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Social Support Reported by Adult Blacks with Cancer

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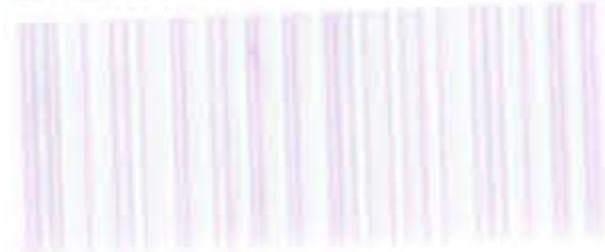
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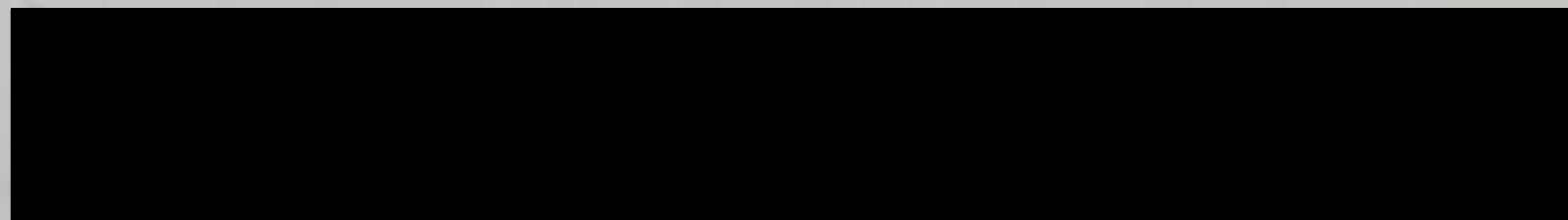
THESIS

SOCIAL SUPPORT REPORTED BY
ADULT BLACKS WITH CANCER

Lynette M. Richardson

December 10, 1987
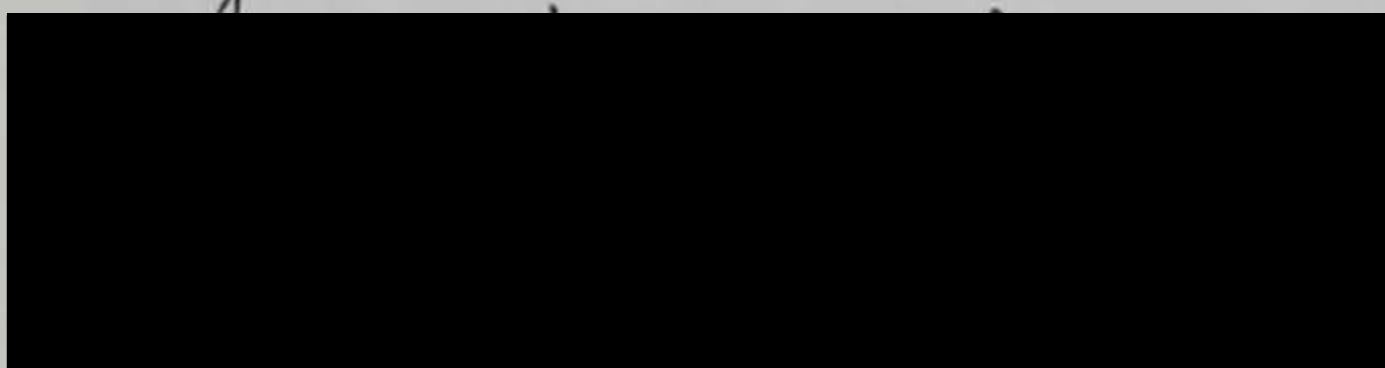
To the Graduate School:

Herewith is submitted a thesis written by Lynette M. Richardson entitled "Social Support Reported By Adult Blacks with Cancer." I recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Science, with a major in Nursing.

Thesis Advisor

We have reviewed this thesis
and recommend its acceptance:

Accepted for the Graduate School:

SOCIAL SUPPORT REPORTED BY

ADULT BLACKS WITH CANCER

A Thesis

Presented to

the Graduate School of

Clemson University

In Partial Fulfillment

of the Requirements for the Degree

Master of Science

Nursing

by

Lynette M. Richardson

December 1987

ABSTRACT

This study investigated the perceived social support network of 20 adult Black cancer clients. Support system properties, funct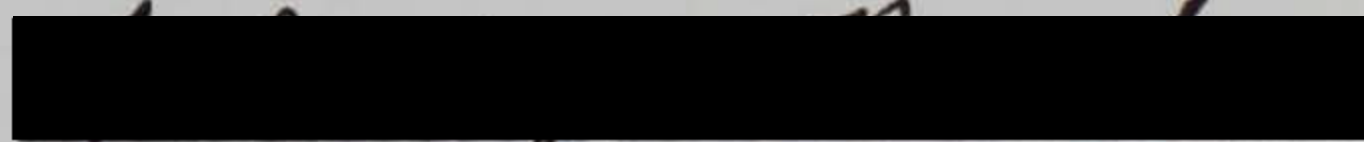ions, and quality as measured by the Norbeck Social Support Questionnaire were reported and compared to the social support data found in Norbeck's, Lindsey's and Carrieri's (1983) study of employed adults. In addition, demographics of the sample were described and examined for differences in reported social support networks. A convenience sample of State Cancer Clinic clients, 50 years of age or older, and informed of the cancer diagnosis, was studied.

Data were analyzed by descriptive, correlational, and analyses of variance statistics. Findings revealed several social support functional and network properties that were different from the original norming data. No significant difference ($p < .05$) was found in the quality of Black cancer clients' social support as compared to that reported in the normative data. The overall quality of social support was perceived as high by the Black cancer clients. There was a significant difference in the mean number of total network members reported by females in the normative study and by those in the study of Black cancer clients with Blacks having fewer network members. There was also a significant difference in quantity lost and total losses between the male Black cancer clients and the male clients in the normative study. In addition, the number of listed network members correlated with quantity of social support lost, $r = .778$, and with number of grandchildren, $r = .647$. The number of grandchildren correlated with the

quantity of social support lost, r = .866. An association was also found between religious participation and frequency of contact.

The data support the importance of social supports for Black cancer clients, and emphasize the importance of recognizing the sources of such support and incorporating these persons in the plan of care.

DEDICATION

This thesis is dedicated to God for His love and guidance, to my
parents, Ernest Roy and Olive Richardson, to my extended family,
Bertram and Marguerite Gibson, and to my loving fiancé, Ron Gibson,
for their continuous provision of affect, affirmation, and aid during my
pursuit of academic excellence.

ACKNOWLEDGEMENTS

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CHAPTER ONE

THE PROBLEM

Introduction

America is a pluralistic society; consequently, health care is
provided to persons from culturally diverse groups. In order to cope
with the many internal, external, and environmental stressors encoun-
tered, it is thought that these culturally diverse groups employ
socially supportive behaviors endemic to their cultures: these beha-
viors may influence the group's state of health, adaptation to
illness, or recovery from an illness such as cancer (Nuckolls, Cassel,
& Kaplan, 1972; Cassell, 1976; Cobb, 1976; Dean & Lin, 1977; Kaplan,
Cassel, & Gore, 1977; Pilisuk & Froland, 1978; Lin, Ensel, Simeone, &
Kuo, 1979; Unger & Powell, 1980; Lindsey, Norbeck, Carrieri, & Perry,
1981; Norbeck, Lindsey, & Carrieri, 1981; 1983). Consequently, in order
to provide genuinely humanistic care, it is vital for nurses in America
to study the perceived socially supportive persons and behaviors of
culturally diverse groups in their respective environments.

Social support has been singled out during the past four decades
as a "complex and multifaceted construct" (Wortman, 1984, p. 2340) that,
under environmental influences, effects physical health, mental well-
being, and social functioning. The construct has been studied by
scientists in various disciplines, including nursing, who have come up
with such diverse and weak definitions and measurement schemes that pro-
gress in reaching conclusions has been impeded (Tilden, 1985). Today,
the construct of social support holds "intuitive appeal for nurses in

practice and in research" and shows "promise for theory development" (Tilden, 1985, p. 199). Thus, there is a need to focus on common research goals.

