships, the presence of a confidante, quality of ties and reciprocal relationships” are important factors in preventing social isolation and depression, in all or any care setting (cited in Davies & Ryan, 2007, p. 23). Additionally, this research endorses the suggestion by Marmot (2005, p. 1103) that participation in society and social security has become a significant issue for public policy and meeting human needs”.

8.5 Final Reflection

Through this study, the experiences of group membership for older people as a source of support have been explored. The two components of successful ageing identified by Bowling and Dieppe (2005) notably that “maintenance of physical and cognitive functioning and active engagement with life (includes maintenance of autonomy and social support)” (p. 1549) and that social functioning “encompasses high levels of ability in social role functioning, positive interactions or relationship with others, social integration, and reciprocal participation in society” (p. 1549) have been strongly supported by the current findings.

This study provides a greater understanding of the benefits of group participation and peer support for older people; stresses the importance of a

social network, and identifies and explores the impact this has on their physical and emotional health and subjective well-being.

Being a member of a group appears to combat loneliness and significantly influences health and feelings of well-being, therefore the aims and objectives of the study were met. A greater scope about the meaning of social support and of the benefits of a network system for older people has also been identified. Being a member of a group acted as a 'life-force', something many members felt greatly enhanced their lives and supported them long after the day of the weekly group attendance. This belief is reinforced by Luffman (2009), who claims that the lasting benefits go further than "increased self-understanding to a greater sense of intimacy and belonging based on empathy and respect" (p. 345).

To conclude this Thesis the researcher provides a reflection on the writings of the British philosopher John Stuart Mills (1806-1873) who wrote:

... the social feeling of mankind; the desire to be in unity with our fellow creatures, which is already a powerful principle in human nature, and happily one of those which tend to become stronger, even without express inculcation, from the influences of advancing civilisations. The social state is at once so natural, so necessary, and so habitual to man, that, except in some unusual circumstances or by an effort of voluntary abstraction, he never conceives himself otherwise than as a member of a body; and this association is riveted more and more, as mankind are further removed from the state of savage independence (Mills, 1998, p. 77).

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Appendix 1 Ethics Approval: ACU National (Australian Catholic University) Higher Research Ethics Committee (HREC).



Australian Catholic University
Brisbane Sydney Canberra Ballarat Melbourne

Human Research Ethics
Committee

Committee Approval Form

Principal Investigator/Supervisor: A/Prof Lyn Coulon Nth Sydney Campus

Co-Investigators: Mr Peter Brown Nth Sydney Campus

Student Researcher: Ms Regina McDonald Nth Sydney Campus

Ethics approval has been granted for the following project:

The lived experience of older adults participating in a social support network group.

for the period: October 2003 to 21 November 2004

Human Research Ethics Committee (HREC) Register Number: N2003.04-8

The following standard conditions as stipulated in the *National Statement on Ethical Conduct in Research Involving Humans* (1999) apply:

- (i) that Principal Investigators / Supervisors provide, on the form supplied by the Human Research Ethics Committee, annual reports on matters such as:
 - security of records
 - compliance with approved consent procedures and documentation
 - compliance with special conditions, and
- (ii) that researchers report to the HREC immediately any matter that might affect the ethical acceptability of the protocol, such as:
 - proposed changes to the protocol
 - unforeseen circumstances or events
 - adverse effects on participants

The HREC will conduct an audit each year of all projects deemed to be of more than minimum risk. There will also be random audits of a sample of projects considered to be of minimum risk on all campuses each year.

Within one month of the conclusion of the project, researchers are required to complete a *Final Report Form* and submit it to the local Research Services Officer.

If the project continues for more than one year, researchers are required to complete an *Annual Progress Report Form* and submit it to the local Research Services Officer within one month of the anniversary date of the ethics approval.

K. Pashley.

Signed:

Date: 1 October 2003

(Research Services Officer, Strathfield Campus)

(Committee Approval.dot @ 28.06.2002)

Appendix 2 Participants Information Letter

Australian Catholic University
Brisbane Sydney Canberra Ballarat Melbourne



INFORMATION LETTER TO PARTICIPANTS

TITLE OF PROJECT: "THE LIVED EXPERIENCE OF OLDER ADULTS PARTICIPATING IN A SOCIAL SUPPORT NETWORK GROUP".

