

Gender and Age Differences in Social Support: A Study of East German Migrants

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Abstract. Independent of traditional risk factors, psychosocial variables such as lack of social support and depression are known to predict coronary heart disease. A study was conducted to examine the current status of these factors and their changes over time in relation to gender and age among East German migrants in a two-year follow-up study initiated shortly before the fall of the Berlin Wall. Longitudinal data were collected starting in September 1989. The second and third waves were conducted during the fall of 1990 and the fall of 1991. A total of 126 men and 109 women between ages 14 and 66 participated in all three waves. Young women reported receiving the highest social support, whereas middle-aged and older women indicated relatively low levels of support. Men of all ages reported similar levels of social support. Social support increased for both sexes during the follow-up period. Social support also predicted negative affect (depression and anxiety) and health complaints. Among women, those who related the most social support (younger women) also had the lowest levels of negative affect and health complaints. Men reported comparatively low levels of negative affect, and men who were older than 45 years indicated strikingly low levels of health complaints. Analyses predicting health complaints and depression by gender, age, and social support showed that women reporting low social support had the highest levels of depression and health complaints, whereas social support levels of men were unrelated to their depression and health complaints.

1. Introduction

Social support and depression are known to modify the impact of stressful life events on coronary heart disease (CHD) and other chronic illnesses. The present study was conducted to examine this process in a group subjected to unusually severe life changes—East German migrants to West Germany during a period that started shortly before the fall of the Berlin Wall to more than a year and a half later. The covariation of social support with gender and age over time was of central interest. Additionally, indicators of psychological and physical well-being were examined as outcome variables predicted by social support, gender, and age.

1.1 Social Support

The benefit of social support for individuals confronted with life crises has been the subject of research for more than two decades. It has been shown, for instance, that greater social integration during periods of high life stress may not only provide sustenance for the psychological well-being of an individual, but might also have a positive impact on a variety of discrete health outcomes [1]. Although the behavioral and physiological

mechanisms that mediate the effects of social support have yet to be thoroughly studied in experimental settings, associations between social network ties and indicators of health and well-being are stable and well-replicated. These beneficial effects may be displayed in a variety of ways. For example, being able to rely on others for social support may reduce stress or acute anxiety and serve to reduce the use of alcohol, cigarettes or other substances consumed in an effort at self-medication. Depending on their nature and level of intimacy, social relations may also contribute to the advance of severe health problems when these ties are threatened or dissolved.

1.2 Social Support Classifications

As has been noted elsewhere [2], social support has to some degree become an omnibus construct that encompasses an array of only partially overlapping characteristics. For example, some researchers focus on social support defined in terms of companionship, interaction with others, intake of information, fulfillment of personal needs, feeling needed or valued, or a transaction of resources [3]. Others highlight the structural components of the construct—whether or not it involves a quantifiable objective social network versus some cognitive representation of expected help. Some authors emphasize the quality, and others the quantity of relationships [4]. Finally, some investigators consider positive as well as negative characteristics of social support, whereas others focus on mere benefits attributable to social networks [5].

Social support as a subjective (anticipated/expected) versus an observable (received) phenomenon is one prominent distinction. B. R. Sarason and colleagues [4] for instance, define social support as a personal and stable expectation closely resembling a personality trait. Sarason et al. also propose that trust that help will be received when needed is propelled by worthiness and love brought forth by the social environment. B. R. Sarason and I. G. Sarason [6] note that "[social support] then is best defined as the sense of acceptance, an inherent, stable personality characteristic that contributes to the perception of social support separately from what the environment actually offers at any particular time" (p. 110).

A very different approach has been suggested by Newcomb [7]. He too agrees that social support is a resource that is perceived or subjectively available to an individual. On a more basic level, however, this perceived availability is displayed in the number of social interactions in which the individual takes part.

Many authors currently view perceived/anticipated and received social support as two different constructs, each deserving attention in its own right. As Norris and Kaniasty [8] assert, "received support is helping behavior that did happen, and perceived support is helping behavior that might happen" (p. 498). There is abundant empirical work on received versus anticipated social support. Dunkel-Schetter and Bennett [9] propose that only received social support can have positive effects on well-being. Nevertheless, they criticize the manner in which received social support is operationalized in many studies. The finding that perceived/anticipated social support seems to be a more powerful predictor of well-being than received social support [10] may be due to deficient measurement of the latter. In the present study, received social support was emphasized. A new, situation-tailored face-valid instrument was constructed to address and minimize some of the reported difficulties prominent in the current literature on received social support.

