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Elements of Supportive Interactions: When Are Attempts to Help Effective?

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A central focus in our research has been to understand the factors that determine when actions are supportive or not for someone who is suffering. This issue is actually two intertwined questions: First, what factors increase or decrease the likelihood of a support attempt or a negative reaction taking place? Second, what factors mediate the effects of a support attempt? The former question concerns the quantity of support, with the possibilities ranging from no support to large amounts of support received. The second question concerns the quality of support received, which varies from poor to excellent. This chapter attempts to shed light on the latter issue—that is, why some support attempts succeed and others fail.

For the past 10 years, the senior author has been interested in how people cope with stress and the role of others' reactions, both positive and negative, in their adjustment. Her work has focused on social

support processes in general such as the definition and measurement of social support (Dunkel-Schetter & Bennett, 1990; Wortman & Dunkel-Schetter, 1987), and on specific issues such as the determinants of support receipt (Dunkel-Schetter, Folkman, & Lazarus, 1987; Dunkel-Schetter & Skokan, 1990).

This program of research has been concerned with the social support that occurs when someone is suffering in some way. Usually, the person is experiencing a specific stressful life event, but we have also been interested in social responses to emotional distress stemming from chronic stress and from psychopathologic origins. Some social support researchers have indicated that exposure to stressful circumstances often leads a person to mobilize supportive resources (e.g., Barrera, 1981; Eckenrode & Wethington, 1990; Gore, 1981; Gottlieb, 1983). Furthermore, social psychological research reviewed by Staub (1974) and Schwarz (1977) has shown that emotional distress elicits attempts to help, in part because it is an indicator of an individual's need. Still other studies on victims suggest that social responses to distress change over time and may be negative as well as positive (see reviews by Herbert & Dunkel-Schetter, in press; Dunkel-Schetter & Bennett, 1990; Wortman & Lehman, 1985). In summary, our interest has been in suffering or distress attributable to a variety of causes, where the negative effect and the events precipitating it act as the stimuli for a range of social responses—in particular, support attempts and negative reactions.

In addressing the issue of why some support attempts succeed and others fail, this chapter draws from our own research as well as research conducted by others. Work by our research group has involved people experiencing a variety of life stresses, including cancer, AIDS, diabetes, and stress in medical school and college. In this chapter, however, we base our discussion on two dissertation projects—that of Blasband (1990), who conducted interviews with 40 men with AIDS regarding their social experiences, and that of Feinstein (1988), who conducted interviews with 20 male and 20 female diabetics and their spouses regarding their support interactions. Other past research that has addressed the question of interest here includes investigations by Lehman, Ellard, and Wortman (1986) of the support experiences of bereaved adults, and by Dakof and Taylor (1990; Taylor & Dakof, 1988) of the support experiences of cancer patients. These studies and ours utilize a similar methodology and, as a set, they inform us about naturally occurring social responses to suffering and distress. Before turning to the observations that can be made based on this body of work, our framework for the conceptualization and study of social support is described.

A Framework for the Study of Social Support

Social support has been defined in many different ways. The definition of social support used here follows in the tradition of a number of researchers (e.g., House, 1981; Kahn & Antonucci, 1980; Shumaker & Brownell, 1984), all of whom focus on social support as interpersonal interactions, transactions, or exchanges. House (1981), for example, defines support as interpersonal transactions involving one or more of the following: emotional concern, instrumental aid, information about the environment, and information relevant to appraisal of self. Our support concept involves the actual exchange of support, sometimes referred to as *received support*.

It should be noted that this conceptualization is quite different from the concept of *available support*, which has been dominant in the literature in the past. Available support is the perception that others are there to depend upon if one needs them, whether or not they are active in providing resources of any kind (see Dunkel-Schetter & Bennett, 1990, for a discussion of this distinction). Conceptions of available support are dispositional and cognitive, whereas conceptions of received support are situational and behavioral, involving interaction among individuals. Both approaches are valuable, and they are not generally inconsistent (Sarason, Pierce, & Sarason, 1990).

Our specific focus has been on dyadic support interactions—ones having the two roles of support provider and support recipient. Figure 4.1 provides a working framework for conceptualizing the perspectives of these two roles within supportive interactions, and it adds the perspective of an observer or third party to the picture. A particular interaction can be seen from each of these three perspectives—that of the *provider* (Circle A), that of the *recipient* (Circle B), and that of the *third party* (Circle C). The third- party perspective might be operationalized as the perspective of a single observer or the average of several judges' assessments (a normative standard). This third perspective

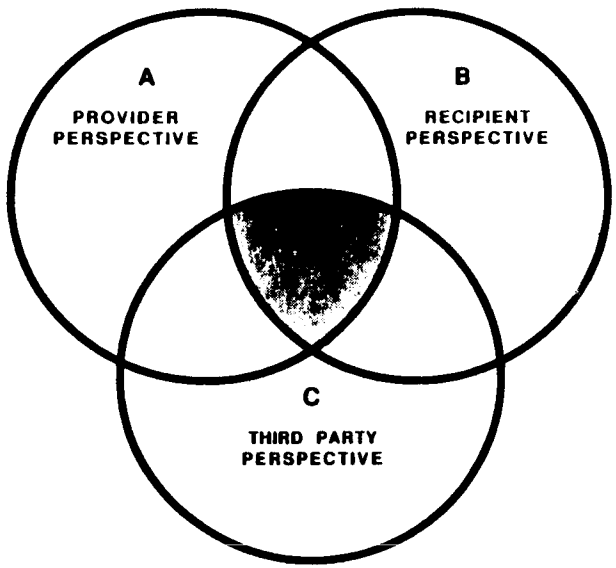

Figure 4.1. Three Perspectives of Supportive Interactions

accounts for the cultural and social relativity of social support interactions; what is viewed as support in one social class or culture may not be seen as support in another. Overlap between two perspectives in Figure 4.1 indicates agreement in the judgment of an interaction on a particular dimension, whereas the absence of overlap suggests divergence in two views of the interaction.

