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Ashley Ermer

Montclair State University, ermera@mail.montclair.edu

Christine M. Proulx

University of Missouri

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Associations Between Social Connectedness, Emotional Well-Being, and Self-Rated Health Among Older Adults: Difference by Relationship Status

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Ashley E. Ermer¹ and Christine M. Proulx²

Abstract

The present study investigates the association between social connectedness (i.e., social network characteristics, family and friend support, and social ties with neighbors), emotional well-being, and self-rated health and whether these associations differ based on respondents' relationship status among adults aged 62 and older. A series of multigroup generalized structural equation models (GSEMs) were conducted using data from the National Social, Health, and Aging Project. Social connectedness items were mostly positively associated with emotional well-being and self-rated health, and several of these associations are stronger for older adults who are unpartnered versus those who are cohabiting or married. Cohabiting and married individuals do not appear to have the same associations between social

¹ Department of Family Science and Human Development, Montclair State University, Montclair, NJ, USA

² Department of Human Development and Family Science, University of Missouri, Columbia, MO, USA

Corresponding Author:

Ashley E. Ermer, Department of Family Science and Human Development, Montclair State University, 1 Normal Avenue, Montclair, NJ 07043, USA.

Email: ermera@montclair.edu

network size, friend support, and emotional well-being compared to unpartnered older adults. The present study lends support for how a variety of social supports are vital for older adults and their well-being.

Keywords

social networks, relationship status, emotional well-being, self-rated health, older adults

Social connectedness, or lack thereof, may be one factor contributing to the experience of mental and physical health during late adulthood. Indeed, poor quality social ties are associated with mortality, increased levels of depression, and poorer overall health (Brummett et al., 2001; Cornwell & Waite, 2009; Heikkinen & Kauppinen, 2004). Positive social ties, in contrast, provide health benefits, including fewer physical and mental health problems (Cornwell & Waite, 2009; Fiori, Antonucci, & Cortina, 2006). Due to the lack of a coresidential partner, unpartnered older adults might rely on social network ties more than married or cohabiting persons to maintain a sense of well-being (Klaus & Schnettler, 2016). Currently, older U.S. adults are experiencing changes in marital status, with the divorce rate doubling from 4.9% to 10.1% between 1990 and 2010 among those aged 50 and older, and the percentage of unmarried middle-aged adults increasing from 22% in 1980 to 34% in 2009 (Brown & Lin, 2012; Lin & Brown, 2012). Therefore, it is necessary to gain an understanding of how relationship status and social ties might be associated with well-being among older adults. In the present study, the term “social connectedness” will be used to encompass the array of social measures used. The term “social network” will be used to discuss types of social networks. The present study investigates the association between social connectedness (i.e., social network characteristics, family and friend support, and social ties with neighbors), emotional well-being, and self-rated health in adults aged 62 and over and whether these associations differ based on respondents’ relationship status.

Social Network Types

The social convoy model (SCM; Antonucci & Akiyama, 1995) frames the current study. The SCM highlights how individuals are linked to others throughout the life course; as we age, we build social networks, and these social networks gain importance over time (Antonucci, Ajrouch, & Birditt,

2014). The present study utilizes the SCM as it provides a framework for understanding how individuals construct their social network when a spouse or cohabiting partner, a critical, common source of support and social interaction late in life (e.g., McPherson, Smith-Lovin, & Brashears, 2006), is not present. Because the convoy model emphasizes degree of closeness with others, those without a spouse or cohabiting partner in later life are likely to meet their closeness needs with other social relations who might be particularly salient to their emotional and physical well-being. Older adults are more apt to have positive interactions and avoid conflict as opposed to other age groups (Miller, Charles, & Fingerman, 2009). Therefore, older adulthood is an especially salient time to examine a variety of social ties and how they may be associated with well-being.

Social relationships may help to ameliorate the negative effects of aging (Antonucci et al., 2014), but the function of relationships might vary across different life stages. For example, close relationships with friends could be more salient for well-being among individuals without a romantic partner. The SCM highlights the importance of examining different types of relationships, along with characteristics of social support received. The current study builds on the SCM by investigating a variety of social network characteristics, social network types (family, friend, and neighbor), and how they are associated with emotional well-being and self-rated health for those who are married or cohabiting versus not in later life.

As individuals enter old age, friendship networks tend to decline in size, whereas family network size remains stable (Wrzus, Hanel, Wagner, & Neyer, 2013). Moreover, social network size, frequency of contact, and closeness with network members may have differing associations with well-being. Closeness may be more salient for older adults' well-being as compared to network size since emphasis is placed on emotionally fulfilling relationships in later life (Lang & Carstensen, 1994). Indeed, compared to younger adults, older adults' friendship support is associated with fewer depressive symptoms (Thomas, 2016). Since traditional notions of successful aging include "active engagement with life" (Rowe & Kahn, 1997, p. 443), positive interactions with neighbors, friends, and family may contribute to successful aging for all older adults but might be particularly important for those without a spouse or partner.

Neighbors might promote well-being among older adults by providing social support (Gardner, 2011), but mixed evidence exists. Litwin (2001) reported neighbors were a distinct social network for older adults and found that older adults who had high levels of contact with neighbors were less likely to have a spouse and had less contact with friends. Neighborhood

social ties appear to be associated with lower levels of loneliness among those who are never married and childless (Pinquart, 2003). However, Pinquart found that neighborhood social ties were not associated with lower levels of loneliness among those who were married; rather, higher quality relationships with neighbors were associated with greater levels of loneliness among the married. Therefore, examining social ties with neighbors in conjunction with relationship status is important, given the differing roles neighbors may play in individuals' lives depending on relationship status.

