

# **International Collaborative Study of Social Support**

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## **Abstract**

Attesting to the importance of social support in health, its absence has been shown to be as lethal as smoking a pack of cigarettes per day (House et al., 1988). Previous research in social support has tended to take a "black box" approach, showing relationships between overall scores on measures of social support and various health indices (risk behaviors, measures of clinical status and chronic disease, morbidity, mortality) but without exploring what are key characteristics of social support.

Dr. Fisher and his colleagues have developed a distinction between "Nondirective" support (cooperating without "taking over," accepting people's feelings, accepting and cooperating with people's choices) and "Directive" support (taking control of tasks, telling people what to do, prescribing "correct" feelings and choices). In general, Nondirective support has been shown linked to better health status and quality of life while Directive support has tended to be associated with poorer health status and quality of life.

A series of studies in this project examined Directive and Nondirective support in a sample of European Americans and African Americans in St. Louis, along with samples from Norway, Thailand, Finland, and Hungary. In general, these studies have indicated that the distinction between Nondirective and Directive support can be generalized across these diverse cultures and settings. Interestingly, specific items (e.g., "Solve problems for you") might end up being viewed as either Nondirective or Directive in different cultures but the overall distinction held across cultures. As with previous research, evidence in several of these studies indicated relationships between Nondirective support and better quality of life and between Directive support and poorer quality of life. Implications of this research have now been incorporated in planning and direction of Peers for Progress, a global program of the American Academy of

Family Physicians Foundation, supported by the Eli Lilly and Company Foundation which Dr. Fisher serves as Global Director and which is designed to promote support for diabetes management around the world.

In particular, the (a) findings that the distinction between Nondirective and Directive support appears stable in different countries and cultures and (b) findings suggesting the generality of the advantages of Nondirective support have been incorporated into a general model of peer support guiding the program.

## **Lay Summary**

Attesting to the importance of social support in health, its absence has been shown to be as lethal as smoking a pack of cigarettes per day (House et al., 1988). Previous research in social support has tended to take a “black box” approach, showing general relationships between individuals’ overall ratings of the support they receive and different indicators of positive health or quality of life. This research, however, has not explored what are key characteristics of social support.

Dr. Fisher and his colleagues have developed a distinction between “Nondirective” support (cooperating without “taking over,” accepting people’s feelings, accepting and cooperating with people’s choices) and “Directive” support (taking control of tasks, telling people what to do, prescribing “correct” feelings and choices). In general, Nondirective support has been shown linked to better health status and quality of life while Directive support has tended to be associated with poorer health status and quality of life.

Through this project, studies in ethnically diverse samples in St. Louis, along with surveys from Norway, Thailand, Finland, and Hungary have found that the distinction between Nondirective and Directive support holds up well across cultures. In some cases, individual survey items may be categorized as Nondirective in one culture and Directive in another (e.g., “Solve problems for you”), but the overall distinction holds up across cultures. As in previous research, Nondirective support was found related to better quality of life and Directive support to poorer quality of life. Findings from this research have guided the planning of Peers for Progress, a global program of the American Academy of Family Physicians Foundation, supported by the Eli Lilly and Company Foundation which Dr. Fisher serves as Global Director and which is designed to promote support for diabetes management around the world. In particular, the findings that the distinction between Nondirective and Directive support holds up across different cultures and that Nondirective support is generally advantageous, have guided development of a general model of peer support for diabetes.

## **Introduction/Brief Literature Review**

Social support is a critical factor in health, its absence having been shown to be as lethal as smoking a pack of cigarettes per day (House et al., 1988). Previous research in social support has tended to take a “black box” approach, showing relationships between total scores on measures of social support and various health indices (risk behaviors, measures of clinical status and chronic disease, morbidity, mortality) but without exploring what are key characteristics of social support (see, e.g., Lieberman, 1986).