Two key dimensions of support interactions can be considered from each of the three perspectives in this framework: (a) the *intentions* behind a particular interaction or support attempt, and (b) the immediate *effects* of an interaction on the recipient. Each of these dimensions is discussed below.

Intentions and Support Interactions

The importance of intentions in social support interactions was highlighted by Shumaker and Brownell (1984) when they defined social

support as social exchanges in which either the provider or the recipient perceives that the provider had positive intent. The significance of intentions to social support research can also be justified in light of Ajzen and Fishbein's (1980) theory of planned action and of planned behavior (Ajzen, 1985). This theory states that the best predictor of a specific and volitional behavior is whether or not one intends to perform that behavior; the stronger the person's intentions, the greater the likelihood a specific behavior will be performed. Evidence for this theory's relevance to helping and social support is accumulating (Borgida, Simmons, Conner, & Lombard, 1990; Dalbert, Montada, & Schmitt, 1988; Montada, Dalbert, & Schmitt, 1982). Given that our goal is to predict the occurrence and quality of social support, the provider's intention seems to be a necessary component of models of support. Another reason for including it is that a long tradition of research in social psychology, and recent emphasis in social cognition research specifically, indicates that most complex social behaviors are goal based (for reviews and cogent discussion, see Bargh, 1990; Gollwitzer, 1990).

Support interactions could be altruistically motivated (which many are) or might involve other motives, chiefly egoistic ones. This distinction between altruistic and egoistic intentions is derived from the work of Batson in social psychological research on helping (Batson & Coke, 1981; Batson, O'Quin, Fultz, Vanderplas, & Isen, 1983). Examples of support attempts motivated by self-interest would include advice given with the expectation of some social reward, or to alter an aspect of the target person's behavior that is annoying. Altruistically motivated support attempts are those made without expectation of reward or personal gain.

This chapter is concerned with recipient, provider, and observer views of whether an act was intended altruistically or not—that is, whether the provider is viewed as intending to help the recipient primarily for the recipient's benefit. The provider is in the best position to know his or her intent, and providers' intentions can be assessed best prior to interaction. However, the perspective of the recipient about the provider's intentions is also important because the effects of support interactions are determined partly by the recipient's judgment of the intent underlying provider behaviors. Recipients who think an action was altruistically intended often view it as helpful, even though it would have had no effect without this imputed intent. Alternatively, recipients can misconstrue intentions, such as inferring ill intent when actions are

well-meant. Hence, third-party or observer perspectives offer another source of information about imputed intentions that may be useful for comparison to recipient and provider views.

Effects of Support Interactions

In social support research, we are accustomed to thinking of the effects of support on physical and mental health outcomes, such as rates of depression, illness, or death. Considerable research has documented that support has many beneficial long-term effects for health, but researchers have been unsuccessful as yet in determining exactly why or how these effects occur (see Cohen, 1988; House, Umberson, & Landis, 1988; Thoits, 1985). Clues to the process by which support is health protective might be found in research on supportive interactions.

When an interactional approach to support is applied, the more immediate or proximal effects of support become evident. Specific immediate effects (for a recipient) of a particular interaction, or a series of consecutive interactions between two individuals, might include one or more of the following: a change in mood, attitude, optimism, or esteem; an enhanced motivation or sense of self-efficacy in coping; new knowledge or information of use in addressing the sources or effects of distress; or the accomplishment of a necessary or intended task. On each of these dimensions, a social support attempt can have *beneficial effects*, *no effect*, or *harmful effects*.

Table 4.1 provides a preliminary sketch of possible ways in which the different effects of support attempts might be conceptualized. Patterns of interaction over time within an individual's entire social network may influence the person's physical and mental health directly or indirectly. For example, social support interactions may enhance the perception that support is available, or may buffer the individual from the detrimental effects of stress on health.

Specific support interactions usually have several co-occurring immediate effects, some of which are helpful and some harmful. For example, aid in tasks can be provided in a manner that is instrumentally effective but that reduces self-esteem or sense of self-efficacy at the same time (Fisher, Nadler, & Whitcher-Alagna, 1982). In addition to considering the multiple effects of any particular interaction, the overall effect can be viewed globally (from each of the three perspectives shown in Figure 4.1) as primarily beneficial, having no effect, or harmful (Shumaker & Brownell, 1984). Global effects of support interactions have been studied in the past almost exclusively from the recipient's perspective. Sometimes social support has even been defined as the recipient's perception that others have been helpful (e.g., Cobb, 1976). One problem with such a definition is that whether an interaction is defined as social support can only be known post hoc.

Another problem is that recipients may be less than veridical reporters of the effects of interactions. For instance, recipients may think that something was helpful when it does not seem so from the perspective of either the provider or a third party. Alternatively, a recipient of a support attempt may fail to observe beneficial effects of the interaction that would be reported by support providers or third persons, or that are objectively verifiable. Yet long-term benefits of social support interactions may be less likely to occur if the recipient is not aware of any immediate positive effects of social support interactions. Thus it is essential to obtain recipient perspectives of the effects of support interactions, but, because they may be biased by the immediacy of the

Table 4.1
Possible Dimensions and Effects of Support Attempts

	Effects		
Dimension	*Benefits*	*No effect*	*Harm*
Mood/affect	improved	no change	made worse
Attitude	increased optimism	no change	increased pessimism
Self-esteem	enhanced	no change	diminished
Coping	greater motivation/ enhanced efficacy	no change	demotivated/ decreased efficacy
Knowledge	gained	not gained	incorrect information
Task	accomplished	not accomplished	performed incorrectly or ineptly

person's support needs, the perspective of third parties also needs to be considered. It may be useful to consider provider perspectives of the effects of interactions as well, but provider reports are also likely to be biased, usually in the direction of perceiving one's support attempts as helpful.

In summary, our framework for the study of support views social support as a subgroup of all forms of social interaction, and takes three perspectives on these interactions (recipient, provider, and observer/third party) along two key dimensions of interactions (intentions and immediate effects). The three perspectives of an interaction on each of these two dimensions may converge or diverge within this general framework.