Gaining an understanding of how neighborhood social ties are associated with well-being outcomes may also contribute to current knowledge about the benefits of aging in place. The importance of acquaintances outside of friends and family appears to take a U-shaped curve, with other acquaintances (i.e., neighbors, helpers) being more common during childhood and older adulthood as compared to middle age (Wrzus et al., 2013). The SCM (Antonucci & Akiyama, 1995) would potentially suggest that neighbors (i.e., acquaintances) serve a different function as individuals age. Older adults may need and benefit from the help of neighbors who perform outside chores or who occasionally check-in with them, and this might be especially true of homebound older adults. The well-being benefits associated with neighbors may stem from their ability to help alleviate social isolation (e.g., de Jong Gierveld, van Tilburg, & Dykstra, 2016).

Differences in Social Network Types

Friends and family also play differing roles in one another's lives during older adulthood. Activities with friends tend to be viewed as favorable and are associated with life satisfaction increases, whereas activities with family members are associated with increases in negative affect (Huxhold, Miche, & Schuz, 2014; Larson, Mannell, & Zuzanek, 1986). Obligation may also look different among friends and family members, with individuals feeling more obligated to help and care for family members than for friends. Family members are more apt to provide care to older adults and rate relationships with close family members as more ambivalent, all in comparison to friends (Fingerman, Hays, & Birditt, 2004; National Alliance for Caregiving, 2015). The obligation family members have toward one another may mean that support received feels like it was done out of obligation, not out of desire, which may have implications for well-being. Indeed, after a stressful life event, interactions with those to whom one is less obligated (i.e., friends, neighbors) reduced anxiety, whereas contact with those one has an obligation to did not (Bolger & Eckenrode, 1991).

Neighborhood social ties also differ from friends and family relationships. Neighborhood social ties depend on location; they are not relationships that one necessarily seeks or that are familial in nature. Moreover, neighborhood social ties are not entirely voluntary, unlike friendship (see Wellman, 1992, for a review). Individuals do not typically choose their neighbors, yet individuals do choose the neighbors who they socialize with. Therefore, the quality of relationship between neighbors may be particularly important to consider as this relationship straddles the line between friend and family in terms of function.

Social Networks, Relationship Status, and Well-Being

Social connectedness may be a route through which positive health benefits are promoted. Cohen (2004) identified three different mechanisms (i.e., stress buffering, main effects, and relationships as a source of stress) through which social factors (i.e., social support, social integration, and negative interactions) may influence health. For example, integrating with others may encourage an individual to pay more attention to their well-being. While the present study is not causal, Cohen's work provides a basis for why associations between social ties and well-being may be linked and provides a rationale for the examination of multiple social connectedness factors.

Relationship status might moderate the association between social connectedness and well-being. Marriage and cohabitation carry benefits in terms of social support, and individuals might not necessarily rely upon their family and friends for support due to the presence of a significant other in the household (e.g., Barrett & Lynch, 1999). Married and cohabiting older adults, therefore, may experience fewer well-being benefits when interacting with their social network. Unpartnered adults comprise a diverse group, including those who are divorced, widowed, and never married, and are more likely to have social networks comprised predominantly of friends compared to married adults (Fiori, Smith, & Antonucci, 2007). Moreover, being widowed is associated with increased closeness to available social network members and a desire to continue social involvement (Utz, Carr, Nesse, & Wortman, 2002). This may be the case as widowhood implies that the loss of a core social network member has occurred. This same idea might apply to those who are divorced; individuals who divorced might have rebuilt their social network to account for the loss of a spouse, a "live-in" source of support. Never marrieds may have crafted a web of social support above and beyond family members and this web of support may carry into older adulthood. Examining how social networks are associated with well-being for

those who are unpartnered is needed due to the increasing number of older adults today who are unpartnered—it is estimated that one third of baby boomers are unmarried (Lin & Brown, 2012).

The Present Study

The present study examined whether the associations between both emotional well-being and self-rated health and (a) social network characteristics and (b) friend, family, and neighborhood social ties differ between those who are married or cohabiting (i.e., partnered) and those who are not currently married or cohabiting (i.e., unpartnered). The decision to combine marrieds with cohabiters largely stems from similarities found between cohabiters and marrieds in previous literature. Cohabiters have more enmeshed social networks than daters and have similar levels of depressive symptoms to marrieds, especially among women (Brown, Bulanda, & Lee, 2005). Older men who are married and cohabiting are quite similar in terms of psychological well-being (Wright & Brown, 2017). Those who are cohabiting or married have a romantic partner living in their household that may serve as a source of social support within the home, whereas this is not the case for the unpartnered. Divorced, never married, and widowed individuals were collapsed into the unpartnered group due to their small sample size and due to prior literature suggesting that unpartnered individuals (i.e., widowed, divorced, and never married) are more likely to have social networks comprised of friends (e.g., Fiori et al., 2007). We examined self-rated health and emotional well-being as the present study focuses on overall well-being as reported on by participants.

Method

Participants

The sample consisted of 2,361 individual respondents from the second wave of the National Social Life, Health, and Aging Project (NSHAP), a national probability sample that oversamples African Americans and Hispanics (Waite et al., 2014). In order to be included in the sample, individuals had to (1) be the original respondent and (2) report that they had at least one social network member outside of a partnership. These requirements decreased the original sample size from 3,377 to 2,361 respondents. The mean age of the sample was 72.54 ($SD = 7.52$), 6.8% identified as Hispanic, 10.3% identified as Black, and 52.9% identified as female. In-person interviews for the second wave of the NSHAP were conducted between 2010 and

2011 and focus on community-dwelling adults born between 1920 and 1947. The first wave of the NSHAP did not ask questions about respondents' neighborhood social ties, and thus, the second wave of data was used for this study. Due to the complex study design, we used weights in our analyses (O'Muircheartaigh, Eckman, & Smith, 2009).