One of the cultural groups which faces a vast array of socioenvironmental stressors and for whom social support has not been studied from a nursing perspective is that of the Black family in America. This group, according to Moyers (1986), is vanishing because of such factors as sexual immorality and illegitimacy. Other such "experts" attribute this condition to richly deserved poverty; and still other "experts" blame the "experts" (Johnson, 1986). While Black men generally are depicted in the media as less intelligent, less productive, more violent, and more irresponsible than White men, Black fathers specifically are described as out-of-wedlock and/or absent, and sexually immoral (Moyers, 1986; Monroe, 1987). In reality, the Black family is struggling because of such factors as "enduring poverty, violence, high drug dependency, chronic unemployment, hopelessness, and despair" (Suggs, 1986, p. 5A). Despite the immeasurable odds, however, the Black family is "resilient" (Suggs, 1986, p. 5A). Major trends that help describe Black family life are "rising levels of poverty, declining levels of income, rising levels of unemployment, declining levels of family stability, a rising underclass, and a struggling middle class" (Billingsley, 1987, p. 103).

In light of this combination of multiple stressors and limited resources, Blacks in America are "highly vulnerable to physical and psychological impairment" (Barbarin, 1983, p. 308). One such impairment is cancer, which has incidence and mortality rates higher for

Blacks than for Whites. Cancer mortality rates for Whites have increased 10 percent, while those rates for Blacks have increased 40 percent over the past 30 years (American Cancer Society, 1986). Thus, it is highly likely that at least one Black family member will contract cancer in his/her lifetime and that that member and his/her family as a whole will require immense social support in order to deal with the multitude of personal and environmental stressors impacting upon them.

Purposes of the Study

The purposes of this study include describing the perceived social support network of Black cancer clients regarding its properties, functions, and quality (specified by Likert-style ratings of affect, affirmation, and aid social support subscales) and comparing these descriptions to the normative social support data found in Norbeck's, Lindsey's, and Carrieri's (1983) study of employed adults. In addition, demographics of the sample will be described and examined for differences related to reported social support networks.

Research Questions

Three questions are addressed in this study:

1. What are the social support functional and network properties as perceived by Black cancer clients,

2. what is the the quality of social support as perceived by Black cancer clients, and

3. is the quality of Black cancer clients' social support different from the reported normative data?

Conceptual Framework

During illness, when a multitude of stressors are evident, social support is provided through the interpersonal transactions of affect,

affirmation, and aid. This support is most beneficial when it is per-

ceived as caring by the client: these perceptions of caring are

strongly influenced by the client's culture, value orientations, and

experiences. Taking these propositions into consideration, the concep-

tual framework for this study consists of social support, perceptions of

caring, and stressors.

Social Support

This study is derived from a view of humans as social beings. This

means that humans live their lives in intersubjective transactional pro-

cesses, each affecting and being affected by the other. When these

transactions are positive and support the functions and experiences of

the person, they are called social support (Paterson & Zderad, 1976).

Social support is considered a multidimensional concept: functional and

network properties are important (Norbeck, Lindsey, & Carrieri, 1981).

In this study, social support, as defined by Kahn (1979) involves inter-

personal transactions that include one or more of the following: "the

expression of positive affect of one person toward another; the affirma-

tion or endorsement of another person's behaviors, perceptions, or

expressed views; the giving of symbolic or material aid to another"

(p. 85). Thus, affect, affirmation, and aid are three functional com-

ponents of supportive transactions. Affective transactions are defined

as expressions of liking, admiration, respect, or love. Transactions of

affirmation are specified as expression of agreement or acknowledgement

of the appropriateness or rightness of some act or statement of another

person. Lastly, transactions in which direct aid or assistance is given

include the donation of money, information, time, and entitlements

(Kahn, 1979).

Caplan (1976) and McElveen (1978) identify similar elements as being characteristic of social support. Caplan (1976) states that these elements include mobilization of the individual by using psychological resources and mastery of emotional burdens through the help of significant others; sharing of the individual's tasks; and provision of material or guidance to assist in handling the situation. MacElveen (1978), while using similar concepts, lists five categories of relational functions: establishment of intimacy or safe, warm closeness where one can be expressive; social integration involving the giving and taking of experiences, information, ideas, and favors; nuturing behavior; reassurance of one's worth; and assistance through help and resources.

Convoy

Social support is provided through a vehicle known as the "convoy" (Kahn, 1979, p. 84). A person's convoy "consists of the set of persons on whom he or she relies for support and those who rely on him or her for support" (p. 84). This support is obtained as that person moves through life, either through a particular transition, such as illness; or from one geographical location to another. A key characteristic of the convoy is the giving and receiving of social support rather than merely occupying a position in a formal organization, family, or other social structure.

An individual's convoy changes over time both chronologically and developmentally. The internal structure, consisting of convoy membership, develops primarily through the performance of roles. Roles performed over the life course of an individual are bases for contact and interaction with others. The first set of roles are those established by being born into a family; for example, daughter, sister,

brother, or grandson. Other roles may be added at a later time, such as friend, student, employee, or spouse. Each role requires interaction with persons in reciprocal or dyadic relationships; daughter-parent; sister-sibling; granddaughter-grandparent; student-teacher; wife-husband; employer-employee; friend-friend; client-nurse (MacElveen, 1978). Most role expectations and requirements are made up of specifications for interpersonal behavior; many times, the actual behavior in related roles differs little from these expectations. The supportive relations of membership will continue, in some cases, to be role constrained; in other cases, the relationship grows beyond the role structure in which it originated (Kahn & Antonucci, 1980).

Kahn and Antonucci (1980) describe the use of a concentric circle diagram to depict changes in an individual's convoy over time. Their main proposition is that persons not confined to role relationships and who remain close to the focal person despite time elapsed are considered to be most supportive. The smallest circle represents the focal person, while the three larger circles represent that person's convoy. Membership in the convoy is limited to people who are important in providing social support. Those persons included in concentric circles farthest away include those least close to the focal person, such as supervisors, neighbors, professionals, and co-workers whose membership is role dependent and extremely vulnerable to role changes. The secondary circle consists of people who are perceived as being more supportive and closer than those in the tertiary circle, but whose relationships are not wholly independent of the role, and may or may not be maintained if either member loses the role. These members are less likely to be stable over adulthood. Examples include a formerly close neighbor who

has moved and whose ties are no longer being kept. The first concentric circle is made up of those close to the focal person who are perceived as very important support givers instead of merely having close family roles or relationships. Membership in this group tends to remain stable over time, despite residence or job changes. Persons include spouses, family members, and friends to whom the focal person turns in a crisis.

Properties

Formal properties of convoys can be designated according to social networks: a social network is "an abstraction or symbol used to organize thinking about a set of relationships among an individual and others with whom he interacts" (MacElveen, 1978, p. 320.). Properties of these convoys consist of two subsets: properties of the convoy as a whole and properties of the separate dyadic links between the focal person and each of the convoy members (Kahn, 1979). Convoy properties as a whole include size, internal connectedness, external connectedness, homogeneity, stability, and symmetry. These can be respectively defined as: number of convoy members, proportion of members acquainted with or related to each other directly through support-giving or receiving; number of members who are related to specific categories of other persons; similarities among members; average duration of membership; and proportion of relationships that are both support-giving and support-receiving.

Properties of dyadic links between convoys include frequency, magnitude, initiative, range, type, symmetry, duration, and capacity. These are defined as number of transactions per unit of time; importance of transactions; number and proportion of transactions initiated by the

focal person and by others; number of life domains included in trans-
actions; transactions involving affect, affirmation, or aid as the pre-
dominant content; relationships involving primarily support-giving,
support-receiving, or both; time elapsed since the inception of the re-
lationship; and maximum potential support under the circumstances of the
relationship (Barnes, 1972).