1.3 Functional Mechanisms in Social Support

Being part of a social network can serve as a powerful buffer against stressful life events. However, social networks may also be stressors in their own right. Moreover, for some

individuals, social support has no effect whatsoever. Such findings raise the question of when social support may be expected to have positive, negative, or no effects on the well-being of an individual. A model proposed by Dunkel-Schetter, Blasband, Feinstein, and Bennett [11] puts an emphasis on all active components within a support interaction—the support recipient, the support provider, and an external observer. From each of these perspectives, an interaction can be appraised as positive, neutral, or negative. Only if there is an overlap between these three perspectives can one perceive someone as having provided true help in the altruistic sense (support provider) to a person who benefits from this help in times of need (receiver perspective), while a third party (observer) discerns it as social support. A lack of overlap in these perspectives may lead to situations such as unwanted help or unanswered need for help, and thus to the negative aspects of a social network.

1.4 Coming to Terms with Stress: Social Support in the Aftermath of Migration

Migration can be considered a nonnormative critical life event [12, 13]. As with other critical life events (such as accidents, losses, divorce, or illness), the corresponding psychological crises may have a tremendous impact on an individual's personality, psychosocial functioning, and health. Not only is it necessary to cope with daily hassles that arise after migration, such as with crowded living conditions in camps or shelters upon arrival, but also with the threat of long-term unemployment and the need to establish a new social network. Thus, migrants are not only disadvantaged by greater demands than previously, but also by increased individual vulnerability to stress because of their loss of vocational and social ties [14, 15, 16]. Addressing this situation, a number of studies have demonstrated that the availability of social support to migrants may result in lower depression rates, lower level of stress hormones, and better general mental health [17, 18, 19].

The present data set comes from the only psychological panel study that was launched early enough to cover the dynamics of social transformation in Germany during the reunification process. Its aim was to investigate social bonding and psychosocial adaptation of East German migrants.

1.5 Gender and Age as Predictors of Social Support

Two sociodemographic characteristics—gender and age—and their association with social support variables were of special interest in this study. Although there is a large body of research examining the relationship of gender to social support, relatively few studies have investigated differences in social support related to age, particularly in young- to middle-aged adults in the context of macrosocial change.

It is likely that men and women do not experience macrosocial changes in the same way when it comes to social losses and social bonding. Gender differences in social networks and social support have been discussed by various authors [20, 21]. Throughout the life-cycle, women generally have more close friends than men [22]. Commencing in childhood, girls tend to develop more intimate interpersonal relationships than boys, although boys tend to gang together in larger groups [23, 24, 25]. Adult women still have a greater number of close relationships and also seemingly more extensive social networks than men [26, 27]. Additionally, women provide more emotional support to both men and women, and they get more help in return [28]. Explanations for such discrepancies typically focus on gender differences in emotionality and emotional expressiveness. Women emphasize intimacy and self-disclosure in their friendships, and are generally more

empathetic, expressive, and disclosing than men [22, 29]. In short, women seem to invest more of themselves in the lives of their family members and friends than do men.

When it comes to chronological age and social support, surprisingly little can be found about middle-aged adulthood in the literature. Most investigations have focused on school-age populations or the elderly. A critical question, thus, is whether age-related changes occur in the association of various social network ties with indicators of psychological well-being and physical health.

Empirical evidence that increased social activity proves beneficial to psychological well-being can likely be generalized to middle-aged adults. Generally, people maintain social connections with numerous others throughout life. However, during the later part of adulthood rates of social interaction begin to decline [30]. Later-life relationships become fewer in number, but deeper in intensity and quality [30, 31]. A study on social interaction and adaptation [32] revealed that, especially for older persons, reporting a stable *intimate* relationship is more closely associated with good mental health and high morale than are higher numbers of social interactions or higher socioeconomic status. Thus, even a comparatively small number of social ties can yield a high level of psychological well-being if a few, more intimate relations exist.

There may also be age-related changes in the association of social ties and mortality. Results from the Alameda County Study [33] suggest that being married is related to lower mortality risk for individuals under 60 years of age. Moreover, the Terman life-cycle study [34] revealed that marital history, number of children, and organizational memberships may all be predictive of mortality risk. Thus, for somewhat younger men (<70 years of age), marital dissolution and subsequent remarriage predicted increased risk of mortality, whereas in older women (>70 years of age) having more living children and organizational memberships predicted decreased mortality.