NAMES OF STAFF INVESTIGATORS or SUPERVISORS: DR SHARON HILLEGE AND MR PETER BROWN

AND/OR NAME OF STUDENT RESEARCHER: REGINA MCDONALD

AND NAME OF PROGRAMME IN, WHICH ENROLLED: ...DOCTOR OF PHILOSOPHY.....

Dear Participants

The purpose of the Study is to explore your experiences of being involved in a group as a means of social or peer support. Data collection methods for this research will include:

- Audio-taped focus group interviews involving a number of other participants of the group you attend
- The completion of a demographic survey questionnaire about yourself and your opinion of group membership, and
- The completion of the 23 -item Duke Social Support Index Tool.

The study should be a rewarding and enjoyable experience for you and the researcher. It is not anticipated that there would be any risks to you nor that the study will cause any inconvenience or discomfort. However, if at anytime any problems arise, support will be offered to you. Please note that you may leave the study at any time. If you do this, your participation in the group will not be affected in any way.

Participation in the Study and focus group is voluntary. If you agree to take part in the Study then you will be asked to spend approximately 1 – 1.5 hours with the researcher on the day the group meets to participate in the focus group and complete the questionnaire and tool.

It is anticipated that the information compiled from these interviews will:
Assist the Nursing profession (and other healthcare professionals) to understand the meaning and need for peer support among older adults
Generate opportunities for similar groups to be established in other Area Health Services in NSW
Encourage more research into the emotional support and needs of older adults.

You are free to refuse consent altogether without having to justify your decision. You may also withdraw consent and discontinue participation in the Study at any time without giving any reason. Your choice to withdraw from the Study will not impact on any current or future care, group attendance or the outcome of the Study.

Any questions regarding this project should be directed to the Principal Investigator or to the Supervisor or the Student Researcher

*Dr Sharon Hillege ,or Mr Peter Brown or Regina McDonald
on telephone number 9739 2335 in the:
Faculty of Health Science
School of Nursing
Australian Catholic University
40 Edward St
North Sydney 2060.....*

Following completion of the Study an information session will be offered to all participants to confirm correct data interpretation of the findings of the Study at a time to be determined.

This study has been approved by the Human Research Ethics Committee of Australian Catholic University.

In the event that you have any complaint or concern about the way you have been treated during the study, or if you have any query that the Investigator or Supervisor and Student Researcher has (have) not been able to satisfy, you may write to the Chair of the Human Research Ethics Committee care of the nearest branch of the Research Services Unit.

NSW/ACT: Chair, HREC
C/o Research Services
Australian Catholic University
Sydney Campus
Locked Bag 2002
STRATHFIELD NSW 2135
Tel: 02 9701 4159
Fax: 02 9701 4350

Any complaint or concern will be treated in confidence and fully investigated. The participant will be informed of the outcome.

If you agree to participate in this project, you should sign both copies of the Consent Form, retain one copy for your records and return the other copy to the Investigator or Student Researcher.

Many thanks for your assistance

Appendix 3: Consent Form

Australian Catholic University
Brisbane Sydney Canberra Ballarat Melbourne



CONSENT FORM

TITLE OF PROJECT: "THE LIVED EXPERIENCE OF OLDER ADULTS PARTICIPATING IN A SOCIAL SUPPORT NETWORK GROUP"

NAMES OF STAFF INVESTIGATORS or SUPERVISORS: DR SHARON HILLEGE AND MR PETER BROWN

NAME OF STUDENT RESEARCHER: REGINA MCDONALD

I (*the participant*) have read (*or, where appropriate, have had read to me*) and understood the information provided in the Letter to Participants. Any questions I have asked have been answered to my satisfaction. I agree to participate in this activity, realising that I can withdraw at any time. I agree that research data collected for the Study may be published or may be provided to other researchers at conferences and education forums in a form that does not identify me in any way.

NAME OF PARTICIPANT:

SIGNATURE DATE
.....

SIGNATURE OF PRINCIPAL INVESTIGATOR or SUPERVISOR: DR SHARON HILLEGE AND MR PETER BROWN

DATE:.....

SIGNATURE OF STUDENT RESEARCHER:

DATE:.....

Appendix 4.1 OLDER PERSONS SUPPORT GROUP SURVEY 2006

Dear Participant

Thank you for agreeing to complete the two survey questionnaires.

The purpose of the surveys is to seek information regarding your experiences of being a member of a support group.

The surveys are confidential and the information collected will only be used for this particular research on the **"Lived experience of older adults participating in a social support network group"**.

