INTRODUCTION

Social relationships play important role in promoting better health and alleviating diseases. However, not all kinds of social relations, interactions, ties, and sharing of social resources have similar health consequences, nor do they always predict improved health outcomes (Cohen, Gottlieb, & Underwood, 2000; Cohen & Wills, 1985; Thoits, 1984; Uchino, 2004). Research has shown that interpersonal relationships can have both positive and negative influences on health and well-being (Cohen, 2004; Vinokur & van Ryn, 1993), and that supportive behavior leads to better physical and mental health outcomes (Cohen, Gottlieb, & Underwood, 2000; House, Landis, & Umberson, 1988; Lakey & Cohen, 2000; Taylor, 2011a; Thoits, 1995; Uchino, Cacioppo, & Kiecolt-Glaser, 1996). One aspect of social relationships is social support (both formal and informal), and this construct has been researched widely by social scientists since 1970s.

Although research involving allied concepts like social network, social capital, social ties, and social integration was abundant prior to 1970s, it was not until mid-1970s that studies on social support as a distinct construct came into existence. In fact, one of the initial systematic definitions of the construct social support was provided by Sidney Cobb in his March 1976 Presidential Address before American Psychosomatic Society. Cobb (1976: 300) defined social support as “information leading the subject to believe that he (or she) is cared for and loved, esteemed, and a member of a network of mutual obligations.” Although this definition ignores the cultural context in which support provision and receipt occurs. The review concludes with directions for further research for a better understanding of the impact of received and provided support on health and well-being.

Received and Provided Social Support: A Review of Current Evidence and Future Directions

Abu Sadat Nurullah, MA

Abstract:
This review highlights some recent developments in the area of received and provided support, and particularly the effect of such support in promoting better health and well-being. Studies conducted in the past ten years suggest that receiving social support has mixed effects on physical and mental health in that the context of support receipt, provider motivation, reciprocity, and the appropriateness of a match between the nature of stressors and the kind of support provided all determine the outcome of support receipt and provision. The benefit of received support is also dependent upon the cultural context in which support provision and receipt occurs. The review concludes with directions for further research for a better understanding of the impact of received and provided support on health and well-being.
individual's social network, the quantity and quality of relationships, the number and kinds of social roles an individual perform, and the frequency of interaction (Mirowsky & Ross, 2003: 213). This means that people who are more socially integrated are more likely to provide supports, but it does not necessarily translate into providing assistance to others in need. In addition, social integration has its associated costs and benefits. For instance, it increases dependency and decreases individual freedom (for a discussion, see Mirowsky & Ross, 2003: 214-216).

The aim of this article is to present a review of current research on received and provided social support. As such, studies dealing with the perceived availability of support are not reviewed here. In addition, research reviewed here focuses on the functional aspects of social support (i.e., emotional, informational, instrumental, and companionship support) rather than the structural aspects social support (e.g., network structure and density, frequency of interaction, social integration etc.). Furthermore, my intent here is to illustrate the support received from informal sources (e.g., spouse, friends) rather than formal sources (e.g., government and private institutions or support agencies). Over the years, empirical studies tend to focus more on the perceived availability of support rather than the actual receipt of support as well as the quality of such support. Existing literature indicates that perceived social support (in particular emotional support) rather than received social support is a target of investigation by most researchers (Dunkel-Schetter & Bennett, 1990; Thoits, 1995). Frazier, Tix, and Barnett (2003) suggested that much of the recent theory and research on social support has mostly ignored the offered and received support that occur in a relational context, and instead has concentrated on perceived support. Therefore, my attempt in this review is to highlight recent developments in research on received and provided social support, and to outline avenues for further research in the field.

Schulz and Schwarzer (2004) referred to received support as the provision of emotional (e.g., loving and caring), informational (e.g., advice), and instrumental support (e.g., financial help) to individuals by close confidants or others, such as family members, friends, or colleagues. In this review, I define received support as the experience of receiving actions and behavior that are considered supportive by the recipient in fostering emotional, instrumental, informational, appraisal, and companionship needs, which matches the types of support sought by the recipient with ones that are provided by close relations and significant others (e.g., spouse, friends, family, relatives, groups etc.) in an effort to improve well-being and effectively deal with life crisis (e.g., stress, depression, and other physical and psychological problems). In addition, provision of support refers to actual offering or conveying of supportive actions and behavior – emotional, informational, and/or instrumental – that matches the kind of support sought by a person facing life strain/stress.

RESEARCH ON RECEIVED AND PROVIDED SOCIAL SUPPORT

OVERVIEW

Although studies on perceived social support have consistently shown to be associated with reduced stress and improved physical and mental health, research on received social support is inconclusive at best (see Haber et al., 2007, for a comprehensive review). Prior research indicates that in general, perceived social support is associated with improved physical and mental health (House, Umberson, & Landis, 1988; Lahey & Cronin, 2008; Uchino, 2009), and that perceived support is more essential than received support in predicting adjustment to life stress (Wethington & Kessler, 1986).