Finally, in a meta-analysis by Uchino, Cacioppo, and Kiecolt-Glaser [1], social support was found to have beneficial effects on markers of health status across a range of age groups. Specifically, it was found that individuals low in social support displayed age-related increases in blood pressure, whereas those high in support maintained low blood pressure as they aged. Provocatively, these authors state that the net effect of such processes may be that individuals with strong social support biologically age at a slower rate than those with weaker social support.

2. Research Questions and Hypotheses

The present study was designed to address the following hypotheses:

- 1) Migration and macrosocial change constitutes a major life event that is both stressful and heavily demanding of personal resources. In accord with numerous findings in the literature, social support is assumed to buffer both health complaints and indicators of negative affect.
- 2) It was predicted that women would report greater amounts of received social support over time than men. As a result of their greater investment in social relationships, it was also expected that women would suffer more health complaints and negative affect than men under conditions of low support.
- 3) A number of age-related factors must be taken into account in connection with migration or macrosocial change. First, individuals at different life stages may well have different motives for choosing to leave their familiar surroundings. In addition, they are likely to face

different challenges after relocation. Young people might view their migration as a new start that allows them the opportunity to excel in their work and build a family. However, for middle-aged adults, migration may require competing in a completely different job-market, training in different skills, and caring for other family members as they migrate. Consequently, it is likely that older persons self-select differently at the time of migration than younger people. This in turn may mean that older migrants require more social support and may report worse physical and psychological health if social support is not provided. It is also conceivable, however, that only extremely resilient older people choose to migrate. If this is the case, having less social support might not affect their overall well-being because other strengths buffer the impact of stress. Given the lack of literature examining the interaction between age and social support, this question was approached as an exploratory topic rather than directional hypothesis.

3. Method

In early October 1989, before the opening of the Berlin Wall, a study was initiated to gain more detailed knowledge about the adaptation and coping processes of people who had recently escaped from East Germany. The project was planned as a longitudinal study with three measurement points during the first two years following relocation. People who arrived from East Germany after November 9th of that year were also included in the sample (see next section on participants).

All potential participants were contacted in their temporary living quarters and were asked to participate in a psychological investigation on their adaptation process in the West. Taking part in the study was voluntary, and respondents were assured of anonymity. Numerical codes were used in place of names or addresses. The first study wave took place in 1989/1990 (median = December 1989), the second-wave data were obtained during the summer of 1990 (median = August 1990), and the third wave was conducted in the summer of 1991 (median = July 1991). A total of 1,036 migrants agreed to participate in the first wave. After two years, the majority of first-wave participants had dropped out because they could no longer be located by the research group. Many participants had changed addresses more than once, making it extraordinarily difficult to track them down later. Those participants who could be located were principally those who had remained in temporary housing. Two hundred and thirty-five individuals from the original group of participants from Wave 1 were followed up at Wave 3, representing the final longitudinal sample. Although this constituted an attrition rate of 78%, those who did participate in Wave 3 did not differ from the remaining members of the original sample in terms of the major variables under analysis [see 3, 19]. It was also explored whether specific conditions of the migration, such as timing, made a difference, but this was not the case.

Panel studies—particularly those conducted with a unique sample—typically suffer from considerable attrition. Perhaps a monetary reimbursement would have enticed people to continue with the study, or maybe they doubted that the study was actually anonymous.

3.1 Participants

The present analyses were conducted with data from the 235 migrants who participated in all three study waves. The majority (62%) of the "migrants" in the present study were actually refugees, who had arrived in West Berlin before November 9, 1989, whereas those arriving after that date were considered to be legal migrants (38%). Originally, refugee

status was included as a predictor in all analyses. These two groups did not differ with respect to the major variables under study¹ and thus were combined [see also, 3].

The migrant sample was comprised of 126 men (mean age = 31 years) and 109 women (mean age = 32 years) who had arrived in West Berlin in 1989. Participants were stratified by age into three different age groups—those from 14 to 25 years of age (Group 1, $n = 67$), 26- to 45-year-olds (Group 2, $n = 144$), and those older than 46 years of age (Group 3, $n = 24$, see Table 1).

