International Collaborative Study of Social Support

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This is a proposal to extend and restructure funding from the Longer Life Foundation to the project, "International Collaborative Study of Social Support," of which Edwin Fisher, PhD, is Principal Investigator. This project was originally funded through the regular grants of the Longer Life Foundation to Dr. Fisher through the Department of Medicine and, within it, the Division of Health Behavior Research at Washington University in St. Louis. Dr. Fisher moved to become chair of the Department of Health Behavior and Health Education in the School of Public Health at the University of North Carolina at Chapel Hill in August of 2005. This is to propose continued funding of the project to Dr. Fisher at the University of North Carolina as a coherent extension of the work begun and funded at Washington University. It would support (a) preparation of manuscripts, (b) international conference presentations, and (c) a proposal to the National Institutes of Health through its Fogarty International Center to extend and expand the research begun with funding from the Longer Life Foundation.

Original funds awarded were $50,000 plus $10,000 overhead. $8,000 has been expended to date. The amount requested here totals $31,800. This would result in a total cost of the project of $39,800, relative to the $60,000 originally awarded.

The focus of the work has been on key aspects of social support and how they may be influenced or may vary in different cultures. 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 score 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., Coyne, et al. 1990; 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). A basis for the International Collaborative Study then was to examine 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.

Progress Report

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 research there of Drs. Holger Ursin and Hege Eriksen examining psychological and rehabilitation factors associated with “subjective health complaints” (Eriksen et al., 2004).

In Hungary, the measure is currently included in research examining social, economic, and psychological factors related to stress, cardiovascular disease, and general health status, coordinated by Drs. Maria Kopp and Adrienne Stauder at Semmelweiss 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.

In St. Louis, Dr. Fisher and his colleagues (Dr. Mark Walker, Ms. Joan Heins, and graduate student, Ms. Jeanne Gabrield) completed 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. Data from these surveys have been presented in 2005 at the Society of Behavioral Medicine (Fisher et al., 2005) and will be presented at that Society’s meeting in San Francisco in 2006 (Gabriele et al., 2006).

In a related project of Dr. Patricia Cavazos, a post-doctoral fellow of Dr. Fisher, 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 December, 2005, Dr. Fisher met with Drs. Nittaya Kotchabhakdi and Naiphinich Kotchabhakdi from Bangkok and Dr. Ericksen from Norway at a meeting in Bangkok, Thailand. This meeting was to review approaches to analyzing data from the several studies and to initiate planning of a symposium for submission to the International Conference of Behavioral Medicine to be held in Bangkok in December,

2006. The due date for that symposium submission is March 1, 2006. Following preparation and submission of the symposium, preparation of manuscripts will take place over the summer of 2006. Concurrent with these activities, Dr. Fisher has initiated contact with the Fogarty International Center at the National Institutes of Health and will coordinate a cooperative proposal to that Center to continue and expand the research; submission of the proposal being planned for late fall, 2006 or winter, 2007.

Funds Requested

Funds requested here are to support continued meetings and communications among the collaborators in the International Collaborative Study. Funds are requested for the following:

Description of Use of Funds	**Cost**
Travel of investigators to attend International Congress of Behavioral Medicine in Bangkok, Thailand, December, 2006 at which plans for the proposal to the Fogarty Center would be finalized and at which it is anticipated the symposium reporting on the International Collaborative Study would be presented. Stipends are requested for four individuals at $1,500 each (Fisher and Dr. Mark Walker from the US, Eriksen from Norway, one to be named from Finland, Hungary, or other country).	$6,000 (4 @ $1,500)
Travel to support consultation by Fisher to potential collaborators; $1,500 for each of three trips to Finland, and/or Budapest and/or potential collaborators in Spain or Latin America.	$4,500 (3 @ $1,500)
Consultation expenses for Mark Walker, PhD, assistant professor in the Division of Health Behavior Research at Washington University, who has collaborated in much of the work on this project, particularly with regard to statistical analyses. Travel is requested for three trips at $1,500 either for Dr. Walker to visit collaborators within their settings or for their statistical analysts to travel to St. Louis to meet with Dr. Walker over the course of at least several days to develop state of the art and consistent analytic strategies across the collaborative groups involved in this project.	$4,500 (3 @ $1,500)
Meeting expenses: $1,500 for meeting expenses (room rental, coffee breaks, etc.) among collaborators at the meetings of the Society of Behavioral Medicine in San Francisco in March, 2006 (at which several of the collaborators will be attending) or at the International Congress of Behavioral Medicine in Bangkok, in December, 2006.	$1,500
Miscellaneous staff support: $10,000 for secretarial and/or data management and/or data analysis to facilitate coordination among collaborators and facilitate preparation of a grant to the National Institutes of Health or other funding organization for continuation of the research.	$10,000
Total Direct Costs	$26,500
Overhead @ 20%	$5,300
Total Costs	$31,800

Note: Total funds originally budgeted for this project were $50,000 plus $10,000 overhead, totaling $60,000. Of this, $8,000 has been expended with $52,000 having been returned to the Foundation concurrent with Dr. Fisher leaving Washington University. The total of the amount already expended and that requested, inclusive of overhead, would be $39,800.

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