Emotional Support Exchange and Life Satisfaction

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Abstract

This study investigated emotional support exchange and the relation between the emotional support exchange and well-being within the context of the socio-emotional selectivity and exchange theory. Consequently, it was determined that the provision and receipt of emotional support decreased with age and older adults with reciprocal and balanced emotional support exchange had higher well-being. In other words, study findings supported the equity and quantity hypothesis.

Introduction

Maintaining high levels of subjective well-being (SWB) is one important aspect of successful aging (Baltes & Baltes, 1990). Subjective well-being in the elderly is considered to be related with such factors as life satisfaction, morale and happiness. (e.g., Kai et al., 1991; McDowell & Newell, 1996). Considering the increased risks of loosing health, competence, social network and income with age, one can conclude that older adults have lower levels of SWB compared to younger individuals. However, contrary to the expectations, a number of meta-analyses in this field have demonstrated that SWB does not decrease with age. Older adults have well-being no less than younger individuals. This paradoxical finding is widely expressed by global dimensions of well-being, namely life satisfaction and happiness. (Pinquart, 1997a; 1998). In order to interpret these counterintuitive results, new studies are needed to investigate the association between SWB and those aspects of life that show increased risk of loss and decline in old age (Pinquart & Sorensen, 2000). Subjective well-being is person's own evaluation of his/her life. This evaluation can be related to cognitive conditions like satisfaction with one's marriage, work, and life, while it can also be affected by ongoing situations (i.e., the presence of positive emotions and moods, as well as the absence of unpleasant effects) (Diener, Sapyta, & Suh, 1998).

In gerontology, there are several ways to assess subjective well-being, for example, by measuring self-esteem, life satisfaction and happiness (Pinquart & Sorensen, 2000). Life satisfaction is one of the most important indicators for the positive effects of subjective well-being in older adults (Siu & Phillips, 2002). It is defined as an overall assessment of one's life including the current life (Bowling, 1990; Neurgarten et al., 1961). Living conditions and technology have advanced since the beginning of the 20th century, which brought in the prolonged average life expectancy. The average life expectancy increased by 20 years worldwide, reaching up to 66 years between 1950 and 2000. Another 10-year increase is expected by the year 2050 (United Nations, 2005). The elderly population is generally in a good physical health in USA, and the life expectancy was estimated as 75.2 and 80.4 years for men and women, respectively (Kung et al., 2008). However, a long life does not guarantee a satisfying life. Life satisfaction has been frequently examined in social gerontology (George & Clipp, 1991). Nonetheless, determinants of life satisfaction are still inconclusive (Chou & Chi, 1999). As the number of aged population has been increased by certain demographic shifts, factors effective on life satisfaction have gained importance.

The documented health benefits of social support may offer a promising avenue for reducing mortality and increasing life satisfaction among older adults. Indeed, there is a robust association between social contact, social support, health and well-being (House et al., 1988; Choi, 2001; Hilleras et al., 2001; Keyes et al., 2002; Landau & Litwin, 2001; Mroczek & Spiro, 2005; Pinquart & Sorensen, 2000; Zhang & Yu, 1998). The growing number of elderly citizens in the general population causes challenges to researchers, policy makers and societies. There is an increasing need for further empirical insight into the needs and functioning of these individuals as new regulations are required to allow effective service delivery to this population. Likewise, due to this growing number, new attitudes should be developed toward the elderly in today's societies (Aureli & Baldazzi, 2002). Studies on wellbeing and life satisfaction of the elderly have intensified in last three decades. Literature consistently emphasizes that life satisfaction of this population is a complex phenomenon influenced by multiple factors. One of the significant factors is the quantity and quality of a social network of loved ones such as spouse, adult children, grandchildren, relatives and neighbors. These sources of social support are considered to have vital impact on the elderly persons well being and life satisfaction (Florence, 2001).

The social network provides emotional (affection, a sense of belonging, a sense of usefulness etc.) as well as instrumental (goods, money, help with needs such as following up their appointments or giving them a ride to a hospital etc.) support (Siu & Phillips, 2000).