Definitions for Different Forms of Support-Related Interactions

Using this framework, definitions of several further constructs are possible. First, *social support attempts* are any behaviors with altruistic intent directed toward another individual. Second, one way in which beneficial or *effective support interactions* may be defined is as interactions with perceived benefit in the eyes of the recipient. This phenomenological view of support effects emphasizes the cognitions of the recipient, who is pivotal in determining long-term effects.

This framework can also be used to operationalize various different forms of support interactions. The circles in Figure 4.2 represent that the provider has positive or altruistic intentions to benefit the recipient (Circle A), that the recipient perceives that personal benefit has occurred (Circle B), and that an outside observer or third party (or the consensus of several outsiders) would define the interaction as supportive (Circle C). The shaded area in Figure 4.2 represents social interactions in which the provider acts with altruistic intention, the recipient perceives benefit, and a third party perspective views the interaction as social support.

Although this shaded area represents classic or prototypical support interactions, interactions represented in other areas of the figure are also worth considering in attempts to understand a broad range of social

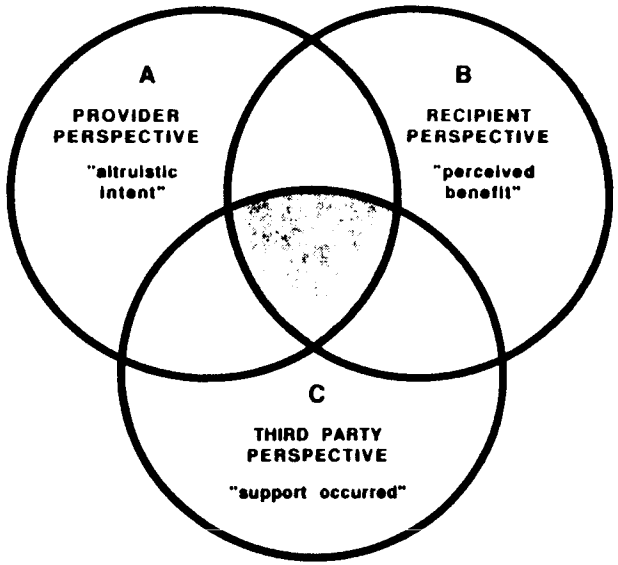

Figure 4.2. A Definitional Framework for Studying Social Support

support phenomena. For example, many support interactions involve positive intentions but no immediate beneficial effects for recipients (i.e., the area of Circle A that does not overlap Circle B); these could be labeled *ineffective support attempts*. Conceivably, an interaction that is not altruistically intended could be perceived as beneficial by a recipient (i.e., *unintended effective support*, or the area of Circle B that does not overlap Circle A). For example, a close relation who rarely gets angry may capture the attention of the distressed person by doing so. Although unintentional and not altruistically motivated, such rare temper outbursts may nonetheless reduce the recipient's maladaptive behavior and elicit his or her constructive action.

Finally, a provider and recipient may interact in ways they view as positively intended and beneficial but that are unrecognizable to an outsider as support acts (i.e., the overlap of Circles A and B that is not shaded). For example, in distressed marriages, criticizing, nagging, or other behaviors that are generally regarded as maladaptive may be

viewed by participants as supportive. Another example involves the codependency occurring in families with substance abuse problems. Although these interactions do not fit the usual notions of what constitutes social support, they can be included in a broad conceptualization of support interactions. Also, given this framework, nonaltruistically intended interactions that are unhelpful or harmful are outside the domain of social support and constitute *negative social reactions* to distress or suffering.

The research covered in the next section of this chapter concentrates on just one aspect of this model—the recipient's global perceptions of benefit. We describe a naturalistic research paradigm for studying support interactions, and discuss the patterns of helpful and unhelpful interactions reported by recipients across studies using this paradigm. In the subsequent section, some of the factors and processes that appear to mediate the effects of a support attempt are explored.

A Naturalistic Paradigm for Studying Support

Pioneering work on social support by Gottlieb (1978) queried 40 single mothers regarding the things done by others that were seen as especially helpful in dealing with their problems. Later research by Dunkel-Schetter (1984), Wortman and Lehman (1985), and Dakof and Taylor (1990) has continued in this general tradition of asking respondents to answer in their own words regarding the most helpful and most unhelpful responses of others to their situation. These studies have focused on new mothers, cancer patients, bereaved parents, and bereaved spouses. Although other investigations have been conducted on various aspects of social support interactions, most do not utilize this methodology. The studies described in this chapter are the most systematic and extensive. The general paradigm used in these studies involves semistructured interviews with individuals who are going through some form of life stress, content analyses of their answers to open-ended questions regarding the most helpful and unhelpful responses of others, and, in some cases, ratings of satisfaction with different kinds of social support.

Background on Our Studies

Recently, we have employed this paradigm to study samples of Type II noninsulin-dependent diabetics (Feinstein, 1988), and gay and bisexual men with AIDS (Blasband, 1990). In our AIDS investigation, 40 gay or bisexual men with AIDS were sampled from an AIDS-assistance organization. They were interviewed in depth regarding their social experiences with family, friends, and lovers, as well as about stress and coping. Open-end and closed-end questions addressed effective and ineffective support received and negative reactions, particularly rejection, experienced by these men. The sample was similar to the population with AIDS in the United States in the mid 1980s in most ways, except that the men were all White and were somewhat better educated.

In the diabetes study, 20 male and 20 female diabetic patients and their spouses, recruited from southern California hospital outpatient programs, were interviewed and completed questionnaires regarding spouse support behaviors and other factors unrelated to this chapter. Open-end and closed-end questions addressed to both partners covered frequency and helpfulness of spouse support of several kinds, patient solicitation of it, and patient responses to support attempts. Standard scales of support and marital functioning were also completed by patients and spouses.

This sample of adult diabetics was characteristically obese, and respondents were experiencing the chronic stress of attempting to control their levels of blood glucose through strict dietary regimens. Continual and lifelong adherence to diet is necessary to prevent or minimize the adverse effects of this chronic disease. The inclusion of spouses in this study enabled us to obtain both recipient and provider perspectives on support interactions within a marital relationship. The spouse is especially important to consider because the diabetic's dietary requirements affect the daily life-style within the family.