This research project has Ethics approval from the Australian Catholic University.

The information received from these surveys will be collated and added to data previously collected from other sources. The information will also form part of the researchers Thesis manuscript and possible future publications, and the findings will be presented at conferences and education sessions.

You are not required to state your name or address that will identify you to others.

INSTRUCTIONS TO COMPLETING THE SURVEY

There are two parts to the first survey and one part to the second survey.

Survey 1

Part A. Demographics and support questions.

Please indicate your answer to any Yes or No question by placing a cross (X) in the box.

Where space has been provided by a series of lines please express your opinions.

Part B asks questions regarding your experiences associated with being a member of a support group.

Questions 25 – 35 refer to the group you attend the most, and asks about your experiences as a group member.

Place an (X) in the box that represents the extent to which you agree with the statements presented. For example, if you feel in response to question Q. 25 that the group is very important to you, you would cross the box under "mostly" or "totally".

Survey 2 The Duke Social Support Index Scale

This has 23- items to complete. Place an (X) in the answer that most suits the way you feel.

Thank you for your participation in completing this survey. It is gratefully appreciated.

Regina McDonald
Student Researcher
C/-School of Nursing
Australian Catholic University
North Sydney NSW

Contact Number if necessary is xxxxxxxx.

PART A. Demographics and Support Questions

Is this an RSL group/club? Yes ☐ No ☐ Location:

If not what type of group/club is it?Location:.....

1. Please indicate your age range
50-59 years ☐ 60-69 years ☐ 70-79 years ☐
80-89 years ☐ 90-99 years ☐
2. Male ☐ Female ☐ Volunteer ☐ or group/club member ☐
3. Do you receive a pension or benefit from the Department of Veterans' Affairs?
Yes ☐ No ☐
4. Are you the spouse/partner/child/widow or widower of a person who receives a benefit from DVA? Please circle which one you are. Yes ☐ No ☐
5. Were you born in Australia?..... Yes ☐ No ☐
6. If you **were not** born in Australia in which country were you born?
Please state the country.
.....
7. If you were not born in Australia, how many years have you been living in Australia?
.....Years.
8. Using numbers, please indicate the postcode where you currently live.
9. For how many years have you lived at this address?Years.
10. Please **tick** the type of accommodation you live in.

Own home	<input type="checkbox"/>
Own flat	<input type="checkbox"/>
Privately rented home	<input type="checkbox"/>
Privately rented flat	<input type="checkbox"/>
Department of Housing house	<input type="checkbox"/>
Department of Housing flat	<input type="checkbox"/>
Other (e.g. in your daughter's house)	<input type="checkbox"/>
Hostel	<input type="checkbox"/>

If other, please state.....

11. Do you live alone?..... Yes ☐ No ☐

12. If you **do not** live alone, whom do you live with or do they live with you? .
Please state.

.....
.....

13. What was your main occupation?

.....

14. For how many years did you work in this occupation? Years.
15. For how many years have you been retired? Years.
16. Do you consider yourself to be in good physical health? Yes ☐ No ☐
17. Do you consider yourself to be in good emotional health?..... Yes ☐ No ☐
18. If you answered **No** to questions 16 and/or 17, what health problems do you have?
- Please list your health problems, stating the **most severe** first.
- 1.....
- 2.....
- 3.....
- 4.....
19. Do you receive any community services? e.g. Homecare or Meals on Wheels
.....Yes ☐ No ☐
- If you have answered **Yes** to the above question, please list these services?
- 1.....
- 2.....
- 3.....
- 4.....
20. How long have you been a member of this group/club?. Years..... Months.....
21. On a typical day what happens at the group/club meetings?
.....
.....
.....
22. Do you belong to any other group other than the one you are attending
today?.....Yes ☐ No ☐
- If yes, how other groups do you attend each week? Please state the number.
.....
23. What type of groups are they? e.g. Senior Citizens Clubs
.....
24. If you attend other groups what is different about them and the group you are
attending today?
.....
.....
Why do you attend other groups?
.....
.....

Questions 25 – 35 ask about your experiences as a group/club member.

Place an (X) in the box to indicate the extent to which you agree with the statements presented. For example, if you feel in response to question Q. 25 that the group is very important to you, you would cross the box under “mostly” or “totally”.