Instruments

Emotional well-being. Measures of depressive symptoms, happiness, overall mental health, and loneliness were used as manifest indicators of a latent construct of well-being. *Depressive symptoms* were measured using a shortened version of the Center for Epidemiological Studies—Depression Scale. Responses range from 1 (*rarely or none of the time*) to 4 (*most of the time*). Responses from the 11 questions were summed together, with all responses reverse coded except for happiness and life enjoyment; higher scores indicated fewer depressive symptoms. The measure had an acceptable level of internal consistency ($\alpha = .78$). *Happiness* was measured using a single question, "If you were to consider your life in general these days, how happy or unhappy would you say you are, on the whole . . ." Responses range from 1 (*unhappy usually*) to 5 (*extremely happy*). Overall mental health was assessed by a single item, "What about your emotional or mental health? Is it excellent, very good, good, fair, or poor?" Responses range from 1 (*poor*) to 5 (*excellent*). Loneliness was assessed using the 3-item NSHAP Felt Loneliness Measure. Questions include "How often do you feel that you lack companionship?" "How often do you feel left out?" and "How often do you feel isolated from others?" Responses range from 0 (*never or hardly ever*) to 2 (*often*); these responses were reverse coded, such that higher scores indicated lower levels of loneliness. The measure had good internal consistency ($\alpha = .82$).

Self-rated health. Self-rated health was measured using a single question, "Would you say your health is excellent, very good, good, fair, or poor?" Responses range from 1 (*excellent*) to 5 (*poor*). This item was reverse scored, such that higher scores reflect better self-rated health.

Social network characteristics. Social network characteristics were taken from respondents' answers to questions posed in the social network roster portion of the NSHAP in-person questionnaire protocol. The social network roster asks respondents to identify up to five individuals to whom they confide, which could include a spouse or romantic partner (Cornwell, Schumm,

Laumann, Kim, & Kim, 2014). Respondents then were asked questions regarding the respondents' relationship to the confidant. This was repeated for up to five confidants. Participants were also asked whether there was anyone else who they felt close with, for a total of six potential confidants. Therefore, all questions from the NSHAP social network roster limit respondents to answering about no more than six network confidants. Questions regarding talk frequency, social network size, and social network closeness were included in this study per Cornwell and Waite's (2009) and Cornwell, Laumann, and Schumm's (2008) suggestion of questions that tap into social network characteristics. Only information on nonromantic partner network members is used in this study (i.e., data on spouse, cohabiting partner, or dating partner are omitted from the social network scales). Therefore, to account for partnered individuals having a maximum five individuals (if they included their spouse or partner in their roster), only the first five nonpartner individuals listed on either roster were included in the following social network characteristic variables. *Talk frequency* was measured using a question that asks "How often do you talk to this person?" about each person listed in the roster. Responses ranged from everyday, several times a week, once a week, once every 2 weeks, once a month, a couple times a year, once a year, and less than once a year. These initial response categories were transformed to a scale that assesses the number of contacts a respondent has with a confidant over the course of the year (Cornwell, Laumann, & Schumm, 2008). This transformation was conducted for all nonpartner confidants present in a respondent's network. Then, each confidant's total contacts per year with the respondent were summed together to reflect the total amount of contact each respondent has with *all* confidants in their social network per year (Cornwell et al., 2008). Higher responses indicate higher talk frequency. *Social network size* was measured by including the number of nonspousal/partner individuals that a respondent discusses in their social network roster. Responses can range from 0 to 5. *Closeness to social network members* was assessed by asking individuals "How close do you feel is your relationship with x?" Responses ranged from 1 (*not very close*) to 4 (*extremely close*). Per Cornwell et al.'s (2008) recommendations, average closeness of network members was calculated by adding together the closeness responses and dividing by the number of nonspousal network members identified.

Support from family. Support from family was assessed with two questions: "How often can you open up to members of your family if you need to talk about your worries?" and "How often can you rely on them for help if you have a problem?" Responses for both questions range from 0 (*never*) to 4

(often). The responses from the two questions were summed together, with higher scores indicating more family support. The Spearman–Brown coefficient was calculated to check reliability. A positive correlation emerged between opening up to family members and relying on family members, $r_s(2,575) = .413, p < .001$.

Support from friends. Support from friends was assessed using the same two questions as support from family, with the referent changed from family to friends. Responses from the two questions were summed together, with higher scores indicating more friend support. A Spearman–Brown coefficient indicated that there was a positive correlation between these 2 items, $r_s(2,574) = .530, p < .001$.

Social ties with neighbors. Social ties with neighbors were measured using 3 items: “How often do you and people in this area visit in each other’s homes or when you meet on the street?” “How often do you and other people in this area do favors for each other?” and “How often do you and other people in this area ask each other for advice about personal things?” These items were measured on a scale from 1 = *never* to 4 = *often*. Items are summed, with higher values indicating higher levels of neighborhood social ties. Acceptable levels of internal consistency were found in the present sample ($\alpha = .76$).

Relationship status. Relationship statuses include currently married or cohabiting (i.e., partnered, $N = 1,367$) and those who are currently not married or cohabiting (i.e., unpartnered, $N = 994$).