The stresses faced by persons with AIDS (PWAs), cancer patients, and the bereaved have certain commonalities. In particular, they all experience a loss (e.g., the bereaved) or a combination of losses and threats of further loss (i.e., cancer and AIDS patients). In contrast, diabetes is somewhat different from many other stressful conditions in its disease characteristics. Diabetics who are noninsulin dependent do not experience a loss, but rather the stressful challenge of daily

adherence to a difficult treatment regimen that involves monitoring virtually every bite consumed.

This distinction between challenge and threat/loss situations develops from work by Lazarus and Folkman (1984) in which they distinguish stress appraisals as benign or stressful, and in stressful situations they distinguish between appraisals of threat, loss, or challenge. An individual can appraise a situation as involving various degrees of each; however, we contend that most situations can be characterized as predominantly one or the other at any point in time. Bereavement is a loss event in general. Cancer and AIDS are typically described in the literature as threat/loss situations: During diagnosis, there is a threat; by early treatment, most people seem to experience a sense of loss; and after diagnosis, there is the continual threat of whether the cancer will recur. Type II diabetes mellitus is predominantly a challenge situation. Like other life-style and behavior change situations, it carries the constant challenge of monitoring and controlling one's behavior. This distinction between situations that can be characterized as predominantly challenge versus threat/loss appears to be important with respect to the effectiveness of support attempts, as elaborated below.

The next section of this chapter discusses general patterns of helpful and unhelpful interactions observed across studies that use the paradigm described. To illustrate these patterns, quotations from both diabetics and PWAs are included.

Recipient Perceptions of Helpful and Unhelpful Interactions

What Are the Most Helpful Types of Support Interactions?

The many discernible types of social support have been classified into a number of typologies, which overlap considerably (Wortman & Dunkel-Schetter, 1987). For the present purposes, we use a simple three-category classification of emotional support, informational support, and instrumental assistance (Dunkel-Schetter et al., 1987; Schaefer, Coyne, & Lazarus, 1976). Emotional support refers to a broad category involving emotional concern for the individual, acceptance, understanding, and encouragement. Informational support includes advice and information of any kind, including information about the environment and about one's self. Instrumental assistance or aid includes task assistance, such as help with chores, and material assistance, such as gifts or loans. Of these three, the last is most similar to the concept of helping typically studied in social psychology.

Of the three types of support, emotionally supportive behaviors seem uniformly extremely helpful. Respondents in all studies reiterate the same themes regarding the helpfulness of expressions of love, caring, concern, understanding, and affection (Blasband, 1990; Chesler & Barbarin, 1984; Dakof & Taylor, 1990; Dunkel-Schetter, 1984; Feinstein, 1988; Lehman et al., 1986). Prototypical illustrations from men with AIDS are "You are still Mike and we love you," and "Mother told me she loved me, and that's all that mattered." Others mentioned listening as a helpful form of support: "When I needed to talk to someone, he listened. Just having someone to listen told me that I was loved and that my friends cared." Emotional support includes not only expressions of love and concern, and listening, but also confirmation of one's physical presence or "just being there." For example, one PWA reported that friends who said, "We're here, we care, call if you need us," were extremely helpful. Another said, "My roommate says, 'Don't worry, I'll always be here for you,' and he really means it." The emotional support provided by knowing that others are available raises again the distinction between, and interconnectedness of, perceptions of available support and support received. When a support interaction involves communication of the availability of others, as in the quote above, it heightens one's sense of available support, which has been related to health benefits in past research (see Dunkel-Schetter & Bennett, 1990 for a review).

Instrumental aid or assistance was also reported by respondents as helpful in most or all of the studies. Grouped together in this category are both material aid and task assistance. The most helpful things done by friends for one PWA were described as follows:

> When I was in the hospital, he cleaned house, did banking, shopping, took care of my family when they came to visit. A friend from New York sent $200 for Christmas. One sent $100 out of the blue. A friend gave me $20 and took me out to lunch. My landlord let me slide on the rent for a month and a half.

Other PWAs vividly described forms of instrumental assistance or aid as among the most helpful things that others had done. For example, financial help, providing a place to stay, transportation to the hospital, and gifts of cars, furniture, dishes, and airline tickets were all seen as extremely helpful.

In contrast to emotional support and instrumental aid, information and advice were *not* seen as uniformly helpful across studies. In fact, this category of support attempt varies across studies from helpful to unhelpful. For example, when family or friends sent the PWAs in our study information about health, nutrition, alternative treatments, or research findings in books and newspapers, it was perceived as helpful. In contrast, there were instances such as this: "My sister-in-law is a born-again Christian. When I told her about AIDS, I got a lecture about drugs, what I'm doing to myself . . . [and] that I should turn to the Lord."

Advice was reported as especially unhelpful. The following is a characteristic comment by diabetic subjects about advice: "I think it is better when people are not telling me what is good for me. I do better when I reach that on my own." In addition, Lehman et al. (1986), in a study of bereaved individuals found advice was one of the two most frequently mentioned unhelpful behaviors. Interestingly, spouses of diabetics consistently reported in interviews in our study that they *knew* advice was not helpful, but they gave it anyway.

Advice appears to be more effective if provided in an emotionally supportive manner. For example, reminding a diabetic partner that he or she cannot eat certain foods is not as problematic if done with concern or affection. Thus, the effects of advice may vary as a function of whether it is provided in combination with other types of support. If provided with emotional support, advice is more likely to be viewed as altruistically intended, and consequently it is more frequently perceived as helpful. In contrast, when advice is given together with task or material assistance, the intent may be unclear or the act may be seen as egoistically motivated. In this form, advice may be seen by the recipient as a social influence attempt rather than as support.