	Not at all	A little	A lot	Mostly	Totally
25. To what extent is this group important to you.					
26. To what extent does this group provide you with social support?					
27. To what extent does this group provide you with emotional support?					
28. To what extent does belonging to this group keep you physically well?					
29. To what extent does belonging to this group influence your feelings of well-being?					
30. To what extent does belonging to this group affect your emotional health?					
31. To what extent does belonging to this group help you feel that others support you?					
32. To what extent does being a member of this group provide you with a “sense of belonging”?					
33. To what extent does being a member of this group raises your self-esteem?					
34. To what extent does being a member of this group increase your self-confidence?					
35. To what extent does being a member of this group increase your feelings of self worth?					

Please feel free to make any other comments about your group experiences that you think may not have been asked in the questionnaire.

.....

.....

.....

Many thanks for your participation.

Appendix 4.2. DUKE SOCIAL SUPPORT INDEX (DSSI) SCALE (23-item)

Duke Social Support Index (DSSI)	Response Code <i>Place a X in the most appropriate box</i>		
Social Interaction sub-scale (4 items)	None	1- 2 people	More than 2 people
1. Other than members of your family how many persons in your local area do you feel you can depend on or feel very close to?			

	Response Code <i>Place a X in the most appropriate box related to the number of times you did these things</i>							
	0	1	2	3	4	5	6	7 or more times
2. How many times during the past week did you spend time with someone who does not live with you, that is, you went to see them or they came to visit you or you went out together?								
3. How many times did you talk to someone (friends, relatives or others) on the telephone in the past week (either they called you, or you called them)?								
4. About how often did you go to meetings of clubs, religious meetings, or groups that you belong to in the past week?								

	Response Code <i>Place a X in the most appropriate box</i>		
Satisfaction with social support sub-scale (7 items)	Hardly ever	Some of the time	Most of the time
5. Does it seem that your family and friend (people who are important to you) understand you?			
6. Do you feel useful to your family and friends (people important to you)?			
7. Do you know what is going on with family and friends?			
8. When you are talking with your family and friends, do you feel you are being listened to?			
9. Do you feel you have a definite role (place) in your family and among your friends?			
10. Can you talk about your deepest problems with at least some of your family and friends?			
	Very dissatisfied	Somewhat dissatisfied	Satisfied
11. How satisfied are you with the kinds of relationships you have with your family and friends?			

Do your family or friends ever help you in any of the following ways?

Instrumental Support Subscale (12 items)	No	Yes
12. Do they help out when you are sick?		
13. Do they shop or run errands for you?		
14. Do they give you gifts (presents)?		
15. Do they help you out with money?		
16. Do they fix things around the house?		
17. Do they keep house for you or do household chores?		
18. Do they give you advice on business or financial matters?		
19 Do they provide companionship to you?		
20. Do they listen to you?		
21. Do they give you advice on dealing with life's problems?		
22. Do they provide transport for you?		
23. Do they provide meals for you?		

Many thanks for your participation in the study

Regina Mc Donald

Appendix 4.3 DUKE SOCIAL SUPPORT INDEX SCALE (23 item)
Scoring Code as per author (2006 via personal email)

Duke Social Support Scale (requires interviewer-administration)

Social Interaction Subscale

1. Other than members of your family, how many persons in this area within one hour's travel (of your home/from here) do you feel you can depend on or feel very close to?
- | | <u>NUMBER</u> |
|------|---------------|
| None | 00 |

[scoring 0=1, 1-2=2, >2=3]

2. (Other than at work) How many times during the past week did you spend some time with someone who does not live with you, that is, you went to see them or they came to visit you, or you went out together?
- | | |
|---------------|----|
| None | 00 |
| Once | 01 |
| Twice | 02 |
| Three times | 03 |
| Four | 04 |
| Five | 05 |
| Six | 06 |
| Seven or more | 07 |

[scoring 0=1, 1-2=2, >2=3]

3. (Other than at work) How many times did you talk to someone -- friends, relatives or others -- on the telephone in the past week (either they called you, or you called them)?
- | | |
|---------------|----|
| None | 00 |
| Once | 01 |
| Twice | 02 |
| Three times | 03 |
| Four | 04 |
| Five | 05 |
| Six | 06 |
| Seven or more | 07 |

[scoring 0 or 1=1, 2-5=2, >5=3]

4. (Other than at work) About how often

did you go to meetings of clubs,
religious meetings, or other groups
that you belong to in the past week?

