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Church-Based Social Support, Functional Disability, and Change in Personal Control over Time

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Abstract

The purpose of this study is to see if measures of church-based and secular social support offset the effects of functional disability on change in feelings of personal control over time. Survey data were obtained from Wave 2 and Wave 3 of a nationwide sample of older adults (N = 583). The findings suggest that spiritual support from fellow church members offsets the effects of functional disability on change in feelings of personal control over time. In contrast, neither emotional support from fellow church members nor emotional support from secular social network members exerted a similar effect.

Keywords

church-based support; functional disability; personal control

Introduction

The purpose of this study is to see if social support offsets the effects of functional disability on change in feelings of personal control over time. A vast literature indicates that feelings of personal control are an essential psychological resource that helps older people deal with the noxious effects of stressful life events (Krause 2003). Based on this research, some investigators assert that a strong sense of personal control is a key marker of successful aging (Rowe and Kahn 1998). Even though there are differences in the way feelings of personal control have been defined and measured, the various perspectives that are found in the literature share a common conceptual core. Embedded in each view is the notion that people with a strong sense of control believe that changes in the social world are responsive to and contingent upon their own choices, efforts, and actions. In contrast, people with a weak sense of personal control believe that the events in their lives are shaped by forces they are unable to influence and they believe they are unable to regulate the things that happen to them (Ross and Sastry 1999).

Unfortunately, a convincing body of research further reveals that feelings of control tend to decline precipitously across the life course (Hayward and Krause 2012; Mirowsky 1995; Shaw and Krause 2001; Wolinsky et al. 2003). Although researchers have identified a number of reasons for this age-related loss of control, one is especially important for the purposes of the current study. More specifically, based on research by Mirowsky (1995) and

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others, we assess whether difficulty with physical functioning is associated with a loss of personal control over time. There are three reasons why focusing on physical functioning makes a good deal of sense in this context. First, physical health problems are included many stressful life events inventories (Turner and Wheaton 1995). This is important because a number of studies suggest that greater exposure to unwanted stressful events lowers an individual's sense of personal control (e.g., Christie and Barling 2009). Second, physical functioning refers to the ability to perform routine activities that are part of daily life (McDowell & Newell, 1996). When older people lose the ability to do things like climb stairs, walk short distances, or lift heavy objects, it is not difficult to see why they may feel they are losing their ability to exercise control over basic areas of their lives. Third, once functional disabilities are encountered, they are difficult to eradicate. This is one reason why the number of functional limitations increases steadily as people move through late life (Hummer, Benjamins, and Rogers 2004). This trend is noteworthy because researchers have argued for some time that chronic problems, especially those involving health, are especially likely to erode feelings of personal control (e.g., Zautra, Hoffman and Reich 1997).

Social Support, Functional Disability, and Control

Rather than focusing solely on factors that erode feelings of personal control, we also want to explore the resources that older people rely on to help offset this unwanted change in their lives. This orientation is consistent with the insights of Schulz and Heckhausen (1996), who maintain that older people typically take steps to offset the loss of personal control they encounter as they grow older. A special emphasis in the current study is placed on the role that social support plays in this process.

Researchers have known for some time that older people who get more informal social support tend to have a stronger sense of personal control (Krause and Borawski-Clark 1994). Caplan (1981) provides a succinct overview of how this takes place. He points out that when stressors arise, social network members help define the problem situation, they help develop a plan of action, they assist in implementing the plan, and they provide feedback and guidance as the plan is being executed. Because of this assistance, the stressed person comes to believe that the problems they face can be controlled and overcome.

Although a number of investigators have assessed the relationship between social support and feelings of personal control they have not taken full advantage of the fact that there are a number of different ways to assess social support. And as a result, they have not exploited the deeper theoretical insights that a more fine grained assessment of social support is capable of providing. In order to address this gap in the literature, we explore the effects of two largely overlooked dimensions of social support in the analyses presented below.