Past research reporting differences in ratings of satisfaction with or helpfulness of different types of support is consistent with our observations (e.g., Camarillo, 1990). Zich and Temoshok (1987), for example, compared ratings of emotionally sustaining help and problem-solving help by 103 persons with ARC or AIDS and found that emotionally sustaining help was viewed as more desirable, more available, more often used, and more useful. Similarly, Cramer (1990) found that acceptance—as measured by listening, empathy, and other behaviors—was a more helpful reaction to personal problems and distress experienced by students than were behaviors labeled as guidance.

What Are the Most Unhelpful Types of Support Attempts?

There are two general themes across many studies regarding unhelpful support attempts. First, any advice that conveys a negative attribution of the recipient, including attributions of blame, incompetence, or failure, tends to be perceived by support recipients as unhelpful. This example from a man with AIDS is about the behavior of a friend: "As long as I had a positive attitude, it was okay with her. There was a time when I got very depressed, suicidal. She said, 'Well, you just don't have a fighting spirit.'" The motive of this friend is not clear. She may not have been altruistically inclined, and thus this would be labeled a negative social reaction rather than a support attempt by our definition. Alternatively, her intention may have been to cheer up the PWA, in which case it was an ineffective support attempt because he perceived her comment as critical and unhelpful.

A second unhelpful cluster of behaviors includes overinvolvement, intrusiveness, oversolicitousness, and overconcern. These behaviors are reported frequently by diabetics, but are also reported by PWAs and cancer patients. This pattern of unhelpful interaction has been discussed by Coyne, Wortman, and Lehman (1988), and by Thompson (see Chapter 5) in her work with stroke patients. A PWA in our study stated, "In the beginning, friends wouldn't let me do anything, wouldn't let me exert myself at all, like grabbing the grocery bags out of my hands. It made me feel like an old person." A diabetic stated, "When I'm doing my blood sugar, she'd ask me, 'Well what is it?' before the test is done. When I go out, she says, 'Oh what did you have? How much did you drink?' And, you know, that kind of thing is very irritating." Again, the motives behind these behaviors are not clear. Yet, it is reasonable to assume that such interactions are often positively motivated despite their ineffectiveness from the recipient's standpoint.

Determinants of Effective Support

Effects of Source of Support on Perceived Helpfulness

The consistent results across studies regarding the helpful and unhelpful patterns of behavior give us some idea of what to do and what not to do if we want to be good support providers, at least in the eyes of support recipients. But clearly more is involved than selecting the correct behavior. The results from various studies suggest additional aspects of support interactions that promote their effectiveness. One finding is that people in particular roles often provide support better than others. These main effects of source (or provider) of support have emerged consistently in the support literature (e.g., House & Wells, 1978; LaRocco, House, & French, 1980; Lieberman, 1982). However, past studies often have concerned effects of social support from different providers on health outcomes, rather than recipient-perceived differences in the helpfulness of social support from different providers (see Vachon & Stylianos, 1988).

One study that focused on the recipient's perceptions of support effectiveness found that rape victims reported that female friends were the most helpful supporters and that physicians were the least helpful (Popiel & Susskind, 1985). Dakof and Taylor (1990) found that spouses of cancer patients were most helpful by their mere physical presence and calm acceptance, and were most unhelpful by criticism of patient responses to cancer. In that study, friends were most helpful by practical assistance and were most unhelpful by avoiding social contact. Somewhat similarly, Camarillo (1990), in a study of ethnically diverse female college students, found students more satisfied with love and assistance from parents and romantic partners than from friends, but friends provided equally satisfactory advice and listening as parents and partners.

In our study of gay men with AIDS, we found that lovers were seen as more effective support providers compared to family and friends, both in the amount of support received and satisfaction with support of each of the three types (i.e., emotional, instrumental, and informational support). Interestingly, more than two thirds of the lovers of our respondents had AIDS, ARC, or were HIV positive themselves.

This similarity may have enabled lovers to be exceptionally supportive. The value of support from others going through similar circumstances has been discussed in the support and self-help literatures (Dakof & Taylor, 1990; Dunkel-Schetter & Wortman, 1982; Lieberman & Borman, 1979). Because they were in similar circumstances, and because of their close relationship to the respondent, lovers may have been capable of providing support of a quality no one else could match.

As mentioned earlier, advice is sometimes helpful but often unhelpful. In addition to the factor of whether it is provided in combination with emotional support, the particular person providing it seems to influence how helpful advice is perceived to be. Certain providers of support seem able to give advice effectively whereas others cannot. In a study of 79 cancer patients, Dunkel-Schetter (1984) found that information and advice from physicians were seen as helpful, but that the same behaviors were unhelpful when performed by family and friends (see also Dakof & Taylor, 1990). These results and those of others suggest that experts are viewed as more credible sources of advice than close personal relations (Zich & Temoshok, 1987). A PWA said that "qualified advice" from two friends, a nurse and a pharmacist, was especially helpful. In contrast, a diabetic respondent said, "I reject comments that come from lack of knowledge." It may be that general information can come from anyone, but that specific guidance, direction, and advice must come from someone perceived as experienced or knowledgeable. This may also explain why peer support, even from strangers, is valued and can be more effective than support from network members not experiencing the problem.

Overall, the results of all these studies indicate strongly that the *type* of support and the *provider* of support are important and interacting factors in determining the helpfulness of particular behaviors. It is also clear that the helpfulness of particular sources or providers varies depending on the stressful situation. In some situations, informal sources such as family members may be best able to provide effective support, whereas in others, particular formal sources of support who are experts may be in a better position to help. Even the effectiveness of different informal role relationships may be altered by the nature of the specific situation. Thus the joint effects of source of support and type of stressful situation warrant further investigation in research on social support effectiveness.

Effects of Type of Support and Type of Stressful Situation on Perceived Helpfulness

The type of stressful situation involved also seems to influence the *type* of support perceived by recipients as helpful or unhelpful. This is an interesting, yet largely unexplored, issue in support effectiveness. Gottlieb (1978), in his study of 40 low-income single mothers, found that the most helpful type of behaviors reported by women varied with the different problems they faced. Specifically, emotional support was perceived as most helpful for problems of an emotional nature, and instrumental support and active helping behaviors were most helpful for financial problems.