Demographics. Demographic variables included as covariates in the models were age, race, ethnicity, education, and activities of daily living (ADLs; see Table 1). Gender was coded as 0 = *male*, 1 = *female*. Age was measured as a continuous variable. Black/African American (1 = *Black/African American*, 0 = *not Black/African American*) and Hispanic (1 = *Hispanic or Latino*, 0 = *not Hispanic or Latino*) were used as race and ethnicity variables, with non-Hispanic White serving as the reference group. Education was measured as 0 = *high school degree/equivalent or less* and 1 = *associates degree or higher*. ADLs were measured using 5 items in the NSHAP (Katz, 1983). Questions about ADLs were introduced with a prompt that asked about difficulties that persisted longer than 3 months. Some of these items include, “Dressing, including putting on shoes and socks?” and “Using the toilet, including getting up and down?” The scale ranged from 0 (*no difficulty*) to 3 (*unable to do*). Items were summed and the scale indicated good internal consistency

Table 1. Descriptive Statistics and Mean-Level Differences.

Variables	M	SD	df	F	Range
Age			1, 2491	198.225**	62–91
Partnered	70.75	6.767			
Unpartnered	74.87	7.812			
Activities of daily living			1, 2490	8.775**	0–15
Partnered	0.533	1.366			
Unpartnered	0.723	1.843			
Talk frequency (inverse hyperbolic sine) ^a			1, 2474	135.137**	1.19–8.2
Partnered	6.569	0.974			
Unpartnered	6.989	0.767			
Closeness			1, 2474	32.313**	0.5–3
Partnered	1.916	0.511			
Unpartnered	2.032	0.494			
Social network size			1, 2348	28.197**	1–5
Partnered	3.642	1.319			
Unpartnered	3.920	1.254			
Family emotional support			1, 2455	12.324**	0–4
Partnered	2.932	1.139			
Unpartnered	3.095	1.140			
Friend emotional support			1, 2436	2.802	0–4
Partnered	2.251	1.290			
Unpartnered	2.341	1.348			
Neighborhood social ties			1, 2156	5.448*	0–9
Partnered	4.559	2.006			
Unpartnered	4.778	2.344			
Self-rated health			1, 2487	11.098**	1–5
Partnered	3.310	1.089			
Unpartnered	3.160	1.082			
Emotional well-being					
Overall mental health			1, 2489	13.506**	1–5
Partnered	3.73	0.973			
Unpartnered	3.58	0.980			
Depressive symptoms ^b			1, 2464	82.517**	14–44
Partnered	15.340	4.379			
Unpartnered	17.110	5.286			
Happiness			1, 2486	91.067**	1–5
Partnered	3.72	0.825			
Unpartnered	3.40	0.878			
Loneliness ^b			1, 2026	119.332**	0–9
Partnered	2.786	2.141			
Unpartnered	3.889	2.358			

(continued)

Table 1. (continued)

	%	%	df	χ^2	Range
Black ^c	Black	Not Black	1	36.568***	0-1
Partnered	38.9	58.6			
Unpartnered	61.1	41.4			
Hispanic ^c	Hispanic	Not Hispanic	1	0.751	0-1
Partnered	59.8	56.3			
Unpartnered	40.2	43.7			
Education ^c	≤HS degree	>HS degree	1	42.057***	0-1
Partnered	49.1	62.1			
Unpartnered	62.1	37.9			
Female ^c	Female	Male	1	231.540***	0-1
Partnered	42.3	72.6			
Unpartnered	56.6	27.4			

^aAn inverse hyperbolic sine was applied due to skewed responses. ^bReverse scored in analyses. ^cPercentage and χ^2 were included for categorical responses as a χ^2 analysis was conducted for dichotomous variables.

* $p < .05$. ** $p < .01$.

($\alpha = .84$). Descriptives and mean-level differences between those who are partnered and unpartnered can be found in Table 1.

Analytic Plan

GSEMs were conducted in Mplus version 8.0 to address the study's research questions. We used GSEM and the weighted least square means and variance adjusted (WLSMV) estimator due to the categorical nature and skewedness of the variables (e.g., Muthén & Muthén, 2010). The decision to use GSEM stems from the use of a latent variable to represent emotional well-being and the relative ease with which moderation using binary groups can be tested. The latent measure of *emotional well-being* included the observed variables of loneliness, depressive symptoms, life happiness, and overall mental health. Emotional well-being and self-rated health served as the dependent variables. One set of GSEMs examined social network characteristics as the independent variable, another examined family and friend support as the independent variables, and the final examined neighborhood social ties as the independent variable. Covariates included gender, age, race, ethnicity, education, and functional limitations due to their associations with emotional well-being and self-rated health (e.g., Johnson & Wolinsky, 1994; Moussavi

et al., 2007). Zero participants had missing data on age, race, gender, and education; however, 500 participants had missing data on the loneliness variable. The loneliness variable was part of the leave-behind questionnaire, which accounts for the high level of missing data. Full information likelihood was used in order to retain all cases with at least some data. Indices of model fit included the root mean square error of approximation (RMSEA), the χ^2 statistic, and the comparative fit index (CFI). To test the moderating role of relationship status, a multigroup analysis was conducted between those who are partnered and those who are unpartnered for each of the three models. A χ^2 difference test using the DIFFTEST option in MPlus due to use of the WLSMV estimator was used to check for significant differences between relationship status groups on the social connectedness variables.

Results

Before examining our primary research question, a measurement model was conducted to assess the factor structure of emotional well-being. All 4 items (i.e., overall mental health, loneliness, depressive symptoms, and happiness) loaded significantly on the latent variable of emotional well-being. A good model fit resulted (CFI = .98, RMSEA = .05).