First, as Cohen and his colleagues maintain, there are different sources of support (Cohen et al. 2000). For example, people may get support from a spouse, friends, or family members. Consistent with this fundamental principle, we compare and contrast the effects of two sources of support: emotional support that is received from fellow church members and emotional support that is received from social network members outside of church. There are sound reasons for making this distinction. As Krause (2008) and others point out, social support in religious institutions may be more efficacious than social support that is received in secular settings because church-based support is presumably based on religious precepts. More specifically, the basic tenets of every major faith tradition emphasize the importance of helping individuals who are in need and forgiving people for the things they have done wrong (Lundberg 2010). In fact, research by Krause (2006) reveals that compared to emotional support that is provided in secular settings, emotional support from fellow church members is more likely to offset the deleterious effects of stressful life events on the health

of older adults. However, we have been unable to identify any studies that assess whether church-based support is more likely than secular support to offset the effects of physical disabilities on feelings of personal control among older people. Examining this issue provides an opportunity to see if there is something unique about social support that arises in religious institutions.

The second dimension of social support that is evaluated in the current study has to do with the type of support that is provided. The discussion that has been provided up to this point focuses solely on emotional support. But people can provide other types of support, as well. We examine one way of helping others that is unique to religious settings. More specifically, we assess whether spiritual support that is provided by fellow church members offsets the effects of functional disability on feelings of personal control. Spiritual support is assistance that is provided with the explicit goal of bolstering the religious beliefs and increasing the religious behaviors of the support recipient (Krause 2008). This means, for example, that fellow church members may help a support recipient find solutions to their problems in the Bible or they may share their own personal religious experiences with them. By comparing and contrasting the effects of spiritual support and emotional support that is provided by fellow church members we aim to further isolate the potentially unique aspects of social support that arise within religious institutions.

Studying Social Support, Health, and Control in Late Life

Before turning to the methodology and study findings, it is important to briefly discuss why it makes sense to study the relationships between social support, functional disability, and feelings of personal control in samples comprised of older people. There are three reasons why working with data provided by older adults is a good strategic context for examining these relationships. First, although the issue is far from resolved, a number of researchers argue that people tend to become more religious as they grow older (see Krause 2008, for a review of this research). Second, research by Carstensen and her colleagues suggests that as people enter late life, they become increasingly aware they have relatively little time left to live. This growing awareness leads older people to seek out relationships that are emotionally close and shed social ties that are more peripheral in this respect (e.g., Fung and Carstensen 2004). Third, research consistently reveals that levels of functional disability escalate rapidly in late life. In fact, 42 percent of people age 65 and older have at least one functional limitation (Federal Interagency Forum on Aging Related Statistics 2010). So if both religion and social support become more important in the later years of life and if functional disability is especially prevalent in old age, then it makes sense to study the relationships among religion, social support, and functional disability in samples of older people.

Methods

Sample

The data for this study come from an ongoing nationwide survey of older whites and older African Americans. The study population was defined as all household residents who were either black or white, noninstitutionalized, English-speaking, and at least 66 years of age. Geographically, the study population was restricted to all eligible persons residing in the coterminous United States (i.e., residents of Alaska and Hawaii were excluded). Finally, the study population was restricted to currently practicing Christians, individuals who were Christian in the past but no longer practice any religion, and people who were not affiliated with any faith at any point in their lifetime. This project was designed to explore a range of issues involving religion. As a result, individuals who practice a faith other than Christianity

were excluded because it would be too difficult to devise a comprehensive battery of religion measures that would be suitable for individuals of all faith traditions.

The sampling frame consisted of all eligible persons contained in the beneficiary list maintained by the Centers for Medicare and Medicaid Services (CMS). A five-step process was used to draw the sample from the CMS Files (see Krause 2002a, for a detailed discussion of these steps).

The baseline survey took place in 2001. The data collection for all waves of interviews was conducted by Harris Interactive (New York). A total of 1,500 interviews were completed, face-to-face, in the homes of the study participants. Older African Americans were over-sampled so that sufficient statistical power would be available to assess racial cultural differences in religion. As a result, the Wave 1 sample consisted of 748 older whites and 752 older African Americans. The overall response rate for the baseline survey was 62%.

The Wave 2 survey was conducted in 2004. A total of 1,024 study participants were re-interviewed successfully, 75 refused to participate, 112 could not be located, 70 were too ill to participate, 11 had moved to a nursing home, and 208 were deceased. Not counting those who had died or moved to a nursing home, the re-interview rate for the Wave 2 survey was 80%.

A third wave of interviews was completed in 2007. A total of 969 older study participants were re-interviewed successfully, 33 refused to participate, 118 could not be located, 17 were too sick to take part in the interview, and 155 older study participants had died. Not counting those who had died, the re-interview rate was 75%.