Social Support

Many terms including social networks, social support, social ties and social integration are loosely used while investigating the effects of social interaction on well-being and health. (Berkman et al., 2000). Social support is often used interchangeably with social integration and social network to imply three different dimensions of social interaction, and its existence or quantity. It is also used to address formal structure and functional content of social interaction like emotional concern, instrumental or tangible aid (Gottlieb, 1985). On the other hand, the careful and restricted use of "social support" commonly refers to dimensions of interaction and its functional content (House, 1987). Social network and social support are two distinct concepts (Berkman, 1984). Social network could be defined as the social relationships of an individual with the surrounding community (Mitchell, 1969; Laumann, 1973; Fischer et al., 1977). Social support can be seen as the emotional, instrumental, and financial aids obtained from one's social network. Not all ties are supportive and supports varry in the type, frequency, intensity, and extent. For example, some ties provide several types of support, while others are more specialized to provide only one type of support. (Berkman et al., 2000). Support is generally considered as an exchange or transaction between people. (Berkman, 1984)

Despite the absence of consensus on the concept of social support (Antonucci 1990), House (1981) identified four types of supportive behavior: (1) emotional support which involves caring, trust, and empathy, (2) instrumental support including helping others with their work, loaning money, and going out with others with difficulty in moving, (3) informational support like giving information or teaching skills to provide a solution to a problem, and (4) appraisal support like providing information to help somebody to estimate personal performance (Leavy 1983). However, some researchers supported the idea that social support only had two types: emotional and instrumental supports (Ingersoll-Dayton & Antonucci 1988). However, the exchange of support depends on social ties and contact which decrease with age (Cumming & Henry, 1961; Lang, 2001; Lang & Carstensen, 1994). Direct social contact is present only 10% of an older adult's day (Baltes et al., 1990). Nonetheless, despite this decrease in the quantity of social contact with age, its quality could increase. In fact, the reduction in social contact may be a deliberate attempt to improve the quality of social contact, and well-being also increases at the same time (Keyes, 2002).

Social Exchange

The scope condition for the exchange dimension of reference was most simply defined by Blau (1964): "Social exchange as here conceived is limited to actions that are contingent on rewarding reactions from others", which implied a two-sided, mutually contingent, and mutually rewarding process involving "transactions" or simply "exchange." (Emerson, 1976). An exchange theory perspective implies that the neutral or negative effect of intergenerational contact on the morale of elderly parents may emerge from an imbalance in costs and rewards within the relationship (Stoller, 1985). Meanwhile, some researchers focused on the reciprocity instead. Consideration in this area is dominated by theoretical perspectives which are equity theory and social exchange theory. According to equity theory (Walster et al., 1978), those receiving more support than they give may be distressed and feel guilty because it violates the norm of reciprocity and may lead to a state of dependency. In contrast, if one seeks to maximize one's rewards and minimize losses in relationships with others, as suggested by exchange theory (Berscheid & Walster, 1969; Homans, 1961), over-benefiting should lead to less distress. In the studies on older adults, empirical findings based on predictions of the equity and exchange theories are quite mixed. Ingersoll- Dayton and Antonucci (1988) assessed the effects of over-benefiting and under-benefiting within the context of specific relationships (i.e., spouse, children, and friends) and particular supportive exchanges (i.e., confiding and sickness care). Minimal support was found for the effects of reciprocity on network demand, life satisfaction, and negative effects by equity theory.

Similarly, McCulloch (1990) did not find any evidence for a positive association between intergenerational reciprocity and the morale among older parents. These findings were replicated by Davey and Eggebeen (1998) who used longitudinal data of the National Survey of Families and Households. However, Antonucci and colleagues (1990) reported that reciprocity generally enhanced the life satisfaction, whereas Stoller (1985) determined that inability to reciprocate in exchanges had a negative effect on morale. At least three hypotheses could be suggested regarding the effects of reciprocity on well-being. First, according to the equity theory, those in an equitable relationship are more content. However, those receiving more support than they give may be distressed and feel guilty because it violates the norm of reciprocity and may lead to a state of dependency (Hatfield et al., 1985; Walster et al., 1978). Those who give more than they receive may feel exploited by others and become irritated.