Thus, social support is a multidimensional concept that has both
functional and network properties. Functions include interpersonal
transactions that provide affect, affirmation, and aid through the con-
voy. Membership in this convoy is made up primarily of persons involved
in role relationships or dyads that change over time. There are also
several network properties both of the convoy as a whole and of the
dyads within the convoy.

<div align="center">Perceptions of Caring</div>

Social support is beneficial or not depending on whether it is per-
ceived by an individual as caring or noncaring. Perception is the mean-
ing that things have for or the mental association ascribed to things by
a person (Paterson & Zderad, 1976). More specifically, perception
involves auditory, olfactory, oral, visual, tactile, kinesthetic, and
visceral sensations and responses which convey unique meaning to men's
consciousness and inform men about their quality of being, thereness, or
degree of presence with others (Paterson & Zderad, 1976). In order for
social support to be perceived as caring by individuals, the relation-
ship between those persons and their convoy members must be a high
quality one.

The humanistic nursing experience, as described by Paterson and
Zderad (1976), best denotes the high degree of quality required. This

is defined as "a responsible searching, transactional relationship whose meaningfulness demands conceptualization founded on a nurse's existential awareness of self and of the other" (p. 3). It involves nurses' knowledge of their unique perspectives and responses, their others' knowable responses, and the reciprocal call and response, the between, as they occur in the nursing situation (Paterson & Zderad, 1976).

In the humanistic nursing experience, perceptions of caring are due to the experience being thought of as a "lived dialogue" (Paterson & Zderad, p. 25). Persons involved are seen as distinct unique individuals with whom one enters into relationship. Perceptions of caring depend on transactions that are intersubjective, authentic, available, intimate, mutual, and that involve "relating as truly present" (p. 30) through being and doing and calling and responding (Paterson & Zderad, 1976). Intersubjective transactions involve participation by both parties and are therefore interdependent; however, each person is the originator of human acts and of human responses to the other, thus making transactions independent (Paterson & Zderad, 1976). Authenticity is "self-in-touchness" (p. 4) or high degree of self-awareness, self-acceptance, or self-actualization of potential: this allows one to share with others so that one can become with these others (Paterson & Zderad, 1976). Authenticity requires that one is "existentially and genuinely present with another" (p. 6). In addition, intimacy is an openness to the "person-with-needs" (Paterson & Zderad, p. 6); it implies a sense of responsibility or regard for what is seen as the other person's vulnerability. Availability is depicted by Paterson and Zderad as "availability-in-a-helping way" (1976, p. 31), while mutuality is described as the reciprocal flow of openness in dialogue and is "felt

as the flow between two persons with different modes of being in the shared situation" (Paterson & Zderad, 1976, p. 31).

In essence, transactions that involve relating as truly present through being and doing and calling and responding are characteristic of those perceived as caring. Paterson and Zderad (1976) state that relating as truly present by being and doing is "genuine intersubjectivity" (p. 30): one's presence lies beyond comprehension, can only be invoked or evoked, has an unpredictable or spontaneous quality, and displays "openness, receptivity, readiness, availability, and reciprocity" (p. 30). They add that being and doing are interrelated inextricably: being with or being there involves one's active presence; therefore, it is a kind of doing. Being with is turning one's "attention to (the other), being aware of and open to the here and now shared situation, and communicating one's availability" (Paterson & Zderad, 1976, p. 14).

True caring is also evident in the "lived dialogue" (p. 25) that occurs during an intersubjective transaction. Communication occurs in this dialogue in terms of a "call and response" (p. 26). The lived dialogue in nursing occurs in "response to a perceived need related to the health-illness quality of human condition" (Paterson & Zderad, 1976, p. 26) of the other. This dialogue is a reciprocal activity. Clients call nurses and expect their needs to be met; nurses expect to be needed and to meet those needs. Both clients and nurses respond in sequential ways. They both "begin, interrupt, resume, or end" (p. 32) the process. Calls and responses may also be simultaneous whereby clients and nurses call and respond at the same time.

Culture

An individual's perceptions of caring are influenced to a large extent by his or her culture, value orientations, and past and present experiences. Culture is defined generally as a group's learned ways of doing, feeling, thinking, and acting that are transmitted from generation to generation: it includes knowledge, beliefs, skills, art, morals, law, customs, and any other acquired habits and capabilities (Branch & Paxton, 1976; Leininger, 1978; Murray & Zenter, 1979; McGoldrick, Pearce, & Giordano, 1982; Orque, Monrroy, & Bloch, 1983). McGoldrick (1982) expands this definition further by tying it to perception. She states that culture "plays a major role in determing how . . . we feel about life, death, and illness" (p. 4); this state- ment can again be expanded to include caring as a perceived entity. Thus, persons perceive caring according to the culture in which they are a part. True caring also involves bracketing - which enables the nurse to be present to others of differing culture and experience (Paterson & Zderad, 1976).

Value Orientation

The way which a person perceives caring is also based on his or her value orientation. This is defined as "a generalized and organized con- ception, influencing behavior of time, of nature, of man's place in it, of man's relation to man, and of the desirable and undesirable aspects of man-environment and inter human transactions" (Kluckhohn, 1951, pp. 409, 411).

Value orientations, according to Spiegel (1982) have three distin- guishing qualities: directional - they provide a program for selecting

behaviors between more or less favored alternative behaviors; cognitive
- they provide a view of the nature of the world and of human affairs;
and affective - they are never taken lightly. They are also classified
according to five common problems for which persons must find solutions:
time; activity in interpersonal relationships; the relational orienta-
tion or the preferred way of relating in groups; the man-nature orienta-
tion or how the persons relate to the environment; and the basic nature
of man or the attitudes held about innate good or evil human behavior.
In addition, there is a range of three possible solutions to each of
these problems. They are:

1. time - past, present future,

2. activity - doing, being, being-in-becoming,

3. relational - individual, collateral, lineal,

4. man-nature - harmony-with-nature, mastery-over-nature,
    subjugated-to-nature, and

5. basic nature of man - neutral/mixed, good, evil (spiegel,
    1982, pp. 38 & 39).

Every society is characterized by a dominant profile of first-order
value choices that are substituted by second- and third-order choices.
Differences in cultures are based on these patterns of preferences for
each of the solutions (Speiegel, 1982). Thus, Black persons generally
would perceive caring according to their first-order value orientations
of living in the present; valuing the Being personality type; relating
collaterally with others; being in harmony-with-nature; and viewing
human nature as neutral or mixed (Bloch, 1983).

Experience

The third factor that influences persons' perceptions of caring is
experience. Depending on past, present, or future experiences, they may

or may not perceive others' behavior as caring. The "lived dialogue" (Paterson & Zderad, 1976) is affected by how persons experience relationships with significant others, with groups of whom they become a part in different degrees, and with the other person involved in the dialogue. Past experiences include relationships with primary and secondary group members. The higher the degree of affiliation persons have had with members of these groups, especially during childhood, the greater the likelihood of behavior being perceived as caring later in life (Paterson & Zderad, 1976). The primary group includes those nuclear and extended family members who provide the person with ideas of "right-wrong," "appropriate-inappropriate," "expected-unexpected" (Paterson & Zderad, 1976, p. 45). Thus, "each family's shaded world echoes (their) procreators' familial, psychosocial-economic, religious, and experiential breadth, closely resembled or distorted" (Paterson & Zderad, p. 45). The secondary group, on the other hand, provides persons with "opportunities for relationships outside the confines of the primary group" (Watson, 1985, p. 188), such as those found with colleagues and neighbors.

Present experiences also affect one's perceptions of caring. Throughout life, one's condition of existence is affected by and desires relationship with others and is never the same as those others; however, they internalize others as part of themselves (Paterson & Zderad, 1976). Persons relate to others in "I-Thou," "I-It," and "I-We" ways (Buber, 1958). The "I-Thou" ways, or ways in which man merges with otherness, (Paterson & Zderad, 1976) involve offering the other one's authentic presence while maintaining the capacity to question. The merging of man with otherness is "the between" (Paterson & Zderad, 1976, p. 49).