For instance, studies have found that under stressful situations, received social support is positively linked with negative affect (Peeters & Le Blanc, 2001; Yang & Carayon, 1995), depression (Frese, 1999), and mental health problems (Iwata & Suzuki, 1997). Deelstra and colleagues (2003) found in a sample of temporary workers that the receipt of ‘imposed’ (compared with ‘no support at all’) instrumental social support was stress-inducing rather than stress-alleviating. Perhaps the support recipients may perceive a very well-intended support provision negatively, for instance, as an invasion of their privacy.

Research attempting to explain these negative findings indicates that the association between received social support and stress is occasionally confounded with the fact that individuals with high stress generally receive the most amount of support and also have the worst mental health (Lakey & Orehek, 2011). Studies suggested that support efforts can be miscarried (Lehman & Hemphill, 1990; Martire et al. 2002), or can create feelings of indebtedness, a threat to self-esteem, or guilt to the support receipt (Bolger & Amarel, 2007; Bolger, Zuckerman, & Kessler, 2000; Martire, Stephens, Druley, & Wojno, 2002). For instance, studies have found that under stressful situations, received social support is positively linked with negative affect (Peeters & Le Blanc, 2001; Yang & Carayon, 1995), depression (Frese, 1999), and mental health problems (Iwata & Suzuki, 1997). Deelstra and colleagues (2003) found in a sample of temporary workers that the receipt of ‘imposed’ (compared with ‘no support at all’) instrumental social support was stress-inducing rather than stress-alleviating. Perhaps the support recipients may perceive a very well-intended support provision negatively, for instance, as an invasion of their privacy.

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and had no effect for women. Some studies found that the outcomes of received instrumental support are mixed; it can be perceived as invasive or demanding (Deelstra et al., 2003). In addition, Frazier et al. (2003) found no link between supportive behaviors by significant others and patient distress.

However, research has suggested that measures of received support reflect social support more accurately than measures of perceived support (Haber et al., 2007). Knoll and Schwarzer (2002) asserted the results showing perceived social support as a stronger predictor of well-being than received social support may suffer from inadequate measurement of support receipt. Because perceived availability of social support leads to changes in the cognitive appraisal of stress, some researchers argue that perceived support is best understood as an individual difference variable (see Pierce, Lakey, Sarason, Sarason, & Joseph, 1997, for a review).

Research has shown that receiving social support can also have positive effects on recipients’ health and well-being. Studies have indicated that receiving supportive behaviors from one’s spouse was related to lower levels of distress (see Druley & Townsend, 1998; Frazier, Davis-Ali, & Dahl, 1995; Schuster, Kessler, & Aseltine, 1990). In a meta-analysis, Thorsteinsson and James (1999) found that received support was related to lower heart rate, systolic blood pressure (SBP), and diastolic blood pressure (DBP) reactivity. Schwarzer, Dunkel-Schetter, and Kemeny (1994) found in a sample of gay males at risk of HIV/AIDS that in terms of sources of support, the participants relied most heavily on support received from friends and partners and relatively little on support from family and organizations. They also found that in terms of the types of support, these males reported similar levels of the four types of support received: advice, assistance, reassurance, and listening. In addition, the participants were equally satisfied with the support they received from all four sources, revealing a satisfactory match between anticipation and support provision.

EVIDENCE FROM STUDIES: LAST TEN YEARS

In this study, I present selected reviews of research on the effect of received support. As shown in Table 1, studies conducted between the years 2002 and 2012 were selected for review, as they are more recent. Another reason for focusing on the last ten years is that reviews of earlier studies (up to the year 2002) have been reported elsewhere (e.g., Barrera, 1986: Table IV; Haber et al., 2007; Uchino et al., 1996). A keyword search in the PsychInfo and PubMed databases as well as in Google Scholar was performed. The keywords used to find the studies were: received+social support, social support receipt, received support+health, provided social support, and provided support+health. I have categorized the studies based on the measurement of support instrument, nature of the study (e.g., survey or experimental, cross sectional or longitudinal), nature of strain or stress/distress, and whether the effect was positive, negative, or mixed (and whether main or buffering). Although studies I have reviewed here are quantitative, qualitative research measuring received social support exists (e.g., King, Willoughby, Specht, & Brown, 2006). In a qualitative study of adult individuals with developmental disabilities, King et al. (2006) found that social support played a significant role in reducing life strains facing individuals with disabilities. The participants experienced receiving emotional, instrumental, and cognitive (e.g., affirmation, confirmation, and coherence in self-concept) support, which fostered resiliency in them. In the following, I discuss the findings based on quantitative studies. To avoid redundancy, I discuss the main results of those studies, while the details on the measurement instruments, methods, and related information can be found in Table 1.