Among the male participants, roughly 42% were married, while the percentage of married women was slightly greater (52 %). Upon arrival in the West, 36% of the men were immediately employed, whereas the employment rate following immigration was considerably lower for women (15%). Employment figures changed notably over the two-year period. In 1991, about 81% of the men held jobs, and among women employment rose to 64 % (see Table 1).

Table 1. Sociodemographic Characteristics of Sample Respondents to all Three Waves

Characteristic	Men ($n = 126$)	Women ($n = 109$)
Mean Age		
14 – 25 years	22.24 years	21.17 years
<i>SD</i>	2.26 years	2.48 years
<i>n</i>	38	29
26 – 45 years	32.53 years	33.57 years
<i>SD</i>	5.45 years	5.45 years
<i>n</i>	75	69
46 + years	50.46 years	54.36 years
<i>SD</i>	6.17 years	6.12 years
<i>n</i>	13	11
Married (%)	42.06	52.29
Employed (%)		
1989 (t1)	35.71	14.70
1990 (t2)	71.43	52.30
1991 (t3)	80.95	64.22

3.2 Measures

Received Social Support. Received social support was defined as a retrospective assessment that social assistance was provided in times of need. The scale consisted of 11 items such as "Friends and relatives have helped me to look for a job." It revealed satisfactory internal consistency (Cronbach's alpha = .81). Items were endorsed on a four-point Likert-type scale. The received social support scale, designed for this specific project, possesses high face validity. For a more detailed discussion of its psychometric qualities, see [3].

¹ With respect to sociodemographic variables, only one difference between refugees and migrants was found: The refugees were more likely to be employed at the first measurement point. In light of the fact that they had relocated earlier and thus had more time to find a new job, this is a plausible finding. The differences in employment status disappeared at later waves of the data collection.

Depression. As a measure of depression, a 16-item German depression scale was selected [35]. Its internal consistency was Cronbach's alpha = .90. Typical items were "I feel simply miserable," or "I feel blue and downhearted." The scale has been validated extensively, and it shows high concordance with expert ratings and other well-established scales [36].

Anxiety was measured by a short subscale of four items from the German version of the State-Trait Personality Inventory (STPI), which has proved to be a valid and reliable instrument for assessing anxiety, curiosity, and anger [37]. The internal consistency of the anxiety scale used in the study was Cronbach's alpha = .74. Item examples are "I get tense and restless when I think of all my worries and problems," and "I worry too much."

Indicators of ill health. Self-reported physical symptoms were assessed with a well-validated German instrument [38]. Twenty-four items were used from this inventory, subdivided into four subscales of six items each: (a) chest pain (Cronbach's alpha = .77), (b) pain in the limbs (Cronbach's alpha = .82), (c) stomach complaints (Cronbach's alpha = .79), and (d) vital exhaustion (Cronbach's alpha = .87). All items were endorsed on a five-point Likert-type scale. The four scales were subsequently aggregated into one total score for which the term "health complaints" is used in this paper. Its scores range from 0 to 96.

4. Results

The first analysis focused on the relationship between gender, age, and received social support across the three waves of data collection. Next, a number of self-reported psychosocial and health-related variables were examined in an effort to identify possible risk patterns among certain subgroups within the migrant population. The principal statistical test was analysis of variance (ANOVA), with gender and age as between-subjects independent variables and the three waves of follow-up as a repeated, within-subjects independent variable. Indicators of negative affect (i.e., anxiety and depression), and physical ill health (i.e., chest pain, exhaustion, and health complaints) served as dependent variables. We also examined the relationship of received social support (aggregated over three waves), gender, and age to depression, anxiety, and health complaints. In these analyses, gender (two levels), age groups (three levels), and dichotomized received social support served as predictors, and depression, anxiety, and general health complaints as outcomes, each aggregated over three measurement occasions.

4.1 Social Support Varies with Gender and Age

First, received social support was examined as a dependent variable in analyses of variance including gender, age, and time as independent variables. A main effect for time ($F[1.96, 430.06; \text{Greenhouse-Geisser correction}] = 79.40, p < .001$) emerged, as did a significant interaction between gender and age ($F[2, 219] = 4.23, p = .02$). Overall, received social support increased over time for migrants of all ages, and for both men and women. However, when aggregated over time points, differences between men and women and among the different age groups became apparent. Table 2 indicates that received social support among men increased with age. Among women, however, received social support decreased with age.