Others, in client terms, include other clients, clients' families or relatives, health care workers, friends, neighbors, and so on. Man's ability to come to know and relate in "I-It" terms is man looking back and reflecting on past "I-Thou" relations (Paterson & Zderad, 1976, p. 49) which become "It," an object to be known. "I-We" relationships involve man's becoming through relationships with family members, others, and the community. When one can internalize the other person in a transaction as "Thou," caring has been perceived (Paterson & Zderad, 1976).

For one to be genuinely with another involves co-experiencing the world with that person (Paterson & Zderad, 1976). "Family, friends, and significant others are a part of this world whether they are physically present or distant" (Paterson & Zderad, 1976, p. 34). Thus, current modes of interpersonal relating reflect the past, through learned habits of response, and the future; for example, clients' concerns about their anticipated changes in interpersonal relationships due to the effects of illness.

Stressors

A stressor is defined as any factor that disturbs the body's equilibrium. Stressors that occur during illness may be both physiological or psychological and may be found in the internal and external environments of the body. The degree to which stressors affect individuals is dependent on the nature of the stressor; the number of stressors to be coped with at one time; the duration of exposure to the stressor; and past experiences with a comparable stressor (Kozier & Erb, 1979).

Cancer as a disease has many of the characteristics of stressors mentioned. It is an internal, physiological stressor that affects

individuals, including Blacks, in numerous physiological, psychological, internal, and external ways. Depending on the type, cancer can affect a large number of body systems, such as the respiratory, metabolic, musculoskeletal, and circulatory ones. It can also elicit major psychological reactions such as a decreased ability to cope with major life tasks, increased self-sensitivity, reduced intellectual processes, and decreased sense of personal effectiveness (Kozier & Erb, 1979). In addition, numerous external stressors become involved, such as decreased finances; changes in family and social activities; increased time away from work and home because of hospitalizations; and family role changes. Consequently, Black individuals with cancer require a great deal of social support in order to cope with the multitude of stressors inherent in contracting the disease.

In conclusion, the Black cancer client may perceive the social support provided by persons within his/her convoy as caring or uncaring. These perceptions vary according to his/her culture, value orientations, and experiences. In order to be interpreted as caring, such characteristics must be taken into consideration during transactions with this client.

Justification

In setting research priorities, the American Nurses' Association Commission on Nursing Research (1980) has noted the need for nurses to identify social support as one of the determinants of wellness and health functioning. In addition, nurses have begun to refine and apply the construct in clinical practice. The present study continues this trend.

One clinical population for whom social support is appropriate to study is that of cancer clients: according to Wortman (1984), social support merits "serious attention among researchers interested in predicting or facilitating positive outcomes among persons with cancer" (p. 2339). In order to predict these health and illness outcomes, however, investigators must first identify those providers and types of social support preferred. In addition, the importance of studying social support from a cultural point of view cannot be over-emphasized: the California Department of Mental Health (1982) states, "social support must be differentiated by race and ethnicity" (p. 4).

Groups of nurses have begun to study these cultural perceptions using the Norbeck Social Support Questionnaire (NSSQ) (Lindsey, Ahmed, & Dodd, 1985; Lindsey, Dodd, & Chen, 1985; Kesselring, Lindsey, & Lovejoy, 1986). This instrument has been used with three cross-cultural groups of cancer clients thus far - Egyptian, Taiwanese, and Swiss; however, it has not been utilized with any American ethnic groups. Because the present study deals with Black cancer clients in America, it provides additional normative and comparative data and facilitates instrument standardization.

The Black family unequivocally is facing the greatest crisis since the time of slavery (Johnson, 1986). These hardships have so escalated that this family structure today is said, by some, to be "crumbling" (Moyers, 1986). "New and ominous questions" (Johnson, 1986, p. 23) have been raised in all branches of the media about the future of the Black family. In Moyer's opinion, the decline of the Black family is largely attributed to a lack of strong male figureheads and a subsequent rise in single-parent homes run by women (1986). However, historical accounts

reveal that the Black family, which has always been extended, is "resilient": it has survived the slave trade with its never-ending middle passage along with two hundred years of bondage (Suggs, 1986). Contrary to popular opinion, two-parent families were the norm then: marriages were marked by fidelity and families had strong kinship bonds (Gutman, 1976). This stable family has survived amongst other "adverse social forces and stresses" (Johnson, 1986, p. 77) such as northern migration, welfare regulations, the Great Depression, poor working conditions, and unemployment (Gutman, 1976; Johnson, 1986). In addition, racial integration has changed some stable, middle-class, Black families to those which at times are alienated, frustrated, and unstable due to the difficulty they have in adapting to membership in a "subdominant racial population" while participating in "the advantaged sector of occupational and educational parameters" (Willie, 1985, p. 75).

However, the Black family "remains intact" despite "external pressures and negative signals in the world" (Leavy, 1986, p. 62). The family or kinship network is comprised of a large group of individuals who may or may not be biologically related and who expect and accept reliance on one another in times of need (Boyd-Franklin, 1982). Thus, this study seeks to examine whether or not this family or network has "endured" (Johnson, 1986, p. 77). In addition, this research is an attempt to indicate those persons within this social unit who provide support during a stressful period and the type and quality of that support. Identification of supportive persons can enable better utilization of that support system when caring for the client who has cancer.

Limitations

The following limitations of external validity may influence the results of the study:

1. The sample upon which results of this study are based is small in size. The small sample decreases the generalizability of the findings (Polit & Hungler, 1978).

2. The sample upon which results of this study are based is homogeneous in regards to ethnic group. This homogeneity decreases the generalizability of the findings (Polit & Hungler, 1978). At the same time, this allows greater confidence that results are group or ethnic related rather than being based on individuals.

3. The study uses nonprobability sampling methods. This type of sampling restricts the generalizability of the results since unknown biasing factors may exist in the sample (Polit & Hungler, 1978).

4. The subjects may respond to the questionnaires in a certain way because they perceive they are expected to; therefore, the perceived social support responses may be elicited in the research setting but may not be generalized to more natural settings (Polit & Hungler, 1978).

The following limitations to internal validity may influence the results of the study:

1. This study assumes that cancer clients will be able to identify their perceived social support networks and functions.

2. This study assumes that perceptions of social support are based on the culture, value orientations, and experiences of Black cancer clients.

3. This study assumes that Black cancer clients, as members of a cultural group historically interdependent, will perceive a higher quality of social support than subjects in the normative study reported by Norbeck, Lindsey, and Carrieri (1983).

CHAPTER TWO

REVIEW OF LITERATURE

Introduction

The literature abounds with studies of social support that
have focused on social support specifically or social support and/or
social networks. These studies correlate social support to job related
issues, stress, health and illness states, physiological processes,
family health and illness behaviors, behaviors during natural disasters,
person and personality factors, cultural factors, social skills, and
mortality. Because of the extent to which this construct has been
investigated, this literature review will focus on those studies dealing
with social support as it pertains to Blacks in America and health-
related issues such as stress; physical, psychological and social out-
comes; and illness behaviors, especially those behavior associated with
cancer.

Social Support and Stress

Several studies linking social support to stress have been carried
out. One of these, by Porrit (1979), is based on Carkhuff's (1969)
model, which deals with the assessment of social support during the
periods of crisis that individuals encounter as they move through the
life span. Two main classes of variable that are suggested as determ-
ing the outcome at each crisis point include the person's developmental
level and the quality of others' responses to the person. This study
specifically examines whether availability of social support network
members or quality of social support from these members affects crisis

outcomes. Carkhuff's (1969) results indicate that the quality of reactions to persons during crisis affects outcomes, especially when deliberate intervention (practical support, such as obtaining financial aid and encouraging emotional support by family, friends and/or community welfare agencies), is provided. The same study showed that availability alone has no effect. Thus, the outcome of a crisis depends mostly on the interaction between the coping behavior of an individual in crisis and the support elicited from the individual in crisis and the support elicited from the individual's social network.