Dr. Fisher and his colleagues have developed a distinction between “Nondirective” support (cooperating without “taking over,” accepting people’s feelings, accepting and cooperating with people’s choices) and “Directive” support (taking control of tasks, telling people what to do, prescribing “correct” feelings and choices). In brief, Nondirective support has been found associated with better metabolic control among adults with diabetes, lower levels of risk factors for cardiovascular and other diseases, and improved quality of life in a variety of populations (community samples and clinical samples of adults with diabetes, breast cancer, lung cancer, Multiple Endocrine Neoplasia, lupus, and HIV/AIDS) (Davis et al., 1997; Fisher, 1997; Fisher et al., 1996; Fisher, La Greca et al., 1997; Harber et al., 2005).

Directive support has been associated with lower levels of quality of life and/or greater levels of depression, but Directive support has also appeared to be of some utility in acute circumstances or situations in which individuals are ill-prepared to cope with challenges or stressors (Fisher, Bickle et al., 1997). This International Collaborative Study examined how these characteristics of support might, themselves, take different forms in different cultures and might be associated with different health indicators (risk behaviors, measures of disease management, morbidity) in different cultures.

## **Methods**

To date, a measure of Nondirective and Directive support developed by Dr. Fisher and his colleagues has been translated into Thai, Norwegian, Hungarian, and Spanish.

In Thailand, the measure has been included in the Thai Family Study, directed by Dr. Nittaya Kotchabhakdi of Mahidol University and the National Institute for Child and Family Development, and Dr. Naiphinich Kotchabhakdi of Mahidol University. This study includes approximately 900 families sampled through stratified random sampling in four regions of Thailand, representing urban and rural settings. Within these families, adults over the age of 50 have completed the measure of Directive and Nondirective support, providing a sample of approximately 700-800. In addition to the measure of Nondirective and Directive support, other measures of health status, quality of life, and family characteristics are available for this very interesting sample.

In Norway, the measure of Nondirective and Directive support has been administered to approximately 100 participants in a rehabilitation program in conjunction with the research of Drs. Holger Ursin and Hege Eriksen examining psychological and rehabilitation factors associated with “subjective health complaints” (symptoms and complaints that account for large amounts of medical care but that generally are vague and only loosely related to diagnosable biological problems, Eriksen et al., 2004).

In St. Louis, Dr. Fisher and his colleagues (Dr. Mark Walker, Ms. Joan Heins, and a then-graduate student, Dr. Jeanne Gabrielle) completed a survey of 300 adults, approximately two-thirds of whom were African American, recruited through community and hospital settings associated with Washington University School of Medicine.

In a related project by Dr. Patricia Cavazos, a post-doctoral fellow of Dr. Fisher at Washington University, now an assistant professor in the Department of Psychiatry at Washington

University, the measure was translated into Spanish as part of a study of social factors surrounding acculturative stress among Latino immigrants in St. Louis. This measure is available for further use in Mexican, Latin and South American, or Spanish samples.

In Hungary, the measure has been included in several pilot projects examining social, economic, and psychological factors related to stress, cardiovascular disease, and general health status, coordinated by Drs. Maria Kopp and Adrienne Stauder at Semmelweis University in Budapest. In Finland, Dr. Antti Uutela of the National Public Health Institute of Finland plans to include the measure in evaluation surveys of community prevention studies, following from the well-known North Karelia studies in Finland conducted by the same Institute.