Table 2. Means and standard deviations of received social support, anxiety, depression, and health complaints of men and women in all age groups.

Variable	Age groups					
	Up to 25 yrs (n = 67)		26 to 45 yrs (n = 144)		46 yrs and older (n = 24)	
	Men	Women	Men	Women	Men	Women
	<i>M</i>	<i>M</i>	<i>M</i>	<i>M</i>	<i>M</i>	<i>M</i>
	<i>SD</i>	<i>SD</i>	<i>SD</i>	<i>SD</i>	<i>SD</i>	<i>SD</i>
Received Social Support	23.75	27.42	24.39	24.42	24.78	21.74
	5.28	5.72	4.77	4.70	5.85	8.63
Anxiety	8.40	9.13	8.33	9.42	8.11	11.48
	1.88	2.27	2.41	2.39	2.64	1.84
Depression	21.12	22.30	20.47	22.64	20.11	25.59
	5.10	4.35	4.34	5.37	3.94	8.31
Health Complaints	10.45	12.51	9.68	16.75	15.03	22.88
	11.36	9.11	10.60	12.61	14.59	13.70

Note. Range of possible values: Received Social Support (11-44), Anxiety (4-16), Depression (16-64), and Health Complaints (0-96).

4.2 Negative Affect, Gender, and Age

We next examined the relationship of gender, age, and time to anxiety and depression. For anxiety, significant main effects were found for time ($F[1.87, 418.98; \text{Greenhouse-Geisser correction}] = 11.46, p < .001$) and gender ($F[1, 224] = 17.87, p < .001$). A significant interaction between time and gender also emerged ($F[1.87, 418.98; \text{Greenhouse-Geisser correction}] = 6.03, p = .003$). Furthermore, a trend was observed for an interaction between gender and age ($F[2, 224] = 2.66, p = .072$).

Generally, the amount of reported anxiety decreased over time for the sample as a whole. Women of all age groups mentioned more anxiety than men. Table 2 shows mean levels of reported anxiety in all age groups for men and women. Reported anxiety in women increased with age, whereas for men there were relatively low levels in all three age groups.

A main effect for gender on depression was also found ($F[1, 219] = 10.99, p = .001$); women reported more depressive symptoms than men regardless of age (see Table 2). There was also a time by age interaction ($F[3.83, 419.48; \text{Greenhouse-Geisser correction}] = 3.32, p = .012$) indicating that depression decreased over time for the younger age groups and increased with time for the oldest age group.

4.3 Health Complaints, Gender, and Age

Overall health complaints, and in particular chest pain and exhaustion, were also examined as outcome measures. For self-reported *chest pain*, a significant time by age interaction emerged ($F[3.98, 427.98; \text{Greenhouse-Geisser correction}] = 3.01, p = .018$). There was a relatively sharp increase in reported chest pain for the oldest age group (46 years and older)

over the three time points among both men and women. The younger subgroups remained at about the same level across the three assessments.

For *exhaustion*, a significant main effect of gender emerged ($F[1, 216] = 8.33, p = .004$), with women recounting greater exhaustion than men over all ages and time points.

As a last indicator of physical well-being, reports of *general health complaints* were assessed. The analysis of variance revealed main effects for age ($F[2, 215] = 3.02, p = .05$) and gender ($F[1, 215] = 7.05, p < .01$). As shown in Table 2, men in all age groups had fewer general health complaints when compared to women of the same age. Moreover, persons in older age groups reported more health complaints.

There was also a significant time by age interaction for general health complaints ($F[3.82, 410.11; \text{Greenhouse-Geisser correction}] = 2.81, p = .027$). Health complaints increased across waves for the oldest age group, but remained unchanged with time for both younger age groups.

4.4 Received Social Support, Gender, and Age Predict Depression, Anxiety, and Health Complaints

For all remaining analyses, variables were aggregated over the three time points. To examine the possible role of received social support in health complaints, three analyses of variance (ANOVA) were performed with received social support (two levels), gender (two levels), and age (three levels) as independent variables, and depression, anxiety, and health complaints as dependent variables.