Caplan and Killilea (1975) agreed with Carkhuff in emphasizing that practical assistance and mutual support are essential for positive stress outcomes to occur. Also, Hirsch (1980) identified cognitive guidance as the most critical variable for coping positively with stress from among four forms of interaction; while Fuller and Larson (1980) speculated that emotional support alone may not be helpful in times of crisis but the knowledge that one is a member of a "network of mutual obligations" (Cobb, 1976) should be helpful. In addition, tangible and emotional support were found to be helpful, while informational support and large social network size were negatively associated with positive stress outcomes (Shaefer, Coyne, & Lazarus, 1981).

Other studies also indicate that mitigation of stress occurs when persons perceive that they have a reliable and accessible social network rather than when they consider the size of the network only (Lowenthal & Haven, 1968; Brown, Lowenthal, & Haven, 1975; Brown, Harris, & Copeland, 1977; Langlie, 1977; Henderson, Duncan-Jones, McAuley, & Ritchie, 1978; Roy, 1978; Conner, Powers, & Bultena, 1979; Lin, Simeone, & Kuo, 1979; Hirsch, 1980; LaRocco, House, & French, 1980;

Abbey, Abrams, & Caplan, 1981; Barrera, 1981; Billings, 1981; Wilcox, 1981; Blazer, 1982; McFarlane, Norman, Streiner, 1983; Fiore, Coppel, Becker, & Cox, 1986). A concept linked with adequacy of social support is that of multidimensionality. Multidimensionality occurs if a "relationship involves engaging in at least two different kinds of activities or behaviors" (Hirsch, 1980, p. 161) important to an individual who is involved in a dyadic relationship. These multidimensional relationships have been perceived as being stronger and more reliable sources of support (Kapferer, 1969; Hirsch, 1979), especially when coupled with low density social support networks (Hirsch, 1980).

Other studies of social support deal with its stress-buffering effect (Weiss, 1974; Cobb, 1976: Pilisuk & Froland, 1978; Dimond, 1979; Eisenberg, 1979; Brandt & Weinert, 1981; Sklar & Anisman, 1981; Levine, Basham, & Sarason, 1983; Lindsey, Ahmed, & Dodd, 1985; Lindsey, Dodd, & Chen, 1985; Kesselring, Lindsey, & Lovejoy, 1986). Cobb (1976) states that social support functions as a moderating variable that facilitates coping with crisis and adaptation to change. In this way, it buffers or protects people from some of the pathological effects of stressful life situations and transitions or life events. A specific example of this cushioning effect was the trend that cancer clients who expressed more active and accepting attitudes towards their illness listed more people in their network and scored these people higher on perceived affirmation support than did clients with more passive, resigned attitudes (Kesselring, Lindsey, & Lovejoy, 1986). Other investigators agree: their studies indicate that the presence of social support reduces the risk of physical illness (Nuckolls, Cassel, & Kaplan, 1972; Cassel, 1976; Kaplan, Cassel, & Gore, 1977; Gore, 1978;

Pilisuk & Froland, 1978; Eisenberg, 1979; Sklar & Anisman, 1981; Norbeck & Tilden, 1983; Brandt, 1984).

However, Lieberman (1982) and Laschinger (1984) found no support for the contention that social resources (or supports) function as stress buffers. In Lieberman's (1982) study, the social support networks studied were not reliable, dependable, or interactive with subjects. The investigator states that the more active, intimate, and dependable the social network, the lower the role strain. On the other hand, Laschinger (1984) supposed that his/her results occurred because of the high degree of variance between the two groups of elderly subjects, aged 65-80 and over 80 years old. These subjects were generally highly functional and had a high range of health scores; thus, they did not need their families' help. Subsequently, the instrument was not sensitive enough to distinguish fine differences in such variances.

Kaplan, Cassel, and Gore (1977) hypothesize that social support is likely to only be protective in the presence of stressful circumstances. They reviewed studies that indicated three types of social support: support as gratification of basic social needs; as the presence or absence of support from significant others (for example, through illness or institutionalization); and as support defined in terms of person-environment-fit (personal need versus level of support available).

A number of studies provide support for the contention that social support mediates the relationship between specific stressors and physiological strain (Cobb, 1974; French, 1974; Caplan, Cobb, Harrison, French, & Pinneau, 1975; Gore, 1978); while others have investigated the

relationship found among social support, stressful events, and psycho-
logical distress (Dimond, 1979; Fiore, Becker, & Coppel, 1980; Shaefer,
Coyne, & Lazarus, 1981; Tilden, 1983; Ward, 1985, Cohen & Syme, 1985).

Dimond (1979) examined the effect of social support on adaptation
to stress from chronic illness. The sample consisted of 36 hospitalized
dialysis clients. Family support was measured by two subscales of the
Family Environment Scale which was developed by Niis and Israel (1974).
This scale measured family cohesion and family expressiveness. Spousal
support was measured by a 10-scale item developed by the investigator.
One question was also included to identify the presence of a confidant.
Adaptative variables were morale and social functioning changes. Family
cohesion, family expressiveness, and spousal support were positively
correlated with morale: the correlation coefficients were .44, .55, and
.44 respectively ($p < .01$). The correlation between family cohesion and
changes in social functioning was ⁻.54 with $p < .01$. The conclusion
reached was that family cohesion was related to continued functioning
during chronic illness.

A second study, by Ahmadi (1985), in which stress levels, client
satisfaction, and social support among clients of different ethnic
groups were compared, resulted in a positive relationship between
potential social support of family/friends and satisfaction with hos-
pitalization. Another positive relationship occurred between potential
social support of other hospitalized clients and subjects' stress
levels. While Black clients experienced more stress thought to be re-
lated to environment and/or nurse-client interaction, there were no
cultural differences in social network members.

In the psychologically-oriented group of studies, social support either acts in a direct manner or acts by moderating stress. Andrews, Tennant, Hewson, and Vaillant (1978) concluded that social support has a modest direct influence on psychological impairment. On the other hand, Lin, Simeone, Ensel, and Kuo (1979) found modest support for the mediating role that social support plays between stressors and psychological symptoms. More recent studies have focused on the impact that specific dimensions of social support have in buffering the effects of certain life events on psychological well-being (Barrera, Sandler, & Ramsey, 1981; Shaefer, Coyne, & Lazarus, 1981; Fiore, Becker, & Coppel, 1983; Fiore, Coppel, Becker, & Cox, 1986). For example, Fiore, Coppel, Becker, and Cox (1986) found that satisfaction with social support was the only support dimension that related significantly to psychological adjustment.

Social Support, Health, and Illness

A number of studies have linked social support with physical health (Dean & Lin, 1977; Gore, 1978; Sarason, Sarason, Potter, & Antoni, 1985) found no significant correlation between social support and physical health status; and another study that indicated a negative relationship between the quality of social support and level of health in older persons, was carried out by Laschinger (1984). Other studies have linked social support to the adoption of specific health practices, such as those which are generally preventive (Pratt, 1971; Coburn & Pope, 1974; Langlie, 1977; Hubbard, Muhlenkamp, & Brown, 1984), and those which specifically deal with decreased cigarette and alcohol use or improved diet and exercise regimens (Brownell, Heckerman, Westlake, Hayes, &

Monti, 1978: Cohen & Syme, 1985; Kranz, Grunberg, & Baum, 1985;
Liechtenstein, Glasgow, & Abrams, 1986). These results were attributed
to social network members who had a high socioeconomic status and
frequently interacted with nonkin (Coburn & Pope, 9174; Langle, 1977);
those who were members of and participated in a group (Coburn & Pope,
1974); and those who were older (55 to 90), married, and/or had a
confidant (Hubbard, Muhlenkamp, & Brown, 1984).