Similarly, we have observed differences in our work between the types of support that are perceived as effective in different situations. Although both emotional support and instrumental support were helpful in diverse circumstances, of the three types of support, emotional support seemed to be most helpful for cancer patients, PWAs, and the bereaved, whereas instrumental assistance seemed most helpful for diabetics. For example, a specific behavior that has been found helpful to cancer and AIDS patients in past research is encouragement, a form of emotional support. One PWA indicated that he appreciated it when his father offered encouragement not to give up, to be optimistic, and to do as much as he could. There were few or no instances like this reported in our diabetes study, although such encouragement might have been expected.

Why shouldn't diabetics find encouragement to stay on their diets helpful? It could be difficult to provide encouragement to diabetics that does not seem intrusive and disabling. Thus supporters may refrain from doing this or do it in an unskilled manner. Instead, instances of instrumental assistance were often related as most helpful by diabetics. Assistance for diabetics generally took the form of buying appropriate foods or preparing meals consistent with their diets.

There also appear to be different *unhelpful* interactions reported for different types of stress situations. Specifically, two types of unhelpful interactions seemed common to cancer, AIDS, and bereavement, and two types seemed unique to our sample of diabetics. One of the most frequent unhelpful behaviors for cancer patients in two studies was minimizing and trivializing their circumstances (Dakof & Taylor, 1990; Dunkel-Schetter, 1984). This occurred in anecdotes related by PWAs as well. For example: "A friend was encouraging me to date. It upset me. I had not had sex with anyone for a year. Dating wasn't on my agenda. My energy was into healing. It was a flippant remark—it trivialized all that I was going through." Minimization was reported as unhelpful by bereaved people in Lehman et al.'s (1986) study also, but it did not feature prominently in the interviews with diabetics. The underlying reasons that others may be inclined to minimize the situation of individuals in threat/loss situations, and not of those facing challenges, deserve exploration.

The second sort of unhelpful interaction that occurred for PWAs, cancer patients, and the bereaved involved closing off communication or changing the topic of conversation. Forty-three percent of PWAs reported that ex-lovers avoided or discouraged discussion of AIDS. This may have been attributable to denial and fear of infection, but it occurred with family members of PWAs somewhat as well. For example: "When I spoke to my sister while in the hospital and tried to tell her about my fears and sorrows, she didn't want to discuss it at all. She changed the subject." These behaviors were not evident in reports of diabetics. In contrast, the troubling behavior was raising the topic of the disease too much. A diabetic, describing what was unhelpful on the spouse's part, said: "Just talking about it, I think that's the thing. I don't really feel like talking about it. I know the situation, I know what I have to do, and I don't really feel like talking about it." Thus whether closing off communication is an unhelpful pattern of interaction or not may depend on the type of stress involved. Although we believe it is generally problematic to discourage communication about the stressful condition in threat/loss situations, there may be circumstances—such as the challenge of diabetes—that call for little discussion of the problem.

In addition to these two sorts of unhelpful interactions common in the AIDS, cancer, and bereaved samples, there were two types of unhelpful interactions specific to diabetes. First, attempts to show love and concern through offering temptations were described as especially unhelpful to diabetics. Spouses were described as constantly bringing home restricted foods such as donuts, cake, cookies, and candy as treats, and frequently offering foods that were not allowed on the diet. One woman said, "He brings home two loaves of hot French bread, fresh and hot. It's unhelpful to me. I think he is trying to be helpful by being nice—but in my mind he knows that I am going to eat more bread than I am supposed to eat." Another diabetic man's answer to the question

of what was most unhelpful was the following: "When you are trying to stay on a diet and you are trying to count your calories, she pushes more food in front of you or offers to give you another portion." These instances seemed to reflect the desires of spouses to communicate their love and affection by offering food, a gesture of emotional support that recipients could not accept if they were to cope well with their diabetes.

A second unhelpful behavior specific to diabetes involved reminders of things the diabetic already knew and reprimands when the person had deviated from the diet. Four quotes illustrate this:

> I know he's right if he says, "You aren't supposed to eat that ice cream." But it isn't helpful for him to tell me because I'm going to do it anyway just because I have already made up my mind to do it, I guess.
>
> I'm not wanting someone to tell me what to do. I want to do things because I want to do them, because *I'm* motivated.
>
> It doesn't motivate me, it just annoys me, because I know I should do it.
>
> Reminders are unhelpful because I know she is right.

Behaviors involving reminders and reprimands, which were seen as demotivating and guilt eliciting, occurred in great frequency only in the diabetes study. "Nudging," as this is sometimes called, is perceived by the diabetic as debilitating rather than enabling. It seems to shift the balance of control or responsibility away from the diabetic, reducing feelings of self-efficacy, and arousing guilt.

In summary, it seems that different kinds of support attempts are helpful for people experiencing cancer, AIDS, and bereavement as compared to diabetes. Furthermore, these differences seem to reflect the underlying psychological properties of the two types of situations. Specifically, the differences observed in what was found to be helpful and unhelpful may reflect differences in the demands of threat/loss situations and challenge situations. On the basis of a review of empirical research and on theoretical premises, Cutrona (1990; Cutrona & Russell, 1990) argues that the controllability and life domain of a stressful life event are good predictors of the types of support associated with positive mental health outcomes. Although the focus here is on recipient perceptions of benefit, rather than health outcomes, the observation that life stresses must be distinguished into conceptual

categories with different social support effects is a common feature in Cutrona's work and ours.

Effects of Relationship Characteristics on Perceived Helpfulness

Besides the provider, the type of support, and the type of stress involved, characteristics of the relationship between the provider and recipient are clearly important in determining whether support attempts will be perceived as effective (Albrecht & Adelman, 1987; Leatham & Duck, 1990; Reis, 1990). In one study, for example, Hobfoll, Nadler, and Lieberman (1986) found that intimacy of the relationship predicted satisfaction with support over time in Israeli new mothers, controlling for self-esteem and network characteristics.