In a sample of 137 HIV-positive individuals, Turner-Cobb and colleagues (2002) found that greater satisfaction with HIV/AIDS-related social support, more secure attachment with others, and less exercise of behavioral disengagement were associated with the experience of positive psychological states (as measured by Positive States of Mind Scale) leading to better adjustment to HIV/AIDS. However, two other studies involving HIV-positive patients receiving antiretroviral treatment (ART) found buffering effect of received support. Simoni, Frick, and Huang (2006) found that negative affect, spirituality, and self-efficacy mediated the relationship between social support and adherence to medication among them. In addition, social support received from a close other, an information provider, an empathic listener, or a spiritual relationship is related to improved medication adherence (Simoni, Frick, & Huang, 2006). Furthermore, Luszczynska, Sarkar, and Knoll (2007) found in a sample of 104 HIV-positive heterosexual men and women that both social support and self-efficacy were related to better physical functioning among them. In addition, their findings showed that received social support predicts adherence to antiretroviral treatment (ART) via self-efficacy.

Several other studies by Schwarzer and colleagues showed positive main effects of receiving social support. Schulz and Schwarzer (2004) found that provided emotional, informational, and instrumental support correlated moderately (r = .31 to .41) with received emotional, informational, and instrumental support. They showed that partner support enhanced the coping ability and well-being of cancer patients but worsened for the unsupported ones, and that
Table 1: Measurements of received social support, the stressors studied, and their effects on health

<table>
<thead>
<tr>
<th>Study</th>
<th>Social Support Measures</th>
<th>Method</th>
<th>Stress/Strain/Distress</th>
<th>Effect</th>
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<tr>
<td>Turner-Cobb, et al. 2002</td>
<td>The UCLA Social Support Inventory (UCLA-SSI): Frequency of Advice, Assistance, Reassurance, Listening, and Satisfaction with support received</td>
<td>Cross-sectional; Self-report questionnaire</td>
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<td>Positive main effect</td>
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<tr>
<td>Knoll &amp; Schwarzer, 2002</td>
<td>Self-constructed 11-item scale</td>
<td>Longitudinal (panel); Self-report questionnaire</td>
<td>Depression, anxiety, and Health Complaints</td>
<td>Positive main effect</td>
</tr>
<tr>
<td>Schulz &amp; Schwarzer, 2004</td>
<td>The Berlin Social Support Scales (BSSS): Received and provided emotional, informational, and instrumental support</td>
<td>Longitudinal (panel); Self-report questionnaire</td>
<td>Cancer</td>
<td>Positive main effect</td>
</tr>
<tr>
<td>Simoni, Frick, &amp; Huang, 2006</td>
<td>Modified UCLA-SSI: Appraisal, informational, emotional, and spiritual support, and satisfaction with support received</td>
<td>Longitudinal (panel); Self-report questionnaire</td>
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<tr>
<td>Luszczynska, Sarkar, &amp; Knoll, 2007</td>
<td>BSSS: Received support and satisfaction with support subscale</td>
<td>Cross-sectional; Self-report questionnaire</td>
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<tr>
<td>Schwarzer &amp; Gutiérrez-Doñã, 2005</td>
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<td>Longitudinal (panel); Self-report questionnaire</td>
<td>Depression, physical and psychological quality of life, Positive affect</td>
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<td>Luszczynska, Boehmer, Knoll, Schulz, &amp; Schwarzer, 2007</td>
<td>BSSS: Received and provided emotional support subscale</td>
<td>Longitudinal (panel); Self-report questionnaire</td>
<td>Cancer</td>
<td>Positive main effect</td>
</tr>
<tr>
<td>Reevy, 2007</td>
<td>The Inventory of Socially Supportive Behaviors (ISSB): Received emotional, informational, and instrumental support</td>
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<td>Lakey et al. 2010</td>
<td>ISSB full scale</td>
<td>Cross-sectional; Self-report questionnaire</td>
<td>Negative and positive affect</td>
<td>Mixed effects</td>
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<tr>
<td>Bolger &amp; Amarel, 2007</td>
<td>Visible, invisible, and no support; self-constructed checklist</td>
<td>Lab experiment</td>
<td>Stress associated with giving a speech and/or writing an essay</td>
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</tr>
<tr>
<td>Study Reference</td>
<td>Instrument</td>
<td>Measurement</td>
<td>Stressor</td>
<td>Effect</td>
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<td>Taylor et al. 2010</td>
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<td>Mixed effects</td>
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<tr>
<td>J. Cohen, 2011</td>
<td>ISSB: Emotional and informational support subscales (28 items)</td>
<td>Cross-sectional; Self-report questionnaire</td>
<td>Cancer</td>
<td>Mixed effects</td>
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<tr>
<td>Reinhardt, Boerner, &amp; Horowitz, 2006</td>
<td>ISSB full scale</td>
<td>Cross-sectional; Self-report questionnaire</td>
<td>Depression, functional disability</td>
<td>Mixed effects</td>
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<tr>
<td>Knoll et al. 2011</td>
<td>BSIS: Received and provided emotional and instrumental support subscales</td>
<td>Longitudinal (panel); Self-report questionnaire</td>
<td>Surgery related stress</td>
<td>Predominantly negative (but mixed) effect</td>
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<td>Maisel &amp; Gable, 2009</td>
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<td>Cross-sectional; Self-report questionnaire</td>
<td>Anxious and sad affect</td>
<td>Mixed effects</td>
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<tr>
<td>Lepore, Glaser, &amp; Roberts, 2008</td>
<td>Modified UCLA-SSI: Friends and family subscale</td>
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<td>Breast cancer</td>
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<td>Depression; multiple sclerosis (MS)</td>
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<tr>
<td>Fekete et al. 2009</td>
<td>UCLA-SSI: Full scale (adapted to HIV patients)</td>
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<td>Rini et al. 2006</td>
<td>Self-constructed 21-item, in-depth structured interview</td>
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<td>Prenatal anxiety, relationship quality</td>
<td>Positive buffering effect: Relationship quality</td>
</tr>
<tr>
<td>Authors</td>
<td>Instrument/Measure</td>
<td>Data Collection Method</td>
<td>Population/Context</td>
<td>Effect Size/Outcome</td>
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<td>Bokszczanin, 2011</td>
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<td>Jaeckla et al. 2012</td>
<td>UCLA-SSI: German version</td>
<td>Longitudinal (panel); Self-report questionnaire</td>
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<tr>
<td>Siewert et al. 2011</td>
<td>BSSS: 11-item subscale</td>
<td>Experimental</td>
<td>Negative affect and perceived stress</td>
<td>Positive main effect</td>
</tr>
<tr>
<td>Simoni et al. 2005</td>
<td>UCLA-SSI: Full scale (adapted to HIV patients)</td>
<td>Cross-sectional; Self-report questionnaire</td>
<td>HIV-related depressive symptomatology</td>
<td>Positive buffering effect: Self-esteem and mastery</td>
</tr>
</tbody>
</table>
patients' received social support could be predicted by provided support. Knoll and Schwarzer (2002) illustrated that women who reported the highest social support had the lowest levels of negative affect and depression, and reported the fewest health complaints, whereas the social support levels of men were not linked to their depression and health complaints. They also found that young women reported receiving the highest social support, whereas middle-aged and older women indicated relatively low levels of support. In addition, men of all ages reported similar levels of social support. Furthermore, Schwarzer and Gutiérrez-Doña (2005) asserted that support receipt was beneficial for the participants, as results showed significant negative associations of the four support measures with depression, and positive relations to physical and psychological quality of life and positive affect. Support received from spouses was negatively associated with depression only in men, but not for women. However, with increasing age older respondent reported receiving the less support their family.