Conversely, a study carried out by Gierszewski (1983), found that
social support was not beneficial to successful weight reduction, es-
pecially in those persons with internal multidimensional health loci of
control as measured by The Multidimensional Health Locus of Control
Scale (Wallston, 1978). Persons with internal loci of control were
thought to lose weight according to their behavior or personal charac-
teristics (Rotter, 1966). Gierszewski (1983) suggested that social
support was perceived by these internals as a threat to their feelings
of control over their rewards. They in turn may have reacted in a
rebellious manner, thus making an effort not to eat the way that they
perceived the supportive others desired them to.

A third group of studies have linked social support to recovery
from surgery. In a study of posthysterectomy clients, a number of nega-
tive features were linked with a lack of social support. Perceived lack
of sympathy from partners and families were associated with increased
reports of postoperative tiredness while discouragement of females' ini-
tiatives in managing their recovery resulted in them experiencing
frustration and annoyance. Of note in this and a similar study reported
by Webb and Wilson-Barnett (1983) was the lack of information from

hospital staff: this contributed to a stressful and unsupported hyster-ectomy experience (Kaplan, Cassel, & Gore, 1977; Gore, 1978). Other studies have supported the finding that social support, especially from a woman's sexual partner, resulted in greater decreases in mean Help-lessness Self-Concept scores, fewer reports of complications, and a greater likelihood of resuming sexual activities earlier than those who were negatively supported (Webb & Wilson-Barnett, 1983; Webb, 1986).

In addition, there are a host of studies depicting the association between social support and mental health outcomes. One survey of persons most likely to be admitted to psychiatric facilities found that admission rates were lowest among married; intermediate among the wid-owed or never-married adults; and highest among the divorced or separa-ted (Crago, 1972). Several studies comparing persons having psychiatric disorders with various normal control populations have found the former to have networks characterized by fewer overall linkages, fewer intimate relationships, greater symmetrical and dependent relationships, and lower indices of perceived support (Tolsdorf, 1976; Cohen & Sokolovsky, 1978; Henderson, Duncan-Jones, McAuley, & Ritchey, 1978; Makiesky-Barrow, & Gutworth, 1978; Froland, Brodsky, Olson, & Stewart, 1979; Mueller, 1980).

For example, Tolsdorf (1976) compared VA psychiatric clients to VA medical clients and found the psychiatric clients to have fewer intimate ties, less reciprocity in relationships, and a greater un-willingness to utilize their networks in times of crisis. Each of the psychiatric clients in the study demonstrated a negative network orien-tation or a "belief or expectation that it was inadvisable, impossible, useless, or potentially dangerous to draw on the advice, support, or

feedback of network members" (Tolsdorf, 1976, p. 412). Qualitative data revealed that all the psychiatric clients had a history of such negative network orientations. Conversely, the majority of members in the medical group held positive network orientations: they did seek out the support and resources of network members, especially if they could not handle a problem themselves.

Other suppositions about these results were the presence and type of stress; the presence and type of network members; and the presence and type of coping responses. The medical subjects reported more intimate relationships with more people in a network that was less dominated by family members and where functional people were on an equal standing with the subject in the exchange of support, advice, and feedback compared to the psychiatric group. In addition, the medical group more frequently reported receiving help from a broad group of people than did the other group.

Another issue that emerged was the presence and type of coping responses that followed the perception of stress. Two categories were suggested by the data: individual mobilization and network mobilization. Individual mobilization was observed as being both behavioral and cognitive. Cognitive mechanisms involved problem-solving and other cognitive attempts at mastery: these usually worked well for the medical subjects. Behaviorally, individual mobilization occurred when "therapeutic withdrawal" (Wing & Freudenberg, 1961) was employed by reducing contact with the stress-producing portion of the network. Medical subjects used this withdrawal in a selective and limited fashion, while the psychiatric subjects were less selective and gradually

withdrew from all close human contacts. Network mobilization occurred as the "singularly most powerful factor" (Tolsdorf, 1976, p. 415) in differentiating the medical and psychiatric subjects.

Similar results occurred in a study by Cohen and Sokolovsky (1978). They found that schizophrenics in a single-room occupancy hotel were more likely to be rehospitalized if their networks were small, low in density, and lacking reciprocal relationships. This finding suggests that it is important to focus on the degree of support available as well as the degree to which the focal person is important to other persons in his or her network.

Another characteristic of networks that has been studied in relation to adaptation is density, which is the extent to which members of an individual's social network contact each other independently of the focal person (Mitchell, 1969). Wellman (1978) found, in a random sample of community residents, that high density networks were associated with a greater degree of perceived support; while Hirsch (1980) found that higher density networks were associated with lower self-esteem, less perceived support, and less successful adaptation in women undergoing major life transitions. Hirsch (1980) suggested that these higher density networks may put more normative pressure on members than less dense ones to maintain existing roles, thus providing less support for persons interested in effecting major life changes. In an earlier study of social networks, Hirsch (1979) found that college students in high density social networks received more social and emotional support than those in low density networks; however, those in higher density ones were significantly more dissatisfied with the emotional support provided.

Several studies have also investigated the role social support plays in specific psychiatric problems. Depression is one of the illness highlighted (Lowenthal & Haven, 1968: Miller & Ingham, 1976; Henderson, Duncan-Jones, Auley, & Ritchie, 1978; Henderson, Fiore, Becker, & Coppel, 1983; Krause, 1986). The classic study by Lowethal and Haven (1968) suggested that the presence of a confidant serves as a buffer against gradual social losses in role status and interaction as well as against more sudden losses associated with retirement and widowhood. Thus, those with a confidant tended to be less depressed. Persons more likely to have a confidant were female, 65 to 74 years old, married, and of a high socioeconomic status. Lower socioeconomic men were more than twice as likely to report a friend and not a spouse: the investigators connected this with "problems of masculine role and identity" (p. 29) - these men considered close association with women a sign of weakness. Persons identified as confidants for the majority of subjects were predominantly spouses, children, and friends. Siblings or other relatives were rarely named. Husbands were least frequently mentioned by wives and wives most frequently mentioned by husbands. Women were also twice as likely as men to mention a child or other relative, and more likely to name friends.

Studies reporting similar results include those by Vaughn and Leff (1976) and Leveton, Griffin, and Douglas (1979). In the former study, it was shown that the withdrawal of social support in neurotically depressed individuals increased the risk of relapse. Other studies indicated that the loss of support in normal persons resulted in depression, suicide, and low morale (Lowenthal & Haven, 1968; Maris, 1969).

Investigators have studied the effects of available versus non-available social support on psychological health also (Tolsdorf, 1976; Shaefer, Coyne, & Lazarus, 1981; Fiore, Becker, & Coppel, 1983; Procidano & Heller, 1983; Sarason, Levine, Basham, & Sarason, 1983; Tilden, 1983; Fiore, Coppel, Becker, & Cox, 1986). One study of college students, for example, concluded that perceived social support from friends (PSS-Fr) and perceived social support from family (Pss-Fa) were inversely related to symptoms of distress and psychopathology with a stronger relationship existing for perceived social support from family (Procidano & Heller, 1983). This study was based on the premise that perceived social support from family and friends were better predictors of symptomatology than life events or social network characteristics.

Another study (Sarason, Levine, Basham, & Sarason, 1983), was involved with the use of the Social Support Questionnaire (SSQ) to identify the number of perceived support people in a person's life, the degree to which these people were personally satisfying, and the relations of these to desirable and undesirable life events, perceived adequacy of childhood relationships, personality characteristics (depression, anxiety, hostility, extroversion, and self-esteem), and outlook toward the future. The investigators compiled a questionnaire consisting of 27-items. Each item asks a question to which all associated social support persons (for example, L.R. [brother]; R.G. [sister]) as well as a 2-part answer are requested (listed social support persons and satisfaction with those persons' social support). A sample question is "Whom can you really count on to listen to you when you need to talk?" (p.129). The questionnaire was given to 100 male and 127 female college students.