In our diabetes study (Feinstein, 1988), qualities of the marital relationships were assessed by both partners using the Dyadic Adjustment Scale (DAS; Spanier, 1976) and the Communications Patterns Questionnaire (CPQ; Christensen, 1988; Christensen & Sullaway, 1984). The DAS contains subscales of cohesion, affective expression, marital satisfaction, and consensus. The CPQ has two subscales, mutual constructive communication (MCC) and demand/withdrawal communication (DWC) patterns. Couple averages on these instruments were tested for their relationships to measures of support available, support received, and the helpfulness of support. It was expected that spouse support would be more optimal in all ways in better functioning marriages.

Results showed that marriages that were rated as well-adjusted, mutually and constructively communicative, and low in demand/withdrawal patterns, had greater diet-related spouse support available, as perceived by the diabetic patients ($r = .64$, $p < .001$, DAS total; $r = .46$, $p < .001$, MCC; $r = -.52$, $p < .001$, DWC), and also greater general support perceived as available ($r = .50$, $r = .51$, and $r = -.42$, respectively, all $p < .001$). Correlations between support received and marital functioning were not as consistently significant. Frequency of spouse support (the average of both partners' ratings) was associated significantly only with cohesion in the marriage ($r = .28$, $p < .05$), marginally with marital satisfaction ($r = .20$, $p = .11$) and with demand/withdrawal communication patterns ($r = -.21$, $p = .09$), but not with consensus,

affective expression, or mutual constructive communication. In contrast, helpfulness of spouse support (again, the average of both partners' ratings) was associated with consensus ($r = .29$, $p < .05$), marital satisfaction ($r = .33$, $p < .05$), cohesion ($r = .33$, $p < .05$), and mutual constructive communication ($r = .26$, $p < .05$) in marriages. Helpfulness was also marginally negatively associated with demand/withdrawal communication patterns ($r = -.20$, $p = .11$), but was not related significantly to affective expression.

Thus for these diabetic patients, marital functioning as assessed along several dimensions was strongly associated with perceptions that the spouse was *available* as a supporter, both in general and with regard to the diet. Marital functioning was also related to the *helpfulness* of the spouse's diet-related support, although much less strongly. Finally, marital functioning was only slightly associated with the *frequency* of spouse diet-related support. The particular dimension of marital functioning that seemed most important was cohesion, whereas affective expression was not related to spouse support at all. Other dimensions of marital functioning, such as mutual constructive communication, consensus, and satisfaction, were related more strongly to the *helpfulness* of spouse support than to the *frequency* of it. Frequency of support may not be predicted by aspects of the marital relationship because the spouse role carries the responsibility to provide fairly steady support. However, quality of the marital relationship does seem to be linked to the quality of support provided (i.e., its helpfulness). From these results, it is clear that at least some aspects of the quality of the marital relationship are important in determining support. In general, relationship characteristics warrant follow-up in future research on determinants of effective support transactions (Fincham & Bradbury, 1990; Reis, 1990).

Effects of Receptivity to Support and Mood of Recipient on Perceived Helpfulness

Whether support is wanted, and whether it is requested or sought, may also influence perceptions of its helpfulness. Most of the unhelpful spouse support described by diabetics was perceived as such because it was unneeded or unwanted (Feinstein, 1988). Diabetic patients' ratings of the degree to which spouse support was wanted and solicited were

significantly related to ratings of helpfulness ($r = .45$, $p < .001$; $r = .39$, $p < .01$). In challenge situations, such as adherence to diet among diabetics, leaving patients alone when they feel they do not need support may convey confidence and encouragement better than most routine support attempts can. Thus assumptions that a person under stress needs active support may be quite erroneous in some situations, a possibility that deserves further attention. Even in threat/loss situations such as cancer or AIDS, unwanted support attempts are likely to be unhelpful. Thus potential support providers need to attend closely to cues from stressed individuals regarding their willingness to accept social support at a given time.

Furthermore, there are indications in our results that the effectiveness of support attempts depends on the mood of the recipient at the time of the interaction. Social psychological research has established that mood of the *helper* is a variable influencing willingness to help (Carlson & Miller, 1987). With respect to the effectiveness of support, mood of the support *recipient* seems to be an overlooked mediator. Seemingly arbitrary conditions such as a stressful day at work, unusually hot weather, or a bothersome viral infection at the time a support attempt occurs may influence its effects. One diabetic indicated that whether something was helpful or not "depends on the mood I'm in too. If I'm kind of uptight, it bothers me more than if I am not."

One implication of these results is that the effects of support attempts can be managed by providers of support through sensitive consideration of the context required for support efforts to help. Support providers can take into account a person's mood and receptivity in deciding when to attempt to provide social support. Skillful social support providers are probably adept at assessing receptivity and mood and targeting their actions accordingly.

Toward a Model of Support Effectiveness

In this chapter we have endeavored to provide a framework for studying social support interactions and an empirically-based description of some of the factors that might be important in determining the effectiveness of support attempts. These factors include characteristics of recipients, providers, and the relationship, and situational contexts

in which the interaction takes place. The specific aspects discussed include the type of support offered, the provider offering it, the type of stressful situation involved, the quality of the relationship between recipient and provider, whether the support was desired or sought, and the mood of the recipient.

A Need to Take into Account the Three Perspectives

This discussion has built on the strong base of studies now available on perceptions of the recipients of support attempts. Regarding the value of this method of studying social support, Gottlieb (1978) has stated, "A classification of informal helping behaviors which is grounded in the everyday experience of those taking part in such transactions can inform our understanding of how citizens define social support and how its forms may differ in natural, as opposed to professional, ecologies" (p. 106).

Although it is extremely valuable to study the recipient's view of effective support interactions, ineffective support attempts, and harmful interactions, this paradigm does not offer information about provider or third-party perspectives. Lehman et al. (1986) studied providers as well as recipients, but they were not parties to the same interactions. Feinstein (1988) studied both diabetic and spouse reports of support interactions in marital relationships, but the study focused retrospectively on general interactions rather than on specific recent interactions. Thus more investment of effort on this topic is still needed. Studies of provider perspectives are especially valuable in contributing yet another view of social support interactions. Research on caregivers, which is an example of a provider focus, may offer much insight into this perspective and how it differs from that of support recipients (Biegel, Sales, & Schulz, in press; Thompson and Pitts, Chapter 5 of this volume).