A number of other studies reported positive effects of social support receipt and provision. In a German sample of cancer patients and their intimate partners, Luszczynska, Boehmer, Knoll, Schulz, and Schwarzer (2007) found that participants reported high levels of both provided support and received support. Their study showed gender differences in support received and provided such that although support received from partners was high for all patients at the beginning, remained high over time for men, but decreased for women within one to six months after surgery; whereas provided support decreased for male partners, but remained relatively high in female partners. In a sample of 109 Latina women with arthritis, Abraido-Lanza (2004) showed that emotional support was directly and positively associated with psychological well-being, and tangible support was directly and negatively related to psychological distress. In a sample of 127 participants with multiple sclerosis (MS) and depression, Beckner, Howard, Vella, and Mohr (2010) found that participants’ reported level of social support receipt at baseline and their satisfaction with that support moderated treatment outcome among participants with MS and depression, such that higher levels of received support and satisfaction with that support resulted in greater reductions in depressive symptoms.

In a sample of 180 patients with chronic stroke, Adriaansen and colleagues (2011) found that even though social support receipt by patients declined significantly over time, receiving social support was positively related to life satisfaction, regardless of the amount of caregiver strain experienced by the partners. In a sample of 262 adolescents, Bokszczanin (2011) revealed that in the aftermath of a flood-related disaster situation, the majority of respondents reported that they provided tangible, emotional, and informational support to others in need. Findings showed that higher levels of support provided following the flood were subsequently associated with higher levels of perceived social support, a stronger sense of community at school, and greater propensity to engage in proactive coping, the effect of which remained significant even after controlling for the impact of exposure to disaster stressors, age, gender, and received social support. Furthermore, in an experimental study, Siewert and colleagues (2011) found that overprovision of emotional support was positively related to higher subjective well-being, whereas underprovision of support was associated with lower well-being. In addition, overprovision of informational and instrumental support was unrelated with well-being, and perceived social support was also unrelated to well-being in daily life.