Second, if one seeks to maximize one's rewards, as suggested by exchange theory (Berscheid & Walster, 1969; Davey & Eggebeen, 1998), over-benefiting should lead to less distress, whereas under-benefiting would make one more distressed. Finally, the third hypothesis is related to self-esteem enhancement (Batson, 1998). It involves providing support for someone in need and under-benefiting enhances self-esteem, and thus increasing the well-being. This hypothesis also offers an explanation for the negative effects of receiving aid. According to the exchange-based theories of relationships, intimacy increases in parallel with the equality of exchange (Deutsch, 1985; Rook, 1987; Sprecher & Schwartz, 1994; Walster, Walster, & Berscheid, 1978). Equitable reslationship provide positive emotion; therefore, the intimacy is expected to increase in this kind fo relationship. On the other hand, one can get less support than one provide in the imbalanced exchanges, which creates negative emotions. According to the equity theory (Walster et al., 1978), perceived inequity generates negative effect. One feels guilt and shame if he/she receives more than he/she gives in a relation (i.e., over benefited).

However, if one receives less than he/she punt into a relation, he/she can become distressed or even angry. (i.e., under benefited). Equitable exchange creates positive emotion and intimate social contacts, while the imbalanced exchange causes negative emotion or diminishes positive feelings (Keyes, 2002). Assistance is not provided in one direction within an informal network. The financial and physical capacity of older persons is quite important in determining the type of exchange. Troll (1971) stated that most of the parents spend as much as they can for their children. However, it becomes quite difficult for older adults to give response in their relations as they need more support with decreasing health status and functional capacity (Stoller, 1985). Since psychological and instrumental factors are involved in the costs and rewards of exchanges between generations, it is rather difficult to determine the degree of imbalance. Relatives may continue to provide assistance because of familial expectations and/or obligations not depending on one's ability to response (Dunkle, 1983). Younger adults could regard helping their parents as an opportunity to reciprocate for the support of their parents in the past (Simmel, 1950).

They could also want to set an example for their children to observe parental caregiving as a filial responsibility. Dono et al. (1978) stated that essential aid might only be given by a group of people who benefitted from the older person in his productive years or who would like to benefit from their contributions in the future. Reciprocity may be more closely related to provision of informal support among friends and neighbors (Boszorneyi-Nagy and Spark, 1973; Dono et al., 1978). Friendship is a voluntary attachment. Lowenthal and Robinson (1976) argued that relationship involves emotional ties, while the relation with friends is reciprocal. Adams (1967) suggested that positive concern (i.e., the interest of the individual in the well- being and activities of another) is an indicator of affinity in relations; on the other hand, consensus (i.e., sharing common values, interests, and attitudes) is the foundation of friendship. Wood and Robertson (1978) regarded "obligation vs. choice" as a key element to distinguish between kinship and friendship.

Social Support and Life Satisfaction

A number of studies have been published in the last two decades regarding the social network and social support. Social relationships and affiliation are now known to have powerful effects on physical and mental health for a number of reasons (Berkman et al., 2000). Social support has a well-documented association with both depressive symptoms (see Cohen & Wills, 1985) and life satisfaction (Markides & Martin, 1979; Palmore & Kivett, 1977; Newsom & Schulz, 1996) . Certain studies demonstrated that old adults receiving considerable amount of support were determined to have higher morale and life-satisfaction (Krause 1986; Sugisawa 1993). For instance, emotional support is an important factor for recipients and providers as it creates attachment sense (e.g., comforting and intimacy), alliance, guidance and appreciation of one’s worth (Mancini & Blieszner, 1992; Weiss, 1969) as well as objective and social contribution (Keyes & Ryff, 1998).