Wave 4 was completed in 2008. A total of 718 older study participants were reinterviewed successfully, 61 refused to participate, 92 could not be located, 77 were too sick to take part in the interview, and 153 had died.

The analyses presented below are based on data from the Wave 2 and Wave 3 surveys. These data collection points are used because measures of functional disability were administered for the first time at Wave 2. Although 969 older people participated in the Wave 3 interviews, the responses of only 583 study participants are analyzed below. Some cases ($N = 342$) were excluded because it does not make sense to ask whether fellow church members provide emotional and spiritual support older people either never go to church or if they attend worship services less than three times a year.

The EM algorithm was used to deal with item non-response (Enders 2010). Simulation studies reveal that the EM produces estimates that are comparable to those that are derived with more time consuming techniques, such as multiple imputation (Enders 2010). There is some evidence that the EM procedure underestimates the size of standard errors and as a result, significance levels are biased (Enders, 2010). The analyses presented below were performed using listwise deletion of missing values. The results based on listwise deletion were identical to those produced by the EM algorithm. Consequently, findings based on the EM procedure are provided below.

Preliminary analysis of the data reveals that the average age of the participants in the current study is 76.8 years ($SD = 5.6$ years), 35 percent were older men, 46% were older whites, 46% were married at Wave 2, and the study participants completed, on average, 11.8 years of schooling ($SD = 3.3$ years).

Measures

Table 1 contains the survey items that were devised to assess the core measures in this study. The procedures that were used to code the responses to these indicators are provided in the footnotes of this table.

Feelings of Personal Control—A sense of personal control was assessed at Wave 2 and Wave 3 with identical measures. These indicators come from the widely cited internal-external locus of control scale (Rotter 1966). A high score on these items denotes a stronger sense of personal control. The mean at Wave 2 is 12.277 ($SD = 2.065$) and the mean at Wave 3 is 12.214 ($SD = 2.594$). The internal consistency reliability estimate at Wave 2 is .854 while the corresponding estimate at Wave 3 is .903.

Functional Disability—Functional disability was assessed at the Wave 2 with 15 items that were taken from the work of Liang (1990). Indicators of instrumental activities of daily living (IADL) as well as activities of daily living (ADL) are included in this index. These measures assess whether older people have any difficulty performing each task. A high score denotes greater difficulty with ADL and IADL tasks. The study participants reported they had difficulty performing an average of 2.610 activities ($SD = 3.237$ activities) at Wave 2.

Spiritual Support—Spiritual support was measured at Wave 2 with four items that were developed by Krause (2002b). A high score on these indicators represents older people who receive spiritual support more frequently from their fellow church members. The mean is 9.254 ($SD = 3.486$). The reliability estimate is .893.

Emotional Support from Church Members—Three indicators were administered at the Wave 2 survey to find out how often older study participants receive spiritual support for the members of their congregation. These indicators were developed by Krause (2002b). A high score means they receive emotional support more often. The mean at Wave 2 is 8.802 ($SD = 2.545$). The reliability estimate for this brief composite is .825.

Secular Emotional Support—Three items that were devised by Krause (2002b) were used to assess how often older study participants receive emotional support from people outside their congregations. A high score denotes more frequent secular emotional support. The mean at Wave 2 is 9.788 ($SD = 2.131$). The reliability estimate is .786.

Religion Control Measures—The relationships among church-based support, functional disability, and control were estimated after the effects of two religion control variables were included in the model. The first assesses how often study participants attend worship services ($M = 7.360$; $SD = 1.379$) while the second measures how often the older people in this study pray when they are alone ($M = 7.290$; $SD = 1.167$). A high score on these measures stands for more frequent church attendance and more frequent private prayer, respectively. Both religion control variables come from the Wave 2 interviews.

Demographic Control Variables—Age, sex, race, education, and marital status were included in the study model to control for the demographic variations in the study sample. Age and education were measured continuously in years whereas sex (1 = men; 0 = women), race (1 = Whites; 0 = Blacks), and marital status (1 = married; 0 = otherwise) were scored in a binary format. Measures of the demographic control variables come from the Wave 2 survey.