Some studies showed positive buffering effects of receiving social support. In a sample of 373 mainly African-American and Puerto Rican women living with HIV/AIDS in the New York City area, Simoni and colleagues (2005) revealed that higher HIV-related social support from friends, relatives, partner, and groups/organizations was negatively associated with lower depressive symptomatology. Additional findings suggested that the effect of social support on depressive symptomatology was mediated by self-esteem and mastery. In addition, Rini and colleagues (2006) found that pregnant women's appraisals of the effectiveness of partner support predicted prenatal anxiety over and above the quality, intimacy, and equity of the relationship context, such that having a higher quality relationship with the partner, more emotional closeness and intimacy, and greater perceived equity were significantly related to a woman's perception that the support provided by her partner was more effective. The findings suggested that an increase in the appraised effectiveness of support leads to support’s ability to reduce the stressful effects of a major life transition (e.g., pregnancy and impending parenthood).

Research also shows mixed effects of social support receipt. Reevy (2007) found that enacted support was not associated with daily hassle frequency, hassle severity, or negative life events stress for either men or for women. However, enacted support was associated positively with positive life events for men, but not for women, suggesting that received support may be linked to positive life events for a specific gender. She asserted that the impact of enacted support received during good times in life reflects a new research area to explore further. Lakey, Orehek, Hain, and VanVleet (2010) asserted that received support was related to negative affect and perceived support when links reflected trait influences, whereas support...
recipients experienced positive affect when correlations reflected social influences; and that regardless of whether correlations showed recipient trait or social influences, received support was linked robustly and significantly to positive affect. Furthermore, findings of Gleason, Iida, Shrout, and Bolger (2008) suggested that the same support events could have both positive effects on relationship closeness and negative effects on mood. For instance, received support was disadvantageous to negative mood on days in which the support recipient did not provide support to his or her partner, whereas on days when support was both received and provided, the receipt of support increased relationship closeness and decreased negative mood. They concluded that support not only affects closeness and negative mood in differential manner, but also operates differently across individuals.

Shrout and colleagues (2010) examined the impact of received and provided support on five different daily moods: anxiety, depression, anger, fatigue and vigor. They found that receiving emotional support was associated with increased vigor and decreased anger, which contradicted the earlier findings by Shrout, Herman, and Bolger (2006). However, they also found that the receipt of practical support was associated with increased anxiety but increased vigor. In addition, practical support provision was linked to decreased depression. These findings reveal that variation in the effects of receiving and providing support depends on the types of support (emotional or practical) received and provided, and the nature of respondents, that is, whether enacted support is reported by the recipient or the provider. They suggested that the practical processes of support provision and receipt are more complex and nuanced than the cognitive processes related to the availability of perceived support.

In an experimental setting, Bolger and Amarel (2007) showed that invisible support — provided in a subtle or indirect way that the recipient does not interpret them as support — was more beneficial to the emotional functioning of a recipient in stressful times compared social support that was visible to the recipient and no support at all. In a series of three experiments, they found that in general explicit, visible support was ineffective in preventing stress-related negative emotions. Similar findings were reported in two earlier studies (Bolger, Zuckerman, & Kessler, 2000; Shrout et al., 2006). These studies suggested that receiving visible social support may pose as a threat to self-esteem of the support recipient, because it entails their inadequacy or inefficacy in dealing with stressful situations by themselves, or may even create a sense of indebtedness to support providers. As such, people with high self-esteem might experience receiving social support as more stressful compared to those with low self-esteem.

J. Cohen (2011) found that, overall, participants reported receiving lower levels of support online compared to face-to-face relations. She found that receiving more emotional support from the main support person was positively associated with positive affect and health related quality of life, whereas receiving emotional support online was only positively associated with positive reappraisal coping. However, receiving informational support from the main support person was neither related to positive affect nor to health related quality of life, but rather was positively associated with avoidant coping. In a sample of 570 elderly (age 65 and above) with functional vision problems, Reinhardt, Boerner, and Horowitz (2006) showed that received instrumental support was positively associated with depressive symptoms, whereas emotional support was negatively related to depressive symptoms and positively associated with adaptation to vision loss.