We then tested the overall GSEM model which examined both the unpartnered and partnered respondents together. Then, for the multiple group models, we begin with a fully saturated model, followed by a fully unconstrained model on the entire sample of individuals. To test group differences between those who are partnered and those who are not partnered, a multigroup model was used. Per Byrne (2010), a fully constrained model was first identified and then paths between social connectedness variables and well-being measures were released (allowed to vary between groups) one at a time to see whether releasing the equality constraints on the paths between groups improved model fit.

Social Network Characteristics

We first examined the association between social network characteristics (i.e., closeness, talk frequency, and network size) and well-being among the full sample. The overall fit of the model was acceptable (CFI = .98, RMSEA = .03). Beyond the control variables which were significant (see Table 2), the only significant finding was that those who were closer to their social network reported greater emotional well-being ($\beta = .155, p < .001$). For self-rated health, those who had greater closeness to their social network ($\beta =$

Table 2. Standardized Estimates and Significance Levels for Social Network Characteristics in Overall Model and Unconstrained Model Assessing Partnered and Unpartnered Adults.

Parameter Estimate	Overall		Partnered		Unpartnered	
	Standardized	p	Standardized	p	Standardized	p
Measurement model						
Emo WB → happy	.573 (.023)	<.001**	.564 (.029)	<.001**	.594 (.031)	<.001**
Emo WB → overall mental health	.861 (.023)	<.001**	.894 (.029)	<.001**	.808 (.029)	<.001**
Emo WB → depressive symptoms	.609 (.032)	<.001**	.656 (.042)	<.001**	.525 (.039)	<.001**
Emo WB → loneliness	.359 (.030)	<.001**	.359 (.031)	<.001**	.328 (.036)	<.001**
Structural model						
Female → Emo WB	-.113 (.030)	<.001**	-.099 (.038)	.010*	-.014 (.046)	.758
Age (centered) → Emo WB	-.038 (.028)	.173	.000 (.035)	.996	.020 (.045)	.657
Hispanic → Emo WB	-.004 (.021)	.844	-.039 (.027)	.145	.042 (.033)	.206
Black → Emo WB	-.045 (.024)	.064	-.083 (.025)	.001**	.043 (.044)	.324
Education → Emo WB	.198 (.029)	<.001**	.178 (.037)	<.001**	.203 (.045)	<.001**
ADLs (centered) → Emo WB	-.305 (.028)	<.001**	-.280 (.032)	<.001**	-.336 (.046)	<.001**
Talk frequency ^a → Emo WB	-.001 (.036)	.977	.065 (.047)	.171	-.013 (.055)	.809
Social network size → Emo WB	.003 (.033)	.918	-.076 ^b (.043)	.074	.127 ^c (.048)	.008**
Closeness to social network → Emo WB	.155 (.030)	<.001**	.131 (.039)	.001**	.211 (.046)	<.001**
Female → self-rated health	.038 (.027)	.156	.043 (.036)	.237	.034 (.037)	.352
Age (centered) → self-rated health	-.032 (.025)	.188	-.037 (.032)	.250	-.010 (.038)	.798
Hispanic → self-rated health	-.058 (.019)	.002**	-.052 (.026)	.047*	-.067 (.028)	.015*
Black → self-rated health	-.065 (.023)	.004**	-.082 (.027)	.002**	-.042 (.038)	.265
Education → self-rated health	.170 (.024)	<.001**	.182 (.031)	<.001**	.156 (.038)	<.001**
ADLs (centered) → self-rated health	-.401 (.019)	<.001**	-.401 (.023)	<.001**	-.395 (.028)	<.001**
Talk frequency ^a → self-rated health	-.077 (.030)	.011*	-.086 (.042)	.042*	-.051 (.041)	.222

(continued)

Table 2. (continued)

Parameter Estimate	Overall		Partnered		Unpartnered	
	Standardized	<i>p</i>	Standardized	<i>p</i>	Standardized	<i>p</i>
Measurement model						
Social network size → self-rated health	.063 (.029)	.032*	.040 (.040)	.320	.102 (.040)	.010*
Closeness to social network → self-rated health	.065 (.027)	.013*	.071 (.036)	.046*	.062 (.040)	.120

Note. *N* = 2,334. Standard errors are given in parentheses. ADLs = activities of daily living.

^aAn inverse hyperbolic sine was applied due to skewed responses. ^{b,c}Different superscripts in a row indicate significant differences between parameter estimates for partnered and unpartnered adults.

p* < .05. *p* < .01.

.066, $p = .013$) and who had larger social networks ($\beta = .063$, $p = .029$) reported greater levels of self-rated health. Conversely, those who reported talking more to their social network had lower levels of self-rated health ($\beta = -.077$, $p = .011$).

For the multiple-group models, comparisons were made between those who were partnered and unpartnered. A fully unconstrained (CFI = .97, RMSEA = .03) and constrained model (CFI = .97, RMSEA = .03) were identified. A χ^2 difference test indicated that these two models significantly differed from one another, $\Delta\chi^2(18) = 41.013$, $p = .002$. Due to the significant difference between models, this finding was followed up to determine significantly different paths. A χ^2 difference test indicated that factor loadings between social network size and emotional well-being differed significantly between those who are partnered and those who are not, $\Delta\chi^2(1) = 10.240$, $p = .001$. Social network size was not associated with emotional well-being for those who were partnered ($\beta = -.076$, $p = .074$) but was positively associated with emotional well-being for those who were unpartnered ($\beta = .127$, $p = .008$). No other structural paths in the model significantly differed between groups.