None	00
Once	01
Twice	02
Three times	03
Four	04
Five	05
Six	06
Seven or more	07

[DO NOT INCLUDE ATTENDANCE
AT RELIGIOUS SERVICES OR
OTHER RELIGIOUS / SPIRITUAL GROUP
MEETINGS]

[scoring 0 or 1=1, 2-5=2, >5=3]

Subjective Social Support

5. Does it seem that your family and
friends (i.e., people who are important
to you) understand you most of the
time, some of the time, or hardly
ever?

Hardly Ever	1
Some	2
Most	3

6. Do you feel useful to your family and
friends (i.e., people important to you) most
of the time, some of the time, or hardly ever?

Hardly Ever	1
Some	2
Most	3

7. Do you know what is going on with your
family and friends most of the time,
some of the time, or hardly ever?

Hardly Ever	1
Some	2
Most	3

8. When you are talking with your family
and friends, do you feel you are being
listened to most of the time, some of
the time, or hardly ever?

Hardly Ever	1
Some	2
Most	3

- | | | |
|--|---|-------------|
| 9. Do you feel you have a definite role (place) in your family and among your friends most of the time, some of the time, or hardly ever? | Hardly Ever
Some
Most | 1
2
3 |
| 10. Can you talk about your deepest problems with at least some of your family and friends most of the time, some of the time, or hardly ever? | Hardly Ever
Some
Most | 1
2
3 |
| 11. How satisfied are you with the kinds of relationships you have with your family and friends -- very dissatisfied, somewhat dissatisfied, or satisfied? | Very Dissatisfied
Somewhat Dissatisfied
Satisfied | 1
2
3 |

If NO FAMILY OR FRIENDS: Would you say that you are very dissatisfied, somewhat dissatisfied, or satisfied with not having any of these relationships?

Now I want to ask you about some of the ways your family and friends help you out. Do your family or friends ever help you in any of the following ways:

[Family includes natural family (parents, brothers, sisters) and acquired family (spouse, children)]

Repeat for each question: "Do they . . .	<u>NO</u>	<u>YES</u>
12. . . . help out when you are sick?	1	2
13. . . . shop or run errands for you?	1	2
14. . . . give you gifts (presents)?	1	2
15. . . . help you out with money?	1	2
16. . . . fix things around your house?	1	2
17. . . . keep house for you or do household chores?	1	2
18. . . . give you advice on business or financial matters?	1	2
19. . . . provide companionship to you?	1	2

20. . . . listen to your problems ?	1	2
21. . . . give you advice on dealing with life's problems?	1	2
22. . . . provide transportation for you?	1	2
23. . . . prepare or provide meals for you?	1	2

[Scoring: Sum up totals for all sections to obtain overall social support score (score range 23-57); best to report totals for each section of the DDSI brief scale [Questions 1-4 (score range 4-12), Questions 5-11 (score range 7-21), Questions 12-23 (score range 12-24)]. For the 11-item index (not including the instrumental support section), the overall score range is 11-33. Both the 11-item and 23-item scales are found in Koenig et al 1993; Psychosomatics 34:61-69. No information on reliability or validity, other than that work done with full version of DDSI (Landerman R, George LK, Campbell RT, et al 1989. American Journal of Community Psychology 17:625-642.)]

Note: Not included here is the Social Network Size subscale of the DSSI (one reason is because it includes questions about religious organizations that may contaminate measure with religious or spiritual content)

Appendix 4.4 Older Persons Support Group Survey (OPSGS)
SPSS DATA CODING SHEET- Part A

QUESTION		Variable No	VARIABLES	RESPONSE	CODE
	Group Location				none
	RSL Day Club group or Other (e.g. Hospital group)		group	Yes No (other) Missing	1 2 9
Variables being analysed					
	Age	1	age	50-59 years 60-69 years 70-79 years 80-89 years 90-99 years Missing	1 2 3 4 5 9
Q. 2	Gender	2	gender	Male Female Missing	1 2 9
	Group member	3	membershiptype	Volunteer Group member	1 2
Q. 3	DVA Pension self	4	dvapension	Yes No Missing	1 0 9
Q. 4	DVA Pension	5	partpension	Yes No Missing	1 0 9
	Pension type	6	relationship	Not relevant Spouse Partner Child Widow/ Widower Not stated Missing	0 1 2 3 4 5 9
Q. 5	Country of Birth	7	cob	Australia - Yes No Missing	1 0 9
Q. 6	What country	8	country	Not relevant	0
			Italy Czechoslovakia Netherlands	Europe	1
			England Ireland Scotland Wales	UK – United Kingdom	2
			Sri Lanka India PNG Albania Philippines	other	3
				Missing	9