Data Analysis Strategy

The hypotheses that were developed earlier specify that functional disability will be more likely to erode feelings of personal control when older people receive less emotional support from their fellow church members, less spiritual support from their coreligionists, and less emotional support from their secular social network members. Stated in more technical terms, these hypotheses call for a statistical interaction effect between the three social support measures and functional disability on change in feelings of personal control over time. Tests for these interaction effects were performed with a hierarchical ordinary least squares regression analysis that consisted of two steps. First, the measures assessing social support, functional disability, personal control at Wave 2 and the control variables were entered into the equation (Model 1). Following this, three multiplicative terms were added to the model in the second step (Model 2). These cross-product terms were created by multiplying each social support measure by the functional disability scores. Following the recommendations of Aiken and West (1991), all independent variables were centered on their means prior to estimating the equation.

Results

The findings from this study are presented below in two sections. The results that emerged from estimating Models 1 and 2 are reviewed first. Following this, a set of supplementary analyses that have not been discussed up to this point is reported briefly.

Main Study Findings

Table 2 contains the findings that emerged from the hierarchical regression analysis that is described above. The results provided by Model 1 are presented in the left-hand column while the findings that were produced by estimating Model 2 appear in the right-hand column of this table.

Three main findings emerge from estimating Model 1. First, the data indicate that more spiritual support is associated with a stronger sense of personal control over time ($\text{Beta} = .103; p < .05$). Second, neither emotional support from fellow church members ($\text{Beta} = .001; n.s.$) nor emotional support from secular network members ($\text{Beta} = .008; n.s.$) has a similar effect. Third, contrary to the findings from previous research, functional disability does not appear to be significantly associated with change in feelings of personal control over time ($\text{Beta} = -.066; n.s.$).

The findings that emerged from estimating Model 2 help bring these results into sharper focus. More specifically, the results reveal that the hypothesized statistical interaction effect between spiritual support and functional disability on change in feelings of personal control is statistically significant ($b = .038; p < .001$; unstandardized regression coefficients are discussed when reporting statistical interaction effects because standardized estimates are meaningless in this context). But in contrast, the corresponding interactions between emotional support received from fellow church members ($b = -.018; n.s.$) and emotional support received in secular settings ($b = -.007; n.s.$) are not statistically significant.

Although a significant interaction effect emerged between spiritual support and functional disability, it is important to determine whether it is in the hypothesized direction. If our hypothesis is valid, then the effects of functional disability on change in feelings of personal control should become progressively weaker at successively higher levels of spiritual support. Although there is more than one way to see if this is so, we use the formulas that are provided by Aiken and West (1991) to illustrate the interaction effect. These formulas estimate the effect of functional disability on control at select levels of spiritual support. Any

values of spiritual support may be used for this purpose. The raw spiritual support scores in this study range from 4 to 16. Therefore, we estimated the effects of functional disability on control at four equally spaced intervals: 4, 8, 12, and 16.

The additional calculations (not shown in Table 2) suggest that older study participants with the lowest spiritual support score (i.e., 4) experienced a fairly sharp decline in personal control over time ($\text{Beta} = -.320$; $b = -.256$; $p < .001$). Further analysis revealed that 65 older study participants had the lowest observed spiritual support score. We report the number of study participants with scores at each selected value for the following reason. As Cohen et al. (2003) point out, there may be very few cases with a select value in the distribution of a study variable and as a result, the computations reflect a relationship that applies to a very small number of people. This is known in the literature as the problem of data sparseness.

The calculations further indicate that older study participants with a spiritual support score of 8 also experienced a loss of control over time, but the magnitude of this decline was not as pronounced ($\text{Beta} = -.130$; $b = -.104$; $p < .01$). A spiritual support score of 8 falls just below the mean spiritual support value ($M = 9.254$). A total of 81 older study participants had a score of 8 on the spiritual support scale.

The stress buffering effects of spiritual support become even more evident for those older respondents with a spiritual support score of 12 ($N = 71$). This score falls approximately one standard deviation above the mean spiritual support value ($+1\text{ SD} = 12.740$). The data suggest that the deleterious effects of functional disability on change in feelings of personal control are completely offset at this point ($\text{Beta} = .060$; $b = .048$; $n.s.$).

Finally, at the highest observed spiritual support score of 12, older study participants experienced an *increase* in personal control over time ($\text{Beta} = .249$; $b = .200$; $p < .05$). A total of 33 older study participants had the highest spiritual support score.