In a recent study, Jaeckela and colleagues (2012) found that women who received a high amount but provided a low amount of support (over-benefitting) had lowered self-efficacy, whereas those who provided high amounts but received low amounts of support reported highest self-efficacy, and the effect was moderate for those women who provided and received similar amounts of support. Maisel and Gable (2009) revealed that visible support was associated with positive outcomes if it was high in responsiveness, and invisible support was related to negative outcomes when it was low in responsiveness; which means that “visible support was not always bad and invisible support was not always beneficial—responsiveness made a difference” (p. 931). In a sample of women with breast cancer, Lepore, Glaser, and Roberts (2008) found a positive correlation between received social support and negative affect within and across time. In addition, a higher level of negative affect (at time 1) was related to a higher level of received social support (at time 2), regardless of the amount of support received at baseline; which suggests that people with high levels of distress were more likely to receive social support. Furthermore, in a sample of 120 men living with HIV, Fekete and colleagues (2009) asserted that ethnicity moderated the relationship between HIV serostatus disclosure to parents and HIV-specific family support and disease status. The findings showed that non-Hispanic White men who had disclosed to mothers and were receiving high family support had a lower viral load, whereas Latino men who had disclosed to mothers and were receiving low family support had a higher viral load, and these associations remained significant even after controlling for medication adherence.

A few studies showed predominantly negative effect of support receipt. In a sample of univer-
sity students and employees, Taylor and colleagues (2010) measured daily general support, daily partner support, and daily specific support in relation to psychological and biological outcomes. Their findings showed that regardless of whether the audience was supportive or unsupportive, the participants experienced high cortisol levels, and strong heart rate and blood pressure responses, indicating that even a supportive audience can make have negative influence on stressors. They also found that social support was associated with lower heart rate during recovery, relatively lower diastolic blood pressure during the tasks and during recovery, and higher positive affect and lower negative affect at baseline, suggesting that support resources are probably more useful before and after stressful events but perhaps less useful during stressful events. Finally, Knoll and colleagues (2011) reported in a sample of 109 male patients and their female partners facing an illness-related stress context that patients’ support mobilization was associated with more support provision by partners. However, they found that support receipt was associated with increases of distress in support recipients. They also reported that partners’ reports of relationship satisfaction were positively associated with their support provision to patients, that partners provided more support to the patients who had more self-efficacy, and that provider factors were not linked to provision of support. Furthermore, they noticed a reciprocal nature of support provision such that partners’ concurrent support provision was positively associated with their own receipt of support in the past.

**SUPPORT RECIPROCITY**

One of the most important predictors of social support provision is the receipt of support from others in the past (Gleason et al., 2003; Liang, Krause, & Bennett, 2001). In a German sample of students, Knoll, Burkert, and Schwarzer (2006) found evidence of reciprocity in that receiving emotional support from cohort members predicted the provision of emotional support to each other. In addition, provision of high reciprocal emotional support was found in extroverts and open individuals, while provision of more reciprocal instrumental support was observed in introverts and less open individuals. Furthermore, female participants received and provided more emotional support, although no such relations were observed for instrumental support (Knoll et al., 2006). Gleason et al. (2003) found that reciprocity in support transactions was associated with positive mood, whereas receiving support without reciprocation was associated with increases in negative mood even in close relationships. The social support is more often labeled as a 'dual exchange' process rather than as a one directional provision of care or help (Uehara, 1990). Schwarzer and Leppin (1991) asserted that social support manifests through an interactive process of giving and receiving, and is associated with the perception of reciprocity, altruism, a sense of obligation.

To summarize, majority of the studies reviewed in this article showed either mixed effects or positive (both main and buffering) effects of social support receipt and provision. Only two studies found predominantly negative effect of social support receipt. Taken together, recent studies conducted in the last ten years showed promising outcomes of receiving and providing social support in reducing life strain/stress and promoting better health and well-being.

**DISCUSSION AND FUTURE DIRECTIONS**

This study aimed at presenting a review of recent studies to show evidence of the effects of received and provided support on reducing stressors and improving physical and mental health. Drawing from past studies as well as some of the recent research published in the last ten years, this review illustrates that although there has been ample progress over the last 36 years (after the publication of Sidney Cobb’s 1976 paper) in research on received and provided social support in improving health and well-being of people, the effectiveness of received social support is still an open debate. As this review of current studies suggest, studies predominantly showed mixed effects of social support receipt and provision. As such, we still have little understanding about how support receipt actually works and under what context. The findings reported in this review indicate various outcomes associated with support provision and receipt. Hence, the general notion of earlier studies about the overall negative consequences of support receipt is questionable. As suggested by Shrout and colleagues (2010), research related to received and provided support are more nuanced and complex than was thought previously. Therefore, more theoretically and methodologically rigorous studies are warranted to further our understanding of social support provision and receipt.