Q.7	Time in Australia	9	time		
				Less than 10 yrs	1
				11 – 25 yrs	2
				26 – 50 yrs	3
				> 50 yrs	4
				Missing	9
Q. 8	Postcode	10	address	Postcode number	none
Q. 9	Years at this address/years	11	years	1 – 9	1
				10 – 19	2
				20 – 29	3
				30 – 39	4
				>40	5
				Missing	9
Q.10	Accommodation	12	housing	Own home/flat	1
				Rented: Private home/flat Department of Housing house/flat	2
				Hostel	3
				Self Care Unit/ Retirement Village/ Independent Living	4
				Other (e.g. in your daughter's house)	5
				Missing	9
Q.11	Do you live alone	13	alone	Yes	1
				No	0
				Missing	9
Q.12	Living arrangements	14	others	Not relevant	0
				Spouse	1
				With Others	2
				Family lives with them	3
				Missing	9
Q.13	Main occupation	15	job	Domestic/housewife	1
				Labourer /Unskilled (shop assistant)	2
				Trade (skilled)	3
				Clerical	4
				Managerial	5
				Professional – nurses/lawyers etc	6
				Missing	9
Q.14	Years in the position	16	worklife	1 – 9 yrs	1
				10 – 19	2
				20 – 29	3
				30 – 39	4
				>40	5
				Missing	9

Q.15	Years retired	17	yearsretired	Not retired 1 – 9 yrs 10 – 19 20 – 29 30 – 39 >40 Missing	0 1 2 3 4 5 9
Q. 16	Physical Health status	18	phyhealth	Yes	1
				No Missing	0 9
Q. 17	Emotional Health status	19	emohealth	Yes	1
				No Missing	0 9
Q. 18	Health conditions	20	hthconditions	None	0
				Cardiac problems / angina	1
				Respiratory problems /asthma	2
				Diabetes	3
				Arthritis	4
				Mental health problems: depression	5
				Others: Cancer, kidney, Osteoporosis Missing	6 9
Q. 19	Community Services	21	services	Yes	1
				No Missing	0 9
	Types of support services	22	servicetype	None	0
				Homecare/cleaning/ CACP	1 2
				Meals in wheels	3
				Home nursing services	4
				Community transport	5
				Others: lawn mowing	9
				Missing	
Q. 20	Years a member of this group	23	yrsmember	< 1 yr 1 – 5 6 - 10 11 – 20 21 – 30 Missing	1 2 3 4 5 9
Q. 21	What happens at the group?	Not Coded			
Q. 22	Other groups attended	24	othergroups	Yes	1
				No Missing	0 9

Q. 23	Group types	25	grouptypes	No groups	0
				Senior Citizens	1
				Legacy /War Widows /Probus/ RSL Clubs/ RSL auxiliary	2
				Church Groups	3
				Others e.g. Voluntary Associations/groups e.g. RFS, St Vincent De Pauls, education, exercise	4
				Missing	9
Q. 24	Difference between other groups?	Not Coded			

Appendix 4.5 Older Persons Support Group Survey (OPSGS)
SPSS Data Coding Sheet- Part B

Question		Variable No	Variable	Not at all 0	A little 1	A lot 2	Mostly 3	Totally 4
Q. 25	To what extent is this group important to you?	26	group important					
Q. 26	To what extent does this group provide you with social support?	27	provide support					
Q. 27	To what extent does this group provide you with emotional support?	28	emotional support					
Q. 28	To what extent does belonging to this group keep you physically well?	29	physically wellnes					
Q. 29	To what extent does belonging to this group influence your feelings of well-being?	30	feelings of well-being					
Q. 30	To what extent does belonging to this group affect your emotional health?	31	emotional health					
Q. 31	To what extent does belonging to this group help you feel that others support you?	32	others support you					
Q. 32	To what extent does being a member of this group provide you with a "sense of belonging"?	33	sense of belonging					
Q. 33	To what extent does being a member of this group raises your self-esteem?	34	raise self-esteem					
Q. 34	To what extent does being a member of this group increase your self-confidence?	35	increase self-confidence					
Q. 35	To what extent does being a member of this group increase your feelings of self-worth?	36	increase self-worth					