Supplementary Analyses

There is a potential source of bias in the findings that have been addressed so far. The results in the previous section are based on data that are provided by older people who attend church on a fairly regular basis. The findings reveal that spiritual support, but not emotional support from secular social network members, offsets the effects of functional disability on change in control. Taken at face value, this would appear to suggest that spiritual social support is more important than secular emotional support. However, these analyses focus solely on people who attend church on a regular basis and as a result, we cannot rule out the possibility that secular emotional support is important for people who have little to do with religion.

We explored this alternative interpretation by testing for a statistical interaction effect between secular emotional support and functional disability on change in control only among older study adults who do not attend church regularly (i.e., they go to church no more than two times a year). These additional analyses (not shown here) suggest that emotional support from secular social network members does not significantly offset the effects of functional disability on change in feelings of personal control over time for the older people in this group ($b = .012$; $n.s.$).

Discussion

In their widely-cited theory of aging, Baltes and his colleagues convincingly demonstrate that the balance between gains and losses becomes less favorable as people grow older (Baltes and Smith 1999). However, a key tenet of their theoretical perspective specifies that

older people take steps to compensate for these losses. Viewed in a more general way, the current study represents a specific application of these insights. More specifically, we evaluated whether older adults attempt to compensate for the losses associated with functional disability by turning to significant others for assistance. In the process, we attempted to contribute to the literature by delving more deeply into the nature of the support they receive. Three different types of social support were compared and contrasted: spiritual support from fellow church members, emotional support from people at church, and emotional support from individuals in secular social networks. The findings reveal that of the three, only spiritual support from church members appears to offset the effects of functional disability on change in personal control over time.

Three issues involving the spiritual support findings should be noted. First, the data indicate that at low levels of spiritual support, functional disability tends to erode feelings of personal control over time. Cast within the context of Baltes' work, this suggests that not only do losses increase with advancing age, but one loss may actually give rise to another loss (Baltes and Smith 1999). Second, the findings reveal that at the highest level of spiritual support, functional disability is associated with *gains* in personal control over time. At first, this finding may seem counterintuitive. However, this result is consistent with a rapidly developing body of research which suggests that a significant number of people are able to experience growth in the face of adversity (Yanez, Hoyt and Lechner 2011). Our study contributes to this literature by suggesting that receiving optimal levels of social support provides one way in which this type of growth may take place. Third, the fact that spiritual support, but not emotional support, appears to offset the effects of functional disability is noteworthy. Perhaps the relatively unique aspects of church-based social support emerged from the data because religious involvement may become increasingly important as people grow older (Krause 2008). Alternatively, spiritual support may be more beneficial because it provides older people with a way to reframe the physical health problems they encounter thereby helping them to find meaning in the face of this type of adversity (Berger 1967). This is important because finding meaning in the face of adversity may represent the first step toward gaining control over it (Frankl 1959). But regardless of the underlying process that may be at work, the fact that only spiritual support appears to provide coping benefits while secular and emotional support do not adds further credence to notion that there is something unique about social relationships that arise in religious institutions.

The conclusion that there is something unique about spiritual support was further bolstered by the findings from the supplementary analyses. These data suggest that emotional support from secular social network members does not buffer the effects of functional disability on control even among older people who do not attend church on a regular basis. Although emotional support may provide comfort, it may not help older people reframe the meaning of physical decline and as a result, it might affect feelings such as happiness, but not a sense of personal control.

Although the findings we report may have contributed to the literature, a significant amount of work remains to be done. Congregational life is a vast conceptual domain in its own right and as a result, other aspects of church involvement may help offset the effects of physical limitations, as well. For example, a number of congregations have prayer groups and Bible study groups that are often used as forums for working through personal difficulties (Wuthnow 1994). Research is needed to see if involvement in these formal groups conveys the same control enhancing benefits that are afforded by informal spiritual support.

In the process of addressing new issues, it is important for researchers pay attention to the limitations in our work. One shortcoming is especially important. Although the data for this study were gathered at more than one point in time, we still cannot claim to have definitively

demonstrated that spiritual support enhances feelings of personal control. One might just have easily argued that people with a strong sense of personal control are able to obtain more spiritual support from their fellow church members. Clearly, nagging issues involving the direction of causality can never be conclusively resolved with survey data.