Support From Family and Friends

First, a GSEM model that contained both partnered and unpartnered individuals was tested (see Table 3). The model had acceptable fit (CFI = .98, RMSEA = .04). Family support ($\beta = .203$, $p < .001$) and friend support ($\beta = .137$, $p < .001$) were positively associated with levels of emotional well-being. A significant association was also found between friend support and self-rated health ($\beta = .057$, $p = .028$), such that higher levels of friend support were associated with higher levels of self-rated health.

For the multiple-group models, comparisons were made between those who were partnered and unpartnered. A fully unconstrained (CFI = .97, RMSEA = .04) and constrained model were identified (CFI = .97, RMSEA = .03). A χ^2 difference test indicated that these two models were significantly different, $\Delta\chi^2(16) = 32.880$, $p = .008$. A follow-up χ^2 difference test indicated that the factor loadings between friend support and emotional well-being differed significantly between those who were partnered and unpartnered, $\Delta\chi^2(1) = 4.879$, $p = .027$. Those who were unpartnered exhibited a stronger, positive association between friend support and emotional well-being ($\beta = .228$, $p < .001$) than to those who were partnered

Table 3. Standardized Estimates and Significance Levels for Family and Friend Emotional Support in Overall Model and Unconstrained Model Assessing Partnered and Unpartnered Adults.

Parameter Estimate	Overall		Partnered		Unpartnered	
	Standardized	p	Standardized	p	Standardized	p
Emo WB → happy	.590 (.023)	<.001**	.600 (.026)	<.001**	.596 (.031)	<.001**
Emo WB → overall mental health	.839 (.020)	<.001**	.852 (.024)	<.001**	.794 (.029)	<.001**
Emo WB → depressive symptoms	.627 (.030)	<.001**	.690 (.038)	<.001**	.544 (.035)	<.001**
Emo WB → loneliness	.380 (.030)	<.001**	.396 (.031)	<.001**	.342 (.034)	<.001**
Structural model						
Female → Emo WB	-.139 (.029)	<.001**	-.115 (.037)	.002**	-.034 (.047)	.459
Age (centered) → Emo WB	-.025 (.028)	.376	.013 (.035)	.722	.030 (.044)	.496
Hispanic → Emo WB	-.021 (.021)	.326	-.009 (.027)	.749	.067 (.033)	.040*
Black → Emo WB	-.009 (.022)	.691	-.046 (.024)	.059	.082 (.041)	.043*
Education → Emo WB	.183 (.029)	<.001**	.166 (.037)	<.001**	.184 (.043)	<.001**
ADLs (centered) → Emo WB	-.306 (.028)	<.001**	-.303 (.032)	<.001**	-.322 (.047)	<.001**
Family emotional support → Emo WB	.203 (.028)	<.001**	.214 (.037)	<.001**	.212 (.042)	<.001**
Friend emotional support → Emo WB	.137 (.029)	<.001**	.083 ^a (.040)	.037*	.228 ^b (.043)	<.001**
Female → self-rated health	.037 (.027)	.171	.047 (.034)	.167	.035 (.037)	.347
Age (centered) → self-rated health	-.029 (.025)	.247	-.025 (.032)	.438	-.009 (.038)	.809
Hispanic → self-rated health	-.064 (.019)	.001**	-.063 (.027)	.020*	-.065 (.029)	.023*
Black → self-rated health	-.071 (.022)	.002**	-.085 (.026)	.001**	-.047 (.037)	.201
Education → self-rated health	.167 (.024)	<.001**	.172 (.031)	<.001**	.162 (.038)	<.001**
ADLs (centered) → self-rated health	-.409 (.020)	<.001**	-.414 (.024)	<.001**	-.395 (.030)	<.001**
Family emotional support → self-rated health	.013 (.025)	.594	.006 (.033)	.845	.031 (.037)	.404
Friend emotional support → self-rated health	.057 (.026)	.028*	.042 (.035)	.232	.086 (.035)	.014*

Note. N = 2,263. Standard errors are given in parentheses. ADLs = activities of daily living.

^{a,b}Different superscripts in a row indicate significant differences between parameter estimates for partnered and unpartnered adults.

*p < .05. **p < .01.

($\beta = .083, p = .037$). No other structural paths in the model differed significantly between groups.

Neighborhood Social Ties

First, a GSEM model that contained both partnered and unpartnered individuals was tested (see Table 4). The model had acceptable fit (CFI = .98, RMSEA = .03). A significant association was found between neighborhood social ties and emotional well-being, with those who had stronger neighborhood social ties reporting significantly higher emotional well-being ($\beta = .089, p = .001$). No significant association emerged between neighborhood social ties and self-rated health ($\beta = .033, p = .164$).

For the multiple-group models, comparisons were made between those who were partnered and unpartnered. The fully unconstrained model (CFI = .96, RMSEA = .04) and constrained model (CFI = .96, RMSEA = .04) were identified. A χ^2 difference test determined that these two models significantly differed from one another, $\Delta\chi^2(14) = 24.549, p = .039$. However, no structural paths between neighborhood social ties, emotional well-being, and self-rated health differed significantly between groups.

Discussion

Drawing on the convoy model of social relations (Antonucci & Akiyama, 1995), the current study examined the interplay of relationship status, social connectedness, and well-being. The present study builds on the convoy model of social relations (Antonucci & Akiyama, 1995) by examining a variety of social connectedness measures and assessing their associations with well-being. Our findings suggest that the factors comprising social connectedness are differentially associated with well-being. Partnered and unpartnered individuals had similar associations between social connectedness and well-being on neighborhood social ties, family support, and most social network characteristics. The differences that existed between unpartnered and partnered individuals pertained to partnered individuals having weaker associations between friendship support, social network size, and emotional well-being compared to the unpartnered.