Results generally indicated that social support was inversely related to states of psychological discomfort. For women, low social support was associated with unpleasant memories of early parent-child relationships. For men and women, the number of members and satisfaction with social support correlated significantly and negatively with anxiety and depression. Women's hostility scores were also significantly negatively correlated with the number of network members and satisfaction with social support. Male scores demonstrated similar results when compared with hostility but this relationship was not as strong. Thus, women with low social support scores were less happy and more introverted than women with high social support scores. It was suggested by the investigators that sex differences may have related to women's tendency to report more symptomatology than men, especially those related to affect (Weisman & Kierman, 1979).

Other investigators have constructed measures of social support which vary from the simple identification of confidants and acquaintance (Miller, Ingham, & Davidson, 1976; Miller & Ingham, 1976) to simple (Barrera, 1981) plus complex and comprehensive interview formats (Henderson, 1980; Hirsch, 1980; Fiore, Becker, & Coppel, 1983) to assessments of social support type and frequency (Barrera, Sandler, & Ramsay, 1981; Brandt & Weinert, 1981; Norbeck, 1981; Norbeck, Lindsey, & Carrieri, 1983; Fiore, Becker, Coppel, & Cox, 1986). Of note is Fiore, Becker, and Coppel's (1983) interview, which measures the degree to which relationships are perceived to be helpful and upsetting with respect to each of five different categories of social support. The five categories include socializing (Weiss, 1974; Cobb, 1976; Berghorn & Shaefer, 1979; Lin, Simeone, Ensel, & Kuo, 1979; Hirsch,

1980; Henderson, 1981); tangible assistance (Dean & Lin, 1977; Berghorn & Shaefer, 1979; Hirsch, 1980; Barrera, 1981; Wellman, 1981); cognitive guidance (Hirsch, 1980; Barrera, 1981; Wellman, 1981); emotional support (Antonovsky, 1974; Caplan, 1974; Cobb, 1976; Henderson, 1980); and self-disclosure (Henderson, 1980). Subsequently, it can be seen how multidimensional the construct of social support is.

Determinants of Social Support

Social support may or may not be perceived as being helpful by persons, especially those who are ill. In some ill clients, the presence of strong interpersonal support and perceived adequacy of support are viewed as psychosocial assets that contribute to successful coping and are therefore associated with positive outcomes (Carey, 1974; Maguire, 1976; Cobliner, 1977; Grandstaff, 1977; Bloom, Ross, & Burnell, 1978; Gibbs & Achterberg-Lawlie, 1978; Jamison, Wellisch, & Pasnau, 1978; Northouse, 1981). However, a lack of interpersonal support or negatively perceived social support may be due to a variety of factors, such as personal attributes and social competence.

Personal attributes, such as age, sex, marital status, cultural group, income level, and physical and personality characteristics, may influence the availability of social support. The amount of social support available increases during young adulthood and stabilizes during the period from 35 to 55, according to a study by Kahn (1978). Norbeck (1981) adds that decreased opportunities for social support and a decrease in social network members occurs with age. Sex differences also play a factor in social support availability: females receive more social support than men and have larger social networks than males

(Lowethal & Haven, 1968; Burke, 1978; Hirsch, 1979; Sarason, Levine, Basham, & Sarason, 1983). Also, married persons are more likely to have a confidant than are widowed persons, widowed more likely than divorced or separated persons, and divorced or separated more likely than single persons to have a close confidant (Lowenthal & Haven, 1968). In a study by Hays and Mindel (1973), Blacks were found to interact more frequently with extended kin and receive a greater amount of help from their kin than did their White counterparts. Social support has also been found to increase when support groups are utilized: such groups are generally attended by more educated and affluent middle-class women (Weiss, 1976; Cronenwatt, 1980); however, behaviorally-oriented self-help groups are usually comprised of working-class individuals, including men (Knight, Wolert, & Levy, 1980). Personal factors that are linked with decreased social support availability or use are poor social integration (Croog, Lipton, & Levine, 1972); social isolation (Renne, 1974); and poor quality of parental involvement in childhood (Sarason, Sarason, Hacker, & Basham, 1985; Sarason, Sarason, & Shearin, 1986).

In addition, physical and personality characteristics influence the availability of social support. In a study by Sarason, Sarason, and Shearin (1985), women who had more social support were rated as being more physically attractive than men. Also, self-perceived social support correlates with several personality characteristics, such as anxiety, depression, hostility, and locus of control (Justice & Swenson, 1980; Sarason & Sarason, 1982; Sarason, Levine, Basham, & Sarason, 1983).

Another variable that may influence an individual's social support is social competence, which is the use of skills that "allow a person to

regulate his/her behavior according to social cues provided by others" (Wortman, 1982, p. 2355). Sarason, Sarason, and Shearin (1985) found that people who describe themselves as low in number of social supports are less favorably evaluated by the subjects with whom they interact than those high in social support: while persons low in social support are described as less likeable and effective than high social support persons, high social support persons, especially females, are associated with self-rated assertiveness and dating skills (Procidano & Heller, 1983). Women are found to be significantly more socially skilled than men (Sarason, Levine, Basham, & Sarason, 1983). Thus, social competence, sociability, ability to empathize with others, and social problem-solving skills are associated with a higher level of social support. A key contributing factor to social competence is the "predilection to seek support" (Wortman, 1982, p. 2355): support is sought according to the beliefs and values held regarding the moment that others should be called on for help (Eckenrode & Gore, 1981). Thus, a significant relationship exists between positive beliefs about help-seeking and support mobilization (Eckenrode, 1983).

Consequently, social support in general is perceived negatively or positively by people according to certain characteristics that they possess. These include personal attributes and social competence.

Social Support and Cancer

Social support is a powerful variable and constitutes an important resource in coping with cancer (Norbeck, Carrieri, Lindsey, & Perry, 1981; Northouse, 1981; Bloom, 1982; Maxwell, 1982; Peters-Golden, 1982; Wortman, 1984) because the uncertainties, fears and stigma experienced

by a person diagnosed with the disease (Public Attitudes Toward Cancer, 1980; Dimatteo & Hays, 1981; Greer & Silberfarb, 1982) are likely to result in an enhanced need for social support (Sutherland, Orbach, Dyk, & Bard, 1952; Carey, 1974; Lieber, Plumb, Gerstenzang, & Holland, 1976; Schwartz, 1977; Ferlic, Goldman, & Kennedy, 1979; Vachon, Lyal, & Rogers, 1979; Weisman, 1979, Bloom, 1982). However, the availability of social support is related to the degree of threat, discomfort, and re-jection experienced by those around the cancer victim; the more unfortu-nate a person's plight or the more distress the person shows, the more threatened, uncomfortable, and rejecting others may become. Hence, individuals in greatest need of social support, such as cancer clients, who have difficulty coping or have a poor prognosis, may be least likely to get it (Coates, Wortman, & Abbey, 1979; Dunkel-Schetter & Wortman, 1982). Consequently, they experience problems in their interpersonal relationships. These problems may occur in relationships with family, health professionals, friends, and acquaintances (Dunkel-Schetter & Wortman, 1982). A significant aspects of relationship difficulties concerns communication (Cooper, Alpert, & Kipnis, 1980).

Communication difficulties may arise because of client avoidance by others and avoidance of others by the client. Two particular factors may inhibit the client from approaching family, friends, and health care professionals and discussing his or her feelings. First, cancer clients may fear that open discussion of feelings about the illness will upset or hurt family members in particular because the client perceives them as being already overburdened (Harker, 1972; Bean, Cooper, Alpert, & Kipnis, 1980). Second, clients, may believe that it is inappropriate to

discuss feelings or concerns with others, especially health profession-
als (Dunkel-Schetter & Wortman, 1982). On the other hand, those around
the client may physically avoid him or her, avoid open communication
about the disease, or behave in a discrepant manner. Health care pro-
fessionals often avoid cancer clients (Pinkerton & McAleer, 1976;
Schulz, 1978), especially when the client's condition is deteriorating
(Glaser & Strauss, 1967; Kastenbaum & Aisenberg, 1972; Artiss & Levine,
1973; Fosson, 1980). Investigators have also reported avoidance by
friends (Greenleigh & Associates, 1979; O'Malley, Koocher, Foster, &
Slavin, 1979; Silberarb, Maurer, & Crouthamel, 1980) and family (Dyk &
Sutherland, 1956; Greenleigh & Associates, 1979).