The wide majority of studies that assess the relationship between various aspects of religion and health are primarily concerned with the potential ways in which religion may enhance health and help people avoid physical health problems. In contrast, as Levin (2001) and others point out, far fewer studies have been concerned with the ways in which religion may help people who are already experiencing some kind of physical limitations. When viewed at the broadest level, our study was designed to address this gap in the literature. We hope the findings we provide and the issues we raise encourage other investigators to explore the potential ways in which involvement in religion may help older people who have already encountered problems with their health.

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Table 1**Core study Measures**

1	Feelings of Personal Control - Waves 2 and 3 ^a
	<ul style="list-style-type: none"> A. I have a lot of influence over most things that happen in my life. B. I can do just about anything I really set my mind to. C. When I make plans, I'm almost certain to make them work. D. When I encounter problems, I don't give up until I solve them.
2	Functional Disability - Wave 2 ^b
	<ul style="list-style-type: none"> A. Shopping for personal items, such as toilet items or medicine. B. Using the telephone C. Bathing yourself D. Climbing 2–3 flights of stairs E. Walking about 1/4 mile F. Doing heavy work around the house, such as shoveling snow nor washing walls G. Taking a train or bus by yourself H. Stooping, crouching, or kneeling I. Standing or being on your feet for about 2 hours J. Reaching over your head K. Using your fingers to grasp or handle L. Lifting or carrying something as heavy as 25 pounds M. Dressing and undressing yourself N. Feeding yourself O. Getting in and out of bed.
3	Spiritual Support - Wave 2 ^c
	<ul style="list-style-type: none"> A. Not counting Bible study groups, prayer groups, or church services, how often does someone in your congregation share their own religious experiences with you? B. Not counting Bible study groups, prayer groups, or church services, how often does someone in your congregation help you find solutions to your problems in the Bible? C. Not counting Bible study groups, prayer groups, or church services, how often do the examples set by others in your congregation help you lead a better religious life? D. Not counting Bible study groups, prayer groups, or church services, how often does someone in your congregation help you live according to your religious beliefs?
4	Emotional support from Fellow Church Members - Wave 2 ^c
	<ul style="list-style-type: none"> A. Not counting your minister, pastor, or priest, how often does someone in your congregation let you know they love and care for you? B. How often does someone in your congregation talk with you about your private problems and concerns? C. How often does someone in your congregation express interest and concern in your well-being?
5	Secular Emotional Support - Wave 2 ^c
	<ul style="list-style-type: none"> A. Not counting your minister or fellow church members, how often do your family and friends let you know they love and care for you? B. Not counting your minister or fellow church members, how often do your family and friends talk with you about your private problems and concerns? C. Not counting your minister or fellow church members, how often do your family and friends express interest and concern in your well-being?

^aThese items are scored in the following manner (coding in parenthesis): strongly disagree (1), disagree (2), agree (3), strongly agree (4).

^bA simple count was taken of the number of activities study participants had difficulty performing.

^cThese items were scored in the following manner: never (1), once in a while (2), fairly often (3), very often (4).

Table 2Social Support, Functional Disability and Change in Personal Control ($N = 583$)

	Model 1	Model 2
<u>Independent Variables</u>		
Age	-.001 ^a	.002
	(-.001) ^b	(.001)
Sex	.042	.037
	(.230)	(.203)
Education	.066	.057
	(.052)	(.045)
Race	-.001	-.005
	(-.002)	(-.025)
Marital Status	-.005	-.004
	(-.024)	(-.020)
Church Attendance	.015	.015
	(.028)	(.028)
Private Prayer	-.003	-.005
	(-.006)	(-.011)
Functional Disability	-.066	-.070
	(-.053)	(-.056)
Spiritual Support	.103*	.120**
	(.077)	(.089)
Emotional Support from	.001	-.010
Church Members	(.001)	(-.011)
Secular Emotional Support	.008	.012
	(.010)	(.014)
Personal Control - Wave 2	.199***	.193***
	(.250)	(.243)
(Spiritual Support X	---	---
Functional Disability)	---	(.038)***
(Emotional Support at Church	---	---
X Functional Disability)	---	(-.018)
(Secular Emotional Support	---	---
X Functional Disability)	---	(-.007)
Multiple R ²	.080	.097

^a standardized regression coefficient^b metric (unstandardized) coefficient* $p < .05$;** $p < .01$;

 $p < .001$