Although much literature suggests that partnered individuals have a health advantage over the unpartnered (e.g., Schone & Weinick, 1998), the present study suggests social connectedness might be more important for unpartnered's well-being compared to partnered. Unpartnered older adults may use social connectedness to confer the benefits that partnered people get from

Table 4. Standardized Estimates and Significance Levels for Neighborhood Social Ties in Overall Model and Unconstrained Model Assessing Partnered and Unpartnered Adults Separately.

Parameter Estimate	Overall		Partnered ^a		Unpartnered ^a	
	Standardized	p	Standardized	p	Standardized	p
Measurement model						
Emo WB → happy	.560 (.023)	<.001	.604 (.027)	<.001**	.561 (.028)	<.001**
Emo WB → overall mental health	.877 (.023)	<.001	.846 (.027)	<.001**	.827 (.029)	<.001**
Emo WB → depressive symptoms	.634 (.034)	<.001	.684 (.042)	<.001**	.542 (.035)	<.001**
Emo WB → loneliness	.359 (.030)	<.001	.384 (.031)	<.001**	.342 (.033)	<.001**
Structural model						
Female → Emo WB	-.065 (.028)	.019*	-.056 (.037)	.131	.047 (.046)	.304
Age (centered) → Emo WB	-.046 (.027)	.089	-.003 (.036)	.930	.002 (.044)	.966
Hispanic → Emo WB	-.007 (.021)	.727	-.033 (.027)	.213	.030 (.034)	.384
Black → Emo WB	-.030 (.022)	.179	-.067 (.025)	.008**	.055 (.040)	.168
Education → Emo WB	.179 (.028)	<.001**	.154 (.038)	<.001**	.196 (.043)	<.001**
ADLs (centered) → Emo WB	-.315 (.028)	<.001**	-.286 (.031)	<.001**	-.359 (.045)	<.001**
Neighborhood social ties → Emo WB	.089 (.028)	.001**	.093 (.037)	.013*	.116 (.043)	.007**
Female → self-rated health	.048 (.025)	.048*	.051 (.032)	.108	.055 (.036)	.122
Age (centered) → self-rated health	-.041 (.025)	.099	-.039 (.033)	.236	-.023 (.037)	.539
Hispanic → self-rated health	-.063 (.019)	.001**	-.059 (.027)	.026*	-.071 (.028)	.010*
Black → self-rated health	-.069 (.022)	.002**	-.082 (.026)	.002**	-.050 (.036)	.166
Education → self-rated health	.172 (.024)	<.001**	.183 (.031)	<.001**	.161 (.037)	<.001**
ADLs (centered) → self-rated health	-.408 (.019)	<.001**	-.409 (.024)	<.001**	-.404 (.028)	<.001**
Neighborhood social ties → self-rated health	.033 (.024)	.164	.018 (.031)	.570	.062 (.035)	.076

Note. N = 2,351. Standard errors are given in parentheses. ADLs = activities of daily living.

^aNo significant differences occurred between parameter estimates for partnered and unpartnered adults.

*p < .05. **p < .01.

their partners. Considering committed relationships are often viewed as paramount (e.g., McPherson et al., 2006), the present findings show that sources of social connectedness beyond a committed relationship have associations with well-being outcomes. The present study advances knowledge on social connectedness by examining the integral role of relationship status in the association between social connectedness and well-being—with unpartnereds having a greater number of and stronger associations between social connectedness and well-being—while simultaneously conveying the necessity of social connectedness during older adulthood, irrespective of relationship status, given the domains in which social connectedness was associated with greater well-being for both the partnered and unpartnered.

For both partnered and unpartnered older adults, those who were closer to their social network reported greater emotional well-being. Individuals who had greater closeness to their social network and larger social networks reported better self-rated health, whereas those who reported talking more to their social network had worse self-rated health. It could be that older adults who are in poorer health talk more frequently with their social networks, possibly because they are receiving help from their networks or because their network members are checking in on them. It should also be noted that not all conversations are necessarily positive or supportive in nature, which may be another reason why talk frequency and self-rated health have a negative association. For example, an individual may talk frequently to a sibling or a child but the conversations may pertain to stressful topics. One might expect that as an individual's health declines, conversations about health behaviors may become more common and potentially more stressful. Closeness is the one dimension that was consistently beneficial for well-being among both partnered and unpartnered older adults. The finding that larger social networks are associated with better self-rated health may be indicative of the role health plays in an individual's ability to maintain social contact. However, it should be noted that this finding emerged above and beyond the association between ADLs and self-rated health.

Multigroup models indicated partnered and unpartnered older adults differed in their association between social network size and emotional well-being. Larger social networks may be of greater benefit to unpartnered older adults as they enable them to have a variety of individuals to draw upon for social support, which may be important for relationships that are considered voluntary in nature (i.e., nonfamilial relationships). A larger social network enables individuals to draw upon a greater number of individuals for social support, which may be especially vital when a greater number of voluntary members are present in a social network. This may particularly be the case

when a spouse or partner is not present in the household, as spouses and partners often serve as a first line of social support for those who are partnered (McPherson et al., 2006).