The question remains as to how much progress have we made regarding social support research in the last 36 years or so that leads us to formulate better support interventions? This short review raises more questions than reflecting any definitive pattern of findings, as can be seen with perceived support research. What kind of support is beneficial against which stressors and for whom? What kind of support promotes best outcome in what socio-cultural context under what stressful circumstances? Who provides better support to whom in what situation? What are the motivations for support provision? Does reciprocity of support provision and receipt indicate that support will be effective? These are some of the questions that need to be addressed in future...
research. There is no question that the need of the support provider should be equally emphasized in future studies. Uchino, Carlisle, Birmingham, and Vaughn (2011) suggested three contextual processes for received support to be effective: (1) task-related factors such as the type of support and its match to the needs associated with distinct stressor, (2) recipient-related factors like whether one has chosen to receive the support, and (3) provider-related factors such as the quality of the relationship. It is the position of this review that despite a large volume of research on social support in the past four decades, the field has become relatively stagnated. Therefore, there is a need for paradigm shift in research on received and provided social support – a radical shift in the way of doing research and framing questions.

In my view, the first step in this regard pertains to advancement in theoretical frameworks in social support research. It can be observed that although a number of theories exist in relation to the perceived social support research, relatively little theoretical development has been made with regard to received and provided social support. It has been suggested by Bolger and Amarel (2007) that support works best when it is ‘invisible’, meaning when the recipient is unaware of support provision at the time of providing support. This is because explicit support provision might create a sense of indebtedness or reduce self-esteem of the support recipient. However, a recent replication of the ‘invisible support hypothesis’ by Taylor and colleagues (2010) did not find evidence that explicit social support receipt is a threat to self-esteem. Therefore, it raises question about the efficiency of this model of social support. The optimal support matching hypothesis (Cutrona & Russell, 1990) may be beneficial in that it suggests that for support provision and receipt to be effective, the support should match with the stressors as well as the need of individuals who seek the kind of support they think would benefit them. However, as this theory does not outline the nature of behaviors outside controllability that influences instrumental, informational, or emotional support (Thrasher, Campbell, & Oates, 2004), further modifications are needed to this theory.

The next step in this regard concerns methodological advancement in the field of social support research. There is a need for more theoretically guided scales measuring received and provided support. The two most reliable and valid measures of received and provided support – the Inventory of Socially Supportive Behaviors (ISSB) and the UCLA Social Support Inventory (UCLA-SSI) – are about thirty years old, and perhaps need modifications (although I am not suggesting to overlook them). There are some new measures of received and provided support, such as The Berlin Social Support Scales (BSSS) developed in 2000 for cancer patients in a German context. Some measures also exist for use in specific contexts, for instance, the Social Support List (SSL-12), Desired and Experienced Support Scales (DESS), among others. However, the psychometric properties of these measures need to be validated for general use.

Another important avenue to focus on is the cross-cultural contexts in which social support receipt and provision occur. Research by Kim and colleagues (Chen, Kim, Mojaverian, & Morling, 2012; Kim, Sherman, & Taylor, 2008; Kim, Sherman, Ko, & Taylor, 2006; Taylor, Welch, Kim, & Sherman, 2007) is an important first step in this regard. They differentiate between implicit and explicit support in cultural contexts, which is important to consider in future research. As Kim et al. (2008) asserted, “Social support is probably most effective when it takes the form that is congruent with the relationship expectations prevalent in a given culture” (p. 525). However, their research so far focuses on the perceived availability of social support and not the actually enacted social support. Therefore, more research is needed focusing on received and provided support in different ethno-cultural contexts.

Majority of the studies do not focus on the life-course perspective in social support research. However, little is known about received and provided social support through the life course, particularly in adolescents and children. Although there are some theoretical works in existence (e.g., Schulz & Rau, 1985), little empirical work has been done. Future research should focus on social support in developmental context across the life course. Another issue requires further research attention. Although religion and coping has been researched extensively, the relation between religion and social support provision and receipt is not a focus of a large majority of research. We know more about religion and coping but less about how religion fosters the provision of social support. Future studies should highlight this aspect of social support.

Receiving and providing social support is beneficial at both an individual and societal level as they predict better health and well-being (see Shakespeare-Finch & Obst, 2011). As such, the contextual aspects of social support provision and receipt needs further exploration. Research increasingly shows that relationship quality acts as a mediator of social support receipt. However, research thus far reflects link between stress or illness and social support, but does not consider well-being as an independent variable, as it has been neglected in decades of research on social support. A focus of future research should be to consider social support for thriving within a life context (i.e., engagement in life opportunities).

Recent research has shown a link between biolo-
gy and social support. Taylor (2011b) suggested that research has started to shed lights on genetic bases of social support provision and receipt. Particularly among females, she found that facing stressors they showed biological need to affiliate, which she termed ‘tend and befriend’ (as opposed to ‘fight or flight’ response typically seen in males). Furthermore, the link between technological advancement and social support provision and receipt has gained attention in recent years. The widespread use of the Internet for socializing and making friends (e.g., Facebook) as well as the use of new technologies like video conferencing through Skype and smart phones facilitate social support provision, particularly emotional and informational support. Further research is needed on the quality and benefit of social support received online and offline.