Inadequate emotional support may result in loneliness, anxiety, uncertainty, a sense of meaningless (Rook, 1987; Weiss, 1974), and vulnerability to stress (Stroebe & Stroebe, 1995). Receipt of the social support does not necessarily bring about benefits. (Lu & Argyle, 1992). Social-support hypothesis suggesting that receiving support improves health and well-being was tested and accordingly, some inconsistent results were obtained (Kahn, 1994), demonstrating that receiving support could be harmful in some instances (Hays et al., 1997; Seeman, Bruce, & McAvay, 1996). For example, dependency on other people for support can cause guilt and anxiety; on the other hand, feeling like a burden to others who presumably provide support is associated with increased suicidal tendencies even after controlling for depression (Brown et al., 1999; De Catanzaro, 1986). The correlation between social support and dependency could explain the failure of previous studies which consistently supported the social support hypothesis. Furthermore, the benefits of social contact may extend beyond the received support to include other aspects of the interpersonal relationship that may protect health and increase longevity, for example, giving support to others (Brown et al., 2003).

However, despite the few exceptions (e.g., Liang et al., 2001), studies investigating the social-support have so far have focused on the effect of receiving support on old adults who are regarded as weak and dependent on help of others. Sanders (1988) pointed out that little focus was given on their contributions to their families; however, the majority of the old adults, especially the newly old ones are relatively healthy and active. Both the receipt and provision of support leads to a positive psychological outcome among the old people (Kim et al, 2000). Therefore, some of the researchers stressed the importance of balance between the receipt and provision of support, namely the reciprocal support exchange (Antonucci & Akiyama 1987; Ingersoll-Dayton & Antonucci 1988; Maton 1988; Rook 1987; Stoller 1985). In their studies, adult people that experienced reciprocal support exchange were determined to have better psychological outcomes than those with an exchange imbalance. Considering the equity theory, Walster et al. (1978) argued that inequitable exchanges cause distress and diminish the satisfaction level from individual relationship. In general, over-benefiting causes a feeling of dependency or indebtedness, while under benefiting makes one feel burdened and frustrated in interpersonal relationships (Davey & Eggebeen 1998; Lee & Ellithorpe 1982; Lu & Argyle 1992; McCulloch 1990; Rook 1987; Sprecher 1986).

In fact, a recent study performed in America indicated that the provision of support was determined to have positive effects on the psychological well-being of people by enhancing the personal control in an informal network (Krause, Herzog & Baker 1992). In addition, Adams (1968) determined that reciprocity as an important factor to sustain satisfactory relation with middle- class adults and widowed mothers. The relationship with mother was more commonly described by adult daughters as balanced and satisfying, while it was defined as one-direction, responsibility and obligation by adult sons. In a study on intergenerational relations, Silverstein et al. (1996) suggested that receipt of the support causes distress among older adults These findings are generally interpreted in terms of the loss of autonomy and control associated with dependency on others to meet basic needs. In particular, highly vigorous support of adult children could incite a deep-seated desire for independency.

This is consistent with the social breakdown syndrome (Bengtson & Kupers, 1986), suggesting that overly strong social support provided to vulnerable older persons results in greater dependency by causing erosion in skills of atrophy and competence, which further increases vulnerability and distress. There are, at least, two reasons for a greater sense of psychological well-being caused by the provision of support. First, helping needy people created an experience of fulfillment and self-validation, which increases well-being as well. Second, it provides intimacy and trust (Liang et al., 2001). The effects of receipt and provision of support and reciprocity are not clear nor direct (Liang et al.,2001). Empirical findings are still indeterminate for these influences. Psychological functions were reported to increase in parallel with support of others (Krause, 1986; Larson, 1974; Wood & Robertson, 1978), whereas some researchers reported little or no effect (Cohen & Sokolovsky, 1980; Lee & Ellithorpe, 1982). The present study was organized to analyze the following hypotheses put forward by socio-emotional selectivity and social exchange theories.

Hypotheses

1- Balanced emotional support exchanges indicate higher levels of life satisfaction compared with unbalanced exchanges (i.e., giving more or receiving more).
2- The amount of received or given support is changed with age.
3- The difference between the received and given emotional support is reduced and becomes more balanced with age.