For family and friend support, higher levels of support were associated with greater emotional well-being when examining the whole sample. Multi-group models indicated that while friend support was associated with greater emotional well-being for both unpartnered and partnered adults, friend support was associated with emotional well-being to a greater degree for unpartnered older adults. Unpartnered older adults may cultivate friendships as a primary source of social support and may rely on friends more than partnered adults (Barrett & Lynch, 1999; Fiori et al., 2007). Regardless of relationship status, there was a clear association between support from family and emotional well-being. Thus, supportive family relationships and friendships are important in later life and might be particularly important for those not coresiding with a partner. It is crucial to continue exploring these associations, given that it is well known that social connectedness has numerous health benefits during later life (e.g., Cornwell & Waite, 2009), and this connectedness does not always occur within one's household.

Possessing strong neighborhood social ties was associated with greater emotional well-being for those living with and without a partner, emphasizing the importance of connectivity with neighbors. Neighbors may serve as an important source of social and health support, and support provided by neighbors could allow for a better quality of life and help to lessen the need for formal supports (Greenfield, 2016). Neighbors, and serving as a neighbor, could enable older adults to feel they are enacting an important social role (Heller, 1993). Moreover, the SCM lends some support for these findings. Since older adults socialize more with neighbors as compared to younger adults (Cornwell et al., 2008), what it means to be and act like a "neighbor" may change over time. For older adults, socializing with neighbors may serve as a common form of social support. Future research should examine what the role of neighbor means to older adults, which would allow researchers to deconstruct why the association between neighborhood support and emotional well-being exists.

The convoy model of social relations would suggest that social network size and friends may have different functions depending on relationship status (Antonucci & Akiyama, 1995), with the present study supporting this notion. Friends may serve as a primary emotional support mechanism for those who are not partnered, which may be why there are stronger associations between friend support and emotional well-being among the unpartnered. For those who live with a partner, social networks outside of the

romantic relationship may have been pruned to place emphasis on the spousal and romantic relationship—typically a strong source of support and importance in later life (e.g., McPherson et al., 2006). The present findings emphasize both similarities and differences between unpartnered and partnered older adults' social convoys. Neighbors, family members, friends, and closeness to one's social network appear to be important social convoy members in older adults' lives, all of which are positively associated with emotional well-being for the unpartnered and partnered. Unpartnered individuals are socially connected and even appear to have stronger associations between social network size, friendship support, and emotional well-being than the partnered, which runs counter to views of unpartnered individuals as socially immature and not social (see DePaulo & Morris, 2005, for a review). Knowledge about how relationship status is associated with social connectedness enables a greater understanding of the ways in which relationship status may serve as a help, or serve as a hindrance, in social connectedness outside of a relationship. Considering the increasing number of unmarried individuals (Lin & Brown, 2012), continued research on unpartnered older adults is necessary.

The present study has implications for policy, practitioners, and future research. Initiatives that promote neighborhood social activities and social activities within the community may help to strengthen the emotional well-being of older adults. Programs such as the Elder-Friendly Communities Program and Beacon Hill Village have demonstrated success in fostering neighborhood social ties and other forms of social connectedness (Austin, McClelland, Perrault, & Sieppert, 2009; McWhinny-Morse, 2009). Practitioners should also attend to an individual's available family, friend, and neighborhood supports when working with older adults. Future research should explore who initiates social contact, which would help parse out whether older, less healthy adults are turning to their networks for emotional support or whether networks are initiating contact to check the status of less healthy older adults. Exploring these constructs longitudinally could help illuminate whether health status prompts older adults to reach out to their networks or vice versa. Examining social connectedness and its associations with biomarkers and physical measurements is another promising area of future research.

Strengths and Limitations

Strengths of this study include using data from the NSHAP, a nationally representative sample of older adults. Interviews for the second wave of the

NSHAP were conducted between 2010 and 2011, making the data utilized in this study relatively up to date. The study also addresses social support above and beyond romantic partners, a research area that is understudied. The questions asked in the NSHAP enabled us to include a broad range of social connectedness measures and their potentially differing associations with both relationship status and well-being. However, data examining social network size are limited. The NSHAP methodology only allowed participants to note up to five core social network members, which creates an artificial ceiling on the number of network members that can be mentioned. The measures regarding family and friend emotional support were relatively crude, as individuals were asked broadly about family and friend emotional support that was received and could not go into extensive detail regarding who they were thinking of when they completed these measures. Since this is the second wave of a longitudinal study, attrition between Waves 1 and 2 may be of concern. It should also be noted that causality cannot be inferred from this study due to the reciprocal nature of social connectedness and well-being.

Conclusion

Encouraging social connectedness appears to be important, particularly as one becomes older. Among those who are partnered, a diverse support network may be especially vital considering potential care needs and the heightened risk of a spouse/partner's death during older adulthood. The present study lends support that various types of social connectedness are associated with well-being outcomes. Emphasizing the importance of a diverse social network throughout the life course, regardless of relationship status, may be of importance for practitioners given its association with well-being outcomes. Longitudinal work could shed light on how social networks expand and contract over time and how relationship status changes may be associated with changes in social connectedness. The present study exemplifies how imperative it is to cultivate social ties outside of a committed relationship, especially considering today's strong focus on both spousal relationships and committed romantic relationships throughout the life course.

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Author Biographies

Ashley E. Ermer's research focuses on examining how the social environment matters for older adults, including forgiveness in the context of health and social relationships. Her research pertains to social relationships, particularly romantic relationships and friendships, older adulthood, and well-being. She earned her PhD from the University of Missouri in 2017.

Christine M. Proulx's research program emphasizes the longitudinal and dyadic study of marital and family relations, emphasizing a holistic approach to adult health and well-being. This approach applies cutting edge research methodology to understand the association between marital quality and personal well-being and the social and productive engagement of aging adults.