LIMITATIONS AND IMPLICATIONS

This review of research has several limitations. Studies reviewed here come from a keyword search in the PsychInfo and PubMed databases as well as in Google Scholar, which are limited to publications in the English language and primary empirical studies. As such, they are not exhaustive in relation to the vast field of research on social support. The findings reported here are based on quantitative studies only, and hence they do not reflect the qualitative impact of social support receipt and provision on health and well-being. Because this review focused on received and provided social support, a comparison on the effects between perceived and received social support is not possible (such comparison has been made elsewhere; e.g., Haber et al., 2007). Furthermore, studies reviewed here employ various methods (e.g., cross-sectional, longitudinal, experimental) and measures of received and provided support (e.g., UCLA-SSI, BSSS, ISSB, and self-constructed checklist) using diverse samples, which makes drawing general conclusions difficult.

Despite these limitations, the findings have a number of implications on health and well-being. First, recent evidence suggests that receiving social support can lead to more positive health outcome than was thought previously. Although past studies generally suggest that support receipt negatively affects physical and mental health (Bolger & Amarel, 2007; Bolger et al., 2000; Frese, 1999; Iwata & Suzuki, 1997; Martire et al., 2002), this review illustrates that receiving social support produces mixed outcome, with many of these studies showing predominantly positive effect on health. Second, the critical factor that makes the difference is the appropriate match between the need of individuals who seek social support and the quality of support provided targeting specific stressors (Cutrona & Russell, 1990; Lakey & Cohen, 2000). It means that for social support to be effective, support provision should correspond to the particular demands of the person who receive social support. For instance, when a person faces death of a spouse, emotional support would probably be the most beneficial in promoting well-being for that person. Conversely, if a person experiences a stressor such as a financial crisis, instrumental support would be more appropriate in dealing with such stressors.

Third, the benefit of received support is dependent on the cultural context in which support provision and receipt occurs. Studies have examined the provision of social support in different cultural contexts (Chen et al., 2012; Kim et al., 2008; Kim et al., 2006; Taylor et al., 2007). Taylor et al. (2007) found that Asians and Asian Americans experienced more distress and had higher levels of cortisol in explicit support condition than in either implicit support or control conditions. On the other hand, European Americans experienced less distress in explicit support conditions in comparison to implicit support and control conditions. Furthermore, Chen et al. (2012) suggested that the very meaning and conceptualization of ‘social support’ may differ in different cultural contexts. In a sample of female college students (study 1), they found that Japanese reported providing more problem-focused support than emotion-focused support, whereas European Americans reported providing more emotion-focused support than problem-focused support in their daily lives. Chen et al. (2012) also asserted the possibility of blurriness of these two concepts such that a particular supportive behavior (e.g., loaning money) may be recognized as problem focused in one culture and emotion focused in another.

Fourth, the impact of support receipt and provision should be interpreted in the context of gender. For instance, Luszczynska, Boehmer, Knoll, Schulz, and Schwarzer (2007) found that men reported receiving more emotional support (from their spouses) than women did, and that pattern remained stable for the duration of the study (six months). Research has consistently shown that within a particular social support network, men received more support from their spouses, and women received more support from relatives and friends (Glynn, Christenfeld, & Gerin, 1999; Reeyv, 2007; Schulz & Schwarzer, 2004; van Daalen, Sanders, & Willemsen, 2005). There are exceptions, however, as Cohen and Wills (1985) found that women showed more benefit from spousal support. Some researchers have argued that men benefit more from instrumental support, particularly from other men (Craig & Deichert, 2002), whereas women benefit more from emotional support (Uno, Uchino, & Smith, 2002). In addition, women seem to get benefit more from other women (Uno et al., 2002). Moreover, women seem to be
particularly susceptible to relationship quality as a requirement of received support (Hagedoorn et al., 2000; Uno et al., 2002). Past research also indicates that although males have extensive support network, the kind of support provided through the network is relatively superficial; contrarily, although females have limited support network, the nature of support received are often intensive and intimate (Shumaker & Hill, 1991).

To conclude, social support receipt can occur with or without the presence of life strains/stressors. Under stressful situations, individuals will need to receive emotional, informational, and/or instrumental support from their close others and significant others (e.g., spouse, friends, family members, colleagues, groups etc.). Depending on the nature and quality of that support, it can have a direct (main) effect on health and well-being (either positive, negative, or no effect). In addition, social support receipt may assist individuals in coping with stressors (McColl, Lei, & Skinner, 1995; Thoits, 1986), and coping process in turn will have positive or negative effect on health (depending on the nature and effectiveness of that coping process). Furthermore, support received (or lack thereof) prior to the occurrence of life strains may change the appraisal of that particular stressor, and thereby facilitating (or hindering) effective coping, which in turn will lead to better (or worse) health outcomes. Thus, received social support affect physical and mental health and well-being in three ways: (a) directly, (b) through assisting the coping process, and (c) changing the impact of life strains/stressors.

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