For *depression*, there were significant main effects for both received social support ($F[1, 199] = 17.09, p < .001$) and gender ($F[1, 199] = 8.19, p = .005$), and significant interactions were found between social support and gender ($F[1, 199] = 14.28, p < .001$), and social support, gender and age ($F[2, 199] = 3.15, p = .045$). Follow-up analyses revealed no significant effects for men, but a significant main effect on received social support ($F[1, 101] = 28.23, p < .001$) and an interaction of received social support and age ($F[2, 101] = 2.93, p = .058$) for women.

Figure 1 shows mean depression scores for men and women by age and level of received social support. It is apparent that, regardless of age, women who received little social support report more depression than do women receiving high levels of social support or men of all ages and at all levels of social support. Furthermore, there are no obvious differences in depression scores between men of all ages receiving little support and men receiving more support.

For *anxiety*, a main effect of gender ($F[1, 223] = 17.03, p < .001$) as well as a trend for an interaction between gender and received social support ($F[1, 223] = 3.31, p = .07$) were found. Women reported greater anxiety than men. Women proclaiming higher received social support also indicated that they were less anxious than women receiving little social support. For men, amount of received social support was not related to anxiety.

Finally, there were significant main effects for both gender ($F[1, 214] = 8.26, p = .004$) and received social support ($F[1, 214] = 6.42, p = .01$) as well as a trend for age ($F[2, 214] = 2.69, p = .07$) on self-reported *health complaints*. Moreover, an interaction between received social support and gender ($F[2, 214] = 5.18, p = .02$) was observed. Follow-up analyses for men and women separately revealed no significant effects for men; however, a significant effect of received social support was found for women ($F[1, 99] = 10.11, p = .002$). Women receiving little social support had more health complaints than women receiving greater social support. Interestingly, for men level of social support did not seem to affect the amount of health complaints. For both sexes, reported health problems were comparatively few (see Figure 2).

5. Discussion

The present study adds to the literature on social support as a moderator of the stress–illness relationship [1, 3]. Under stressful circumstances, the incidence of illness and health

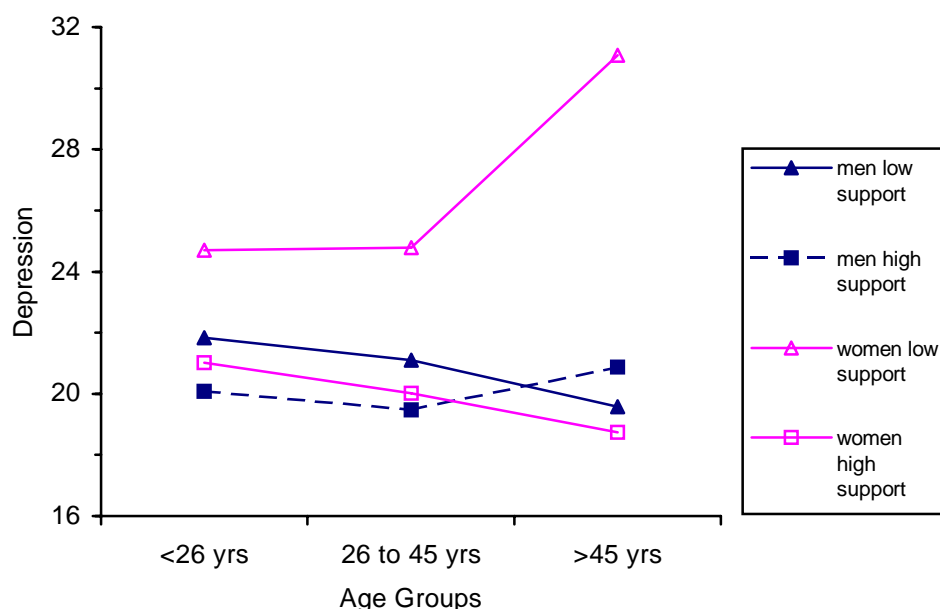


Figure 1 . Depression means for men and women of different age groups receiving high and low social support.

complaints increases, but this is particularly true for those who suffer from a lack of support. In part, our results confirm those of previous studies in a unique sample of East Germans migrating to the West shortly before the fall of the Berlin Wall [19, 39].

The experience of migration at a time of macrosocial crisis and political ambiguity was clearly stressful for migrants, who needed to draw upon all possible resources, including their social networks [3, 19]. The nature of this experience makes it likely that study participants would manifest physical symptoms and impaired quality of life. However, results showed that only the subgroup of socially less embedded women exhibited relatively high levels of health complaints and depression. Men and women receiving more support had few symptoms of depression or ill health.