Past research on social support has focused predominantly on recipients of support, represented in Circle B of Figure 4.1 (House, 1981; Wortman & Dunkel-Schetter, 1987). In contrast, much of social psychological research on helping has focused on providers or helpers (Circle A in Figure 4.1). Integration of our knowledge in these two areas is desirable in understanding support effectiveness (Dunkel-Schetter &

Skokan, 1990). Little research whatsoever has been conducted on third-party perspectives of support interactions (Circle C in Figure 4.1), and this seems a very fruitful area for future investigation. By studying observer views, we may be able to untangle the extent to which effective support is determined by perceptions of participants in an interaction, and to explore whether there are standard elements in most or all effective social support attempts that can be objectively defined. Also, if studies on third-party perspectives systematically vary the demographics of observers, we can learn about cultural differences in support. Thus naturalistic studies that involve recipient, provider, and observer perspectives of the same specific support interactions all within one research design have much to offer in the next stage of research.

Additional Factors Needing Study for Models of Support Interaction Effectiveness

In attempting to move this area of research forward, it would be useful to specify the theoretical factors determining whether a given support attempt will be effective or not, and to model the interrelationships among such factors. Many additional variables beyond those discussed here may help to predict effective support transactions. This section highlights two provider factors that may be central to improving our understanding of when support attempts succeed or fail—*provider diagnostic accuracy* and *provider support skills* (Dunkel-Schetter & Bennett, 1990). These factors are included within the constructs of social and relational competence (Jones, 1985).

Past research indicates that there is a positive relationship between the distressed person's social competence and perceived availability of support (Cauce, 1986; Heller, 1979; Heller & Swindle, 1983; Procidano & Heller, 1983; Sarason et al., 1990; Sarason, Sarason, Hacker, & Basham, 1985; Sarason, Sarason, & Shearin, 1986). However, social competence and related constructs have not been studied or developed much within the context of work on supportive interactions or received support. We focus here on the social competence of the provider of support as it influences the effectiveness of support transactions (Vaux, 1988). Our discussion of these factors is consistent with a view of social support interactions as a communication process (Albrecht & Adelman,

1987). Burleson's (1984) review and analysis of comforting communications, for example, concludes that the ability to comfort others derives in part from a combination of social perception skills and rhetorical skills.

Provider Diagnostic Accuracy

The accuracy of provider perceptions of what is needed in a particular situation is critical in determining whether a support attempt will be helpful. Many authors propose that the health benefits of support are related to the fit between the demands of the stressor and the support provided (Caplan, 1974; House, 1981; Shinn, Lehman, & Wong, 1984; Thoits, 1985). For example, Cohen and McKay (1984) argue that support will buffer the effects of stress if the support provided meets the needs created by the stressor (see also Cohen & Wills, 1985).

Similarly, a person-environment framework of adaptation has been applied to support research (Caplan, 1974; House, 1981). For example, Shinn et al. (1984) proposed that the appropriateness of the amount, timing, sources, structure, and functions (types) of support will determine whether it is effective (see also Vachon & Stylianos, 1988, on bereavement). Thus converging accounts point to the need to focus on the support provider's cognitive and perceptual skills in diagnosing what is needed in a particular situation prior to enacting specific support behaviors (Burleson, 1984). The earlier discussion of the receptivity and mood of recipients as factors in determining support interaction effects suggests that providers must attend not only to what is needed and when, but also to whether anything at all should be done.

Provider Support Skills

In addition to the accuracy of provider perceptions of recipient needs in a particular situation, the provider's behavioral support skills are an overlooked and important factor to study. Support skills are learned over one's life course and can be practiced and improved upon in adulthood. Early experience in observing and modeling the behavior of parents should be influential in the formation of adult support skills. For example, nurturing parents are likely to have more nurturing offspring. The ability to be nurturing in turn is a valuable skill in providing emotional support.

The concept of social skills may be useful in conceptualizing support skills specifically (Riggio, 1986). Also, communication research on

comforting has delineated many of the particular skills involved in certain forms of emotional support (Burleson, 1984, 1985, 1990). The topic of support skills and their developmental antecedents is a critical one for future investigation of social support interactions. A person with a very socially skilled partner or social network should stand a better chance of receiving effective support in times of need than someone with a less competent partner or network.

Conclusion

This chapter has distinguished between the determinants of quantity and quality of support, and has defined social support as a specific subcategory of the universe of all social interactions. It also has discussed some of the elements in effective support interactions, and has highlighted directions for future research and application. In discussing factors involved in support interaction effectiveness, we tried to illuminate both basic issues facing social psychologists studying helping and the relevance of these matters to professional efforts to provide help to stressed people. Many interesting social psychological variables are involved in support interaction effectiveness, and little work has been done to examine how they exert their effects or whether they interact. Furthermore, there are many implications of this work for helpers in applied settings, some of which have been noted. Like many topics in social psychology, the study of helping encompasses a rich array of closely intertwined basic and applied issues. Many aspects of supportive interactions remain largely unexplored, and they offer both promise and challenge to interested researchers.

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In Sickness and in Health: Chronic Illness, Marriage, and Spousal Caregiving

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The leading causes of death in the United States today are three chronic diseases: coronary heart disease, cancer, and stroke. Most individuals who live to early old age are likely to develop one of these diseases or another common disabling illness, such as arthritis, emphysema, or Alzheimer's disease. Thus, when newlyweds promise to be committed to their partners "in sickness and in health, for better and for worse," the chances are good that eventually this vow will be tested by the care of a chronically ill spouse.

Despite the prevalence of chronic illness and the profound changes it can bring to individual lives, there has not been a great deal of research examining the effects of a long-term illness on the marital relationship, nor on ways in which well spouses help or hinder the adjustment of their ill partners. Our program of research on stroke patients' adaptation to their changed circumstances indicates that relationships can play a major role in psychological recovery from a chronic disorder. Thus this is a particularly interesting topic both at the