Method

Sample

The study was performed on randomly selected 250 old adults aged over 60 years of age including 123 female (50%) and 125 male (50%). Selection was based on voluntary participation. This study aimed to determine the changing emotional support in old adults, related factors and the effects of changing emotional support on life satisfaction of old people. The study of MacArthur Foundation's Midlife in the United States (MIDUS) was benefitted in the determination of data collection tools. Data was collected by face-to-face interviews with participants. 48.8% of the participants were between 60-64 years of age, 26.0% between 65-60, 15.6% between 70- 74 and 9.6% were ≤75 years of age. The majority of the participants (56.8%) had primary or less education level, which was followed by secondary school graduates by 28.0%. 74.4% of the participants had regular income. 52.0% perceived themselves in a good health, while 7.6% perceived their health condition as bad. 72.8% lived in their own houses, while 9.6% were tenant. More than half of them (53.6%) lived with their spouse, 43.2% with spouse and children, while 2.4% lived with spouse and relatives. None of them lived alone. On the other hand, 2.8% had no social security.

Instrumentation

Life satisfaction

Life satisfaction is defined as an overall assessment of one's life, including the current life (Bowling, 1990; Neurgarten et al., 1961)**.** This assessment can be related to the cognitive states such as satisfaction with one's marriage, work, health, children, and overall life**.** In this article, flowing five items were used to calculated life satisfaction level of participants: " how would you rate your life overall these days?", "how would you rate your work situation these days?", "how would you rate your health these days?", "how would you rate our overall relationship with your children these days?", and "how would you rate your marriage or close relationship these days?". Responses were scored based on a 10-point scale. 0 means "the worst possible life in terms of overall/work/health and relationship with children spouse or partner" and 10 means "the best possible life in terms of overall/work/health and relationship with children spouse or partner".

Emotional Support Exchanges

Studies differently defined and measured social support. Received actual support perceived availability of support, density of network, frequency of network contact, and composition of network were used in these definitions and measurements. In the present study, emotional support was used to evaluate social support. Each respondent was asked to define the amounts of receipt and provision of support as hour. Emotional support was evaluated the following titles: "giving or getting comfort," "listening" or "having someone listen to you," and "giving or getting advice". Subsequently, each respondent was asked to estimate the amount of receipt and provision of emotional support in a mounth. The received and given support by respondents was estimated in hour considering the following six types of relations. Receiver and provider of emotional support was "your spouse or partner," "your parents or the people who raised you," "your in-laws," "your children or grandchildren," "any other family members or close friends," and "anyone else (such as neighbors)". The hours of emotional support were recorded into following ranges, each of which was coded to the midpoints: None=0, 1 to 4 hr in a month= 2.5, 5 to 8 hr=6.5, 9 to 16 hr=12.5, 17 to24 hr= 20.5, 25 to 32 hr= 28.5, 33 to 40 hr= 36.5, and 41 or more hr= 44.5 (i.e., all variables were top-coded to reflect the equivalent of a 40-hr "work week"). Total amounts of received and given emotional support were summed and separated into scales.

Social Structural Variables and Controls

In the present study, several socio-demographic variables were measured to predict the receipt and provision of emotional support and well-being. For this purpose, socio- structural variables including age, education, perceived health, income, gender, and marital status were used.

Data Analyses

Data was collected through questionnaire form and the obtained data was evaluated by "SPSS for Windows 15.0" statistic software program. One way variance analysis (ANOVA) was used to determine the relation between age and the provision of emotional support. The source of difference observed in the multiple comparisons was determined by LSD test (Least Significant Difference). In addition, the relation between receipt and provision of emotional support in different ages was evaluated by Pearson correlation analysis.

The effects of individual demographic characteristics on the receipt and provision of emotional support were examined by regression analysis. The relation between the receipt and provision of emotional support in older adults was investigated by one-way variance analysis (ANOVA). LSD test was used to determine the source of difference observed in groups.

Results

The amount of emotional support provided by older adults in a month changed between 125.79 and 158.92 h, while the amount they received was between 152.56 and 162.08 h. (Table 1). Accordingly, the amount of social support provided by older adults was found higher than the amount of emotional support.The relation between age and provision of emotional support was examined by one-way variance analysis. A significant difference was detected between the given and received amounts of emotional support and age ($F=3.192$, $p<.05$). LSD test was used to determine the source of difference. Consequently, the amount of provided emotional support was significantly lower in people ≤75 years of age compared to ones between 65-69 years of age ($p<.05$). In other words, the amount of provided social support decreased with age (Table 1). Analysis results demonstrated that the amount of received emotional support also decreased with age. However, no significant difference was detected between the amount of received emotional support and age ($F=0.118$, $p>.05$) (Table 1).