## **Results**

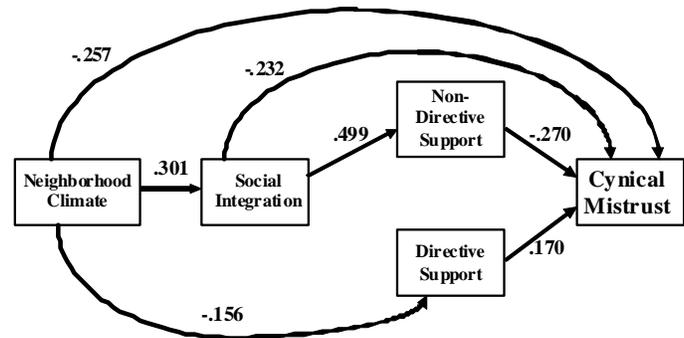
In the Thai Family Study, directed by Dr. Nittaya Kotchabhakdi of Mahidol University and the National Institute for Child and Family Development, and Dr. Naiphinich Kotchabhakdi of Mahidol University, analyses examined whether items that reflect Nondirective and Directive support in U.S. samples also reflect these among Thai adults. Several differences were illuminating. A number of items that U.S. respondents rate as Directive support were rated by Thai adults as Nondirective. These items were: "Solve problems for you," and "Take charge of your problems." These kinds of actions tend to be viewed as intrusive in U.S. culture, but they appear to be expected within Thai culture in which support providers are expected to know how to help without asking recipients having to clarify what they want. This is reflected in a figure of speech within Thai culture, "Don't ask to feed the monk." This does not mean, however, that the distinction between Directive and Nondirective support is not meaningful within Thai culture. As in U.S. samples, "Tell you what to do" was rated by Thai adults as clearly Directive (Fisher et al., 2009).

These findings illustrate an important pattern. Broad categories like Nondirective and Directive support may transcend different cultures. However, the details of how those categories or functions may be manifest within a particular culture may be very specific. Thus, one might develop peer support interventions in Thailand with emphasis on Nondirective and de-emphasis on Directive support, but, in doing so, one would recognize that exactly what typifies Nondirective and Directive support in Thailand may be somewhat different than in the U.S. (Fisher et al., 2009).

From the study of "subjective health complaints" among rehabilitation patients in Norway, a paper has been submitted to the Journal of Rehabilitation Medicine. As with the Thai Family Study, analyses indicated that the distinction between Nondirective and Directive support was sustained in the Norwegian sample. This study examined participants' reports from both staff within the rehabilitation center as well as individuals outside the rehabilitation center. For both groups, reported Nondirective support was greater than reported Directive support, replicating patterns in previous work with other samples. Interestingly enough, Directive support from those outside the rehabilitation center was predictive of greater levels of subjective health complaints.

Data from the surveys conducted in St. Louis have been presented in 2005 and 2006 at the Society of Behavioral Medicine (Fisher et al., 2005; Gabriele et al., 2006). An additional analysis examined relationships among Nondirective and Directive support along with

- (a) social network and integration
- (b) positive and negative neighborhood climate (e.g., “If you fell on the sidewalk or street in your neighborhood, would people help you?” “Do you see people in angry arguments in your neighborhood?”), and
- (c) cynical mistrust, a well documented risk for cardiovascular disease.



As can be seen in the figure, structural equation modeling showed a path from positive neighborhood climate through social integration and Nondirective support to lower levels of cynical mistrust. A second path links poorer neighborhood climate to higher levels of Directive support and, in turn, greater cynical mistrust. At the same time, neighborhood climate and social integration each retain independent links to cynical mistrust. Rather than the several social variables – climate, integration, type of support – collapsing in an amorphous statistical mush, these results illustrate both distinct influences of each and complex layering among them (Fisher, 2008).

## Discussion

Several findings from this research are important in our understanding both of specific features of social support and how they are operative around the world. Although, specific items (e.g., "Solve problems for you") might end up being viewed as either Nondirective or Directive in different cultures, nevertheless the overall distinction held across cultures. Thus, there appears to be generality of broad characteristics of support as well as specificity regarding how those broad characteristics are expressed or manifest in different cultures. As with previous research, evidence in several of these studies indicated relationships between Nondirective support and better quality of life and between Directive support and poorer quality of life. Implications of this research have now been incorporated in planning and direction of Peers for Progress ([peersforprogress.com](http://peersforprogress.com)), a global program to promote support for diabetes management. (Peers for Progress is a global program of the American Academy of Family Physicians Foundation, supported by the Eli Lilly and Company Foundation). In his role as Global Director of Peers for Progress, Dr. Fisher has relied especially on the current findings that (a) the distinction between Nondirective and Directive support appears stable in different countries and cultures and (b) the advantages of Nondirective support appear also to be apparent in varied cultures. These have been incorporated into a general model of peer support guiding Peers for Progress.

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