These results confirm the value of examining the relationships between stress, social support, and health in conjunction with demographic factors such as gender and age. Health complaints, especially chest pains, increased with age for both sexes in the present study. For women, exhaustion, depression, and anxiety were also found to increase with age. Because morbidity increases as people get older, age and life stage need to be considered more closely in studies on social support.

It is well-known that the sexes differ in their need, use, and provision of social support, with women typically both requiring and providing more social support than men [19, 39]. In the present sample, both men and women migrants became more susceptible to ill health with advancing age. However, only the reported health outcomes of women were affected by the amount of social support they received.

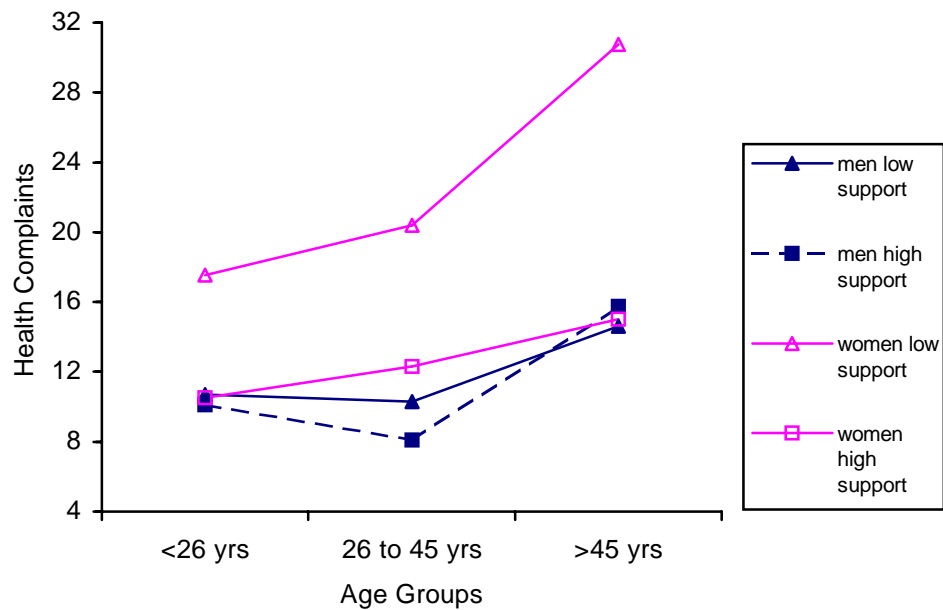


Figure 2 . Health complaints for men and women of different age groups receiving high and low social support.

According to anecdotal information during the interviews, three typical profiles appear to characterize women in this study. One was the prototype of a healthy and young woman who left the East bringing with her or immediately finding new sources of social support. Another prototypical woman was older and arrived in the West without having support available to her. The third was the married middle-age woman who involuntarily moved with her husband to the West. The latter two prototypes seemed to be more at risk for anxiety, depression, and illness. There are, unfortunately, no hard data to quantify the prevalence of these prototypes. Young and old women did not differ, for example, in terms of marital status.

For men in this study, only one pattern of results seems to stand out. Regardless of age, men did not seem to be affected by the amount of social support they were granted, and they appeared to cope fairly well with the situation at hand. Their levels of reported illness, depression, and anxiety remained comparatively low.

Limitations of the study

Two different self-selection biases may underlie the present data. First, although East Germans dealt with a societal crisis situation, there were no forced refugees. Instead, the participants in our study were voluntary migrants who, based on our results, seem likely to have appraised immigration more as a challenge than a threat [19, 39]. These individuals might have been among the first to leave the East, together with their families and long-standing social networks. Thus, generally, this group could be characterized as active and resourceful copers with a small subgroup of women who not only lack social resources, but also suffer from high levels of negative affect and ill health.

Secondly, although initially not different from the participants in all three waves, those persons who dropped out of the study might have faced less favorable developments within the first two years after migration. Lack of “good news” might have kept a share of

the dropout population from answering further questionnaires. Aside from problems of tracking down the participants, lack of incentives for participation, and doubts about the anonymity of the data, overall disappointment with the “West experience” might have contributed to our fairly large dropout rate. Hence, the subsample of men and women who remained may have been psychologically fitter and better able to cope well with the challenges of relocation.

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