Unadjusted means of received and provided emotional support by age are given in Table 2. In the examination of correlation between the amounts of received and provided emotional support and age, high positive correlation was determined in 60-64 and 65-69 age groups, while milde positive correlation was detected in 70-74 and 75-79 age groups (60-64: .70; 65-69: .74; 70-74: .66; ≤75: .49).

Older adults providing more emotional support were observed to receive more emotional support. Therefore, reciprocity is present in emotional support exchange despite the decreases in emotional support with age. There is reciprocity in the exchange of emotional support in each age cohort.

Table 1. Amounts of Received and Provided Emotional Supports by age

Support	Age	N	Mean	Standard Deviation	
Provided Emotional Support	60-64	122	158.92	69.442	p<0.05
	65-69	65	158.79	62.952	
	70-74	39	136.87	83.935	
	≤75	24	125.79	51.841	
	Total	250	151.57	66.262	
Received Emotional Support	60-64	122	162.08	64.334	p>0.05
	65-69	65	157.21	65.923	
	70-74	39	155.07	73.221	
	≤75	24	152.56	53.272	
	Total	250	156.40	65.661	

Table 2. Descriptive Statistics of Total Amount of Received and Provided Emotional Support by Age in a Month (h)

Age	Provided Emotional Support	Received Emotional Support	Correlation
60-64 (n=122)			
Mean	158.92	162.08	0.701
Standard Deviation	69.44	64.33	
65-69 (n=65)			
Mea	158.79	157.21	0.741
Standard Deviation	62.95	65.92	
70-74 (n=39)			
Mean	136.88	155.08	0.662
Standard Deviation	83.94	73.22	
≤75 (n=24)			
Mean	125,79	152.56	0.499
Standard Deviation	51.84	53.27	
Total			
Mean	151.57	156.40	0.670
Standard Deviation	66.26	65.66	

Table 3. The effects of demographic characteristics of older adults on the difference between the receipt and provision of emotional support (Regression)

	The difference between receipt and provision of emotional support	
	b	β
Age		
60-64	-	-
65-69	-0.914	-0.076
70-74	-2.012	-0.139
≤75	-2.131	-0.119
Sex (Male:0)	0.049	0.005
Education Level		
Primary school or lower	-	-
Secondary School	-1.431	-0.122
High School	3.229*	0.158
University	1.698	0.087
Regular Income (none:0)	0.832	0.069
Health Condition		
Good	-	-
Medium	1.446*	0.135
Bad	0.073	0.004
Year of Marriage (<30:0)	-1.251	-0.071
Fixed	1.165	
F	3.245**	
Adjusted R^2	0.090	

*: p<0.05, **:p<0.01

Regression analysis was used to determine the difference between the amounts of received and provided emotional support and the effects of age and control variables. Model was found significant in accordance with the results of regression analysis. The significance rate was detected as 0.090 for the amounts of received and provided emotional support. Education and health condition were determined as effective variables. Despite the absence of a significant relation, the difference between the amounts of received and provided emotional support was found to decrease with age (Table 3).

The relation between the amounts of received and provided emotional support and life satisfaction was analyzed by variance analysis. The participants with equal amounts of received and provided emotional support were included in reference group in order to determine the effects of balanced and unbalanced changes on life satisfaction of older adults. Two dummy variables were created, including ones providing more support than they receive and vice versa. The lowest mean point of life satisfaction was observed as 8.86 in older adults receiving more emotional support than they provided, while the highest mean value was detected as 17.85 in ones with balanced received and provided emotional support. The results of one way variance analysis demonstrated that the level of life satisfaction significantly changed by the receipt and provision of emotional support. The life satisfaction of older adults with balanced received and given emotional support was significantly higher than others (F:41.825, p<.01).