**Appendix 4.6 Scoring Code as interpreted by the researcher for the
DUKE SOCIAL SUPPORT INDEX SCALE (23-item)**

Duke Social Support Index (DSSI)	Response Code Place a X in the most appropriate box		
Social Interaction sub-scale (4 items)	None	1- 2 people	More than 2 people
1. Other than members of your family how many persons in your local area do you feel you can depend on or feel very close to?	1	2	3

	Response Code Place a X in the most appropriate box related to the number of times you did these things							
	0	1	2	3	4	5	6	7 or more times
2. How many times during the past week did you spend time with someone who does not live with you, that is, you went to see them or they came to visit you or you went out together?	1	2	2	3	3	3	3	3
3. How many times did you talk to someone (friends, relatives or others) on the telephone in the past week (either they called you, or you called them)?	1	1	2	2	2	2	3	3
4. About how often did you go to meetings of clubs, religious meetings, or groups that you belong to in the past week?	1	1	2	2	2	2	3	3

	Response Code Place a X in the most appropriate box		
Satisfaction with social support sub-scale (7 items)	Hardly ever	Some of the time	Most of the time
5. Does it seem that your family and friend (people who are important to you) understand you?	1	2	3
6. Do you feel useful to your family and friends (people important to you)?	1	2	3
7. Do you know what is going on with family and friends?	1	2	3
8. When you are talking with your family and friends, do you feel you are being listened to?	1	2	3
9. Do you feel you have a definite role (place) in your family and among your friends?	1	2	3
10. Can you talk about your deepest problems with at least some of your family and friends?	1	2	3
	Very dissatisfied	Somewhat dissatisfied	Satisfied
11. How satisfied are you with the kinds of relationships you have with your family and friends?	1	2	3

Do your family or friends ever help you in any of the following ways?

Instrumental Support Subscale (12 items)	No 1	Yes 2
12. Do they help out when you are sick?		
13. Do they shop or run errands for you?		
14. Do they give you gifts (presents)?		
15. Do they help you out with money?		
16. Do they fix things around the house?		
17. Do they keep house for you or do household chores?		
18. Do they give you advice on business or financial matters?		
19 Do they provide companionship to you?		
20. Do they listen to you?		
21. Do they give you advice on dealing with life's problems?		
22. Do they provide transport for you?		
23. Do they provide meals for you?		

Appendix 5 Study Presentations

Year	Title	Conference	Location	Conference Type
Nov 2004	"The Lived experience of older adults participation in groups" Poster Presentation	AAG National Conference	Melbourne Australia	National
Nov 2005	"Exploring Social Networks For Older Adults: A Hermeneutic Phenomenological Study" Research paper	AAG National Conference	Gold Coast QLD Australia	National
September 2006	Using hermeneutic phenomenology to analyse older people's experiences of group participation: A Preliminary Study	PGNA (Inc) Australia National Conference	Wesley Centre Sydney Australia	National
September 2006	The lived experience of older adults participation in groups	Faculty of Psychiatry of Old Age (FPOA) Scientific Meeting	Prince of Wales Royal Women's Hospital Sydney Australia	NSW State
November 2006	The lived experience of older adults participation in a social support group	Emerging Research in Ageing (ERA)	Darling Harbour Sydney Australia	National
September 2009	Report Social Support Day Club Research	RSL Co-ordinators Conference	Sydney Department of Veterans Affairs (DVA) Australia	NSW State
September 2009	Older People and Mental Health. To what Extent do Support Groups Help?	ACMHN International Conference	Sydney Australia	International
August 2010	Positive Ageing: To what extent do support groups help?	Australian Association of Gerontology: Ageing in the North	Darwin Northern Territory Australia	National
October 2010	The importance of assessing older persons social support networks	Sydney South West Mental Health (SSW) Spring Symposium	Rozelle Sydney Australia	SSW Area Health Service
1 st August 2011	The importance of assessing older persons social support networks	3 rd World Congress on Asian Psychiatry	Melbourne Australia	International

Appendix 6 Study Publications

- 6.1 McDonald , R. "The Lived Experience of Older Adults Participating in a Social Support Network Group". Paper presented and published at the 5th National Conference of Emerging Researchers in Ageing, November 2006.

- 6.2 McDonald, R., & Brown, P. (2008). Exploration of social support systems for older people: A preliminary study. *Contemporary Nurse*, 29(2), 184-194.