Table 4. Results of ANOVA Test Regarding the Effects of Changes in Emotional Support on Life Satisfaction

Emotional Support	N	X	SD	F	P	Difference
Provided more	8	11.38	4. 406			
provided=received	228	17.85	3.961	41.825	**0.000***	**1-2**
Received more	14	8.86	4.470			**2-3**
Total	250	17.14	4.612			

Discussion

Three hypotheses analyzed in the present study include the guidelines of socio-emotional selectivity and social exchange theories. First, the ***quantity hypothesis*** suggests that the hours of given and received emotional support should decrease with chronological age since adults become selective about social contacts with age. Second, *the* ***exchange hypothesis*** suggests that the discrepancy between the hours of given and received emotional support should decrease with age as greater intimacy and satisfaction are caused by more balanced social exchanges and emotional regulation aims to become more salient with age. Third, ***equity hypothesis***, an extension of social exchange theory, maintains that the balanced relationships contribute to higher levels of well-being. On the basis of these theories, following three questions are investigated in the present study: "Does the quantity of emotional support diminish with age?", "Does the exchange of emotional support become more balanced with age?", and "Do unbalanced exchanges of emotional support predict lower levels of subjective (life satisfaction) well-being with age?".

Findings evidently supported the quantity hypothesis and the equity hypothesis. However, exchange hypothesis was refused. The amounts of received and given emotional support were determined to decrease with age. The highest amounts were observed in the 60-64 age group, while the lowest values were detected in the ≤75 age group. These results support the exchange hypothesis. Keyes (2001) reported that the amount of received and given emotional support decreased with age. In addition, a high correlation was detected between received and given emotional support in 60-69 age group, while a mild positive correlation was observed ≤70 age group. Older adults providing more emotional support were observed inclined to receive more support; in other words, the lower amount of given emotional support could cause reduction in the received emotional support. Therefore, reciprocity is present in emotional support exchange despite the decreases in emotional support with age. There is reciprocity in the exchange of emotional support in each age cohort. In the studies performed by Liang et al. (2001) and Keyes (2002), a positive correlation was detected between the received and given support, and they tended to enhance each other.

The exchange hypothesis suggests that the discrepancy between the hours of given and received emotional support should decrease with age to reflect more balanced exchanges with age. However, in the present study, the difference between the received and given emotional support was found not to decrease with age, but increase. For this reason, exchange hypothesis was refused in the present study. Furthermore, Keyes (2002) reported that the discrepancy between the received and given emotional support decreased with age, and they became more balanced. The differences between the studies could be caused by the culture samples and implementation times of the studies. In the present study, older adults with balanced reciprocal support exchange were determined to have higher levels of life satisfaction. In this regard, equity hypothesis was supported.

The results of many studies demonstrated that reciprocal support exchange had positive effects on psychological welfare of older adults (Lowenstein, Katz ve Gur-Yaish, 2007; Antonucci & Akiyama, 1987; Maton, 1988; Walster, Walster &Bersheid, 1978). However, certain other studies reported minimum (Ingersoll-Dayton and Antonucci, 1988) or no relation (McCulloch, 1990) between reciprocal support exchange and welfare. Findings of the present study challenge the convoy model of social support (see Antonucci & Akiyama, 1987; Antonucci & Jackson, 1990). Antonucci and colleagues argued that the norm of reciprocity can be present for longer period of time in human life because individuals keep a mental account of received and given support. People demanding more emotional support than they give might not feel distress if they provided more support to others when they were younger.

Because younger adults could provide more support than they receive, a finding consistent with the results of this crosssectional study, they can benefit from this debt in older ages and receive more support without feeling any guilt. However, in the present study, older adults with the lowest life satisfaction level were composed of individuals receiving more support than they provided. In the study, only the changes in emotional support with age were investigated. It would be useful to investigate different support changes in future studies as social contacts can be defined by company and instrumental support as well as emotional support. In other words, older adults prefer emotionally satisfying activities (i.e. companionship). They also provide instrumental support like money, tools, and favors (e.g., repairing broken objects for others), which creates emotional well-being.

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