Avoidance of open communication about cancer may also be found.
For example, Jamison, Wellisch, and Pasnau (1978) found that 89 percent
of the clients who had mastectomies in their sample reported having had
little or no discussion about their condition while hospitalized, and
50 percent reported this after returning home. In addition to a de-
crease in communication, discrepancies between clients' and family
members' perceptions of the others' perspectives may occur. One study
demonstrating this discrepancy indicated that 46 percent of clients felt
that family members knew they had a malignancy; whereas 87 percent of
family members actually reported that they did (Krant & Johnson, 1977-
1978). Other persons who are involved with decreased open communication
include friends and health personnel, who may be trying to conceal their
feelings (Quint, 1965; Vachon, 1979). Reasons for discouraging the
expression of feelings include a conflict in beliefs regarding what is
good for the client (Kastenbaum & Aisenberg, 1972; Garfield, 1977;

unpleasantness (Kastenbaum & Aisenberg, 1972; Buehler, 1975); intensi-
fied negative feelings; and difficulty controlling those feelings
(Parkes, 1972).

Discrepancies in behavior are likely to occur because of the under-
lying conflict between negative feelings about the cancer client and
beliefs concerned with how to respond to him or her. The client is
often aware of negative nonverbal behaviors and finds them disturbing
(Dunkel-Schetter & Wortman, 1982). Particularly in family members,
discrepancies between verbal behaviors in a given context; behaviors in
different situations and at different times; and between expressed
intentions and subsequent behaviors are especially frequent, largely
because of the exhaustion that family members experience while providing
care for the client (Dunkel-Schetter & Wortman, 1982).

One motive for the avoidance of physical contact and open communi-
cation is confusion about the cancer client's social support needs
during the various stages of the disease. Many of these stages are ex-
tremely difficult for both the client and supportive others to handle.
A number of investigators have come up with psychosocial stages and
their associated feelings and behaviors: these stages usually parallel
the recognized physiological ones. Weisman (1979) has postulated four
dealing with cancer: the existential plight; mitigation and accommoda-
tion; decline and deterioration; and preterminality and terminality.

The existential plight begins with diagnosis and ends at around
100 days, when the initial distress subsides. Two substages, impact
distress and the existential plight proper, make up this stage. Impact
distress occurs at the moment a client first learns definitely that he/
she has cancer. It is an "alarming moment." One third of the research

clients see "death as a real possibility, regardless of treatment, prognosis, or site" (Weisman, 1979, p. 86). The chief sign therefore, is the predominance of life/death concerns, which revolve around worries about health/physical symptoms.

The existential plight proper includes impact and stretches to the point when primary treatment ends or when the client attempts to resume ordinary life. Distress is most likely proportional to the severity of physical symptoms. In a study by Weisman and Worden (1976-1977), having vulnerability is the "emotional or psychosocial distress that develops in response to a predominant concern or accompanies a problematic period" (p. 4). The strength of the vulnerability will determine effectiveness of coping as the disease progresses. In their study, cancer clients had higher average vulnerability during the first 100 days than in the second, when they came to terms with the facts and circumstances of their illness. Those clients who had higher emotional distress, which was manifested as fear of abandonment, loss of control, loneliness, pain, panic, and fear of the unknown, had many regrets about the past, were pessimistic, came from a multiproblem family, and had marital problems. The widowed or divorced and clients who anticipated little or no support from others had higher vulnerability when married or single clients. Although vulnerability increased with advanced staging and increased symptoms, psychosocial distress crossed diagnostic and prognostic boundaries at the time of diagnosis.

The second stage, mitigation and accommodation, occurs at the time of established disease. It can last indefinitely and ranges from clients who have an early and permanent remission or cure to those who remain sick and worsen. This stage is measured by the dissipation of

distress and regaining of accommodation. Many clients, despite posi-tive physical outcomes and lack of progression, remain subclinically vulnerable and thus have difficulty accomplishing this stage. Examples of behaviors and feelings that they experience include "loss of morale, persistent health concerns, and private preoccupations" (p. 87).

The transition to stage 3, decline and deterioration, sometimes occurs without obvious physical changes. However, symptoms associated with this stage include weight loss, fatigue, irritability, anorexia, and depression. Clients without evidence of recurrence may suddenly "slip" (p. 8) into decline and deterioration. Once this stage is reached, only palliative treatment is provided: the client has reached a "point of no return" (p. 8). Preterminality occurs next and signifies accelerating irreversibility - dying begins. Persons in this stage tend to yield active responsibility either by asking for help or withdrawing from further efforts to help themselves. The client is frequently obtunded or semicose (Weisman, 1979).

Other ways of categorizing the psychosocial stages of cancer in-clude crisis points - time of diagnosis, beginning of treatment, nega-tive physical reactions to the treatment, failure of conventional treatments, the end of a treatment protocol, metastasis, the initiation of research treatments, termination of active treatment, and point of terminal illness (Christ, 1983). Dissynchrony of coping between clients, family, and health care staff is more apparent at these crisis points (Christ, 1983). Responses to cancer in general, such as the direct communication found in the initial stage (Abrams, 1966), as well as behaviors and feelings experienced during the "follow-up period" (p. 318), the advanced stage and the terminal stage (hostility; fear of

loneliness, abandonment, and dying; withdrawal; and detachment) comprise
another categorical method. It is suggested that different types of
support should be provided during the various stages of cancer (Abrams,
1966; Moos, 1977; Jamison, Wellisch, & Pasnau, 1978; Lindsey, Norbeck,
Carrieri, & Perry, 1981); for example, diagnosis - provision of informa-
tion; hospitalization for extended periods - tangible support; extended
illness, especially when experiencing physical changes - emotional
support (Moos, 1977).

Several studies have been carried out that emphasize the associa-
tion between breast cancer and social support. In one study of breast
cancer clients by Bloom (1972), findings were that social support: "was
the strongest predictor of coping response and (had) a direct effect on
three measures of adjustment: self-concept, sense of power, and psycho-
logical distress" (p. 1335). The investigation of types of social
support that have been linked specifically with recovery from mastectomy
has been carried out by Funch and Mettlin (1982) who found that social
support from one's doctor and family influenced psychological adjustment
to breast cancer but had no effect on physical recovery; however, finan-
cial support did appear to influence physical recovery. Other types of
social support linked with recovery from mastectomy include those avail-
able from spouse and friends (Cobliner, 1977; Worden & Weisman, 1977;
Jamison, Wellisch, & Pasnau, 1978; Woods & Earp, 1978; Norbeck,
Carrieri, & Perry, 1981). Emotional support, in particular, has been
associated with positive effect on self-esteem and feelings of self-
efficacy (Bloom, Ross, & Burnell, 1978; Ferlic, Golman, & Kennedy,
1979).

Other studies have linked professional and financial support with outcomes from breast surgery. Studies dealing with professional support have focused on the physician-client relationship: client satisfaction with care was significantly positively associated with functional outcome (Kane, Gardner, & Wright, 1977; Wooley, Hughes, & Wright, 1978). Women with financial support, on the other hand, were found to be less vulnerable to additional problems (Weisman, 1976).

One study showed that a wide range of physical recovery symptoms were significantly related to perceived financial support (Funch & Mettlin). The investigators suggested that income level was not as important as having sufficient insurance coverage. One way in which inadequate insurance coverage could affect recovery is if a woman is prohibited from obtaining a desired prosthesis due to a lack of knowledge of partial coverage by federal health benefits. The altered body image that results may inhibit the resumption of normal activities. Another explanation was that reported income may be an inaccurate measure of financial status, especially for elderly subjects, who most likely report social security and retirement funds and withhold re- porting savings and other investments. Of particular note in this study were results that none of the physical recovery symptoms were related to perceived emotional or professional support. The investigators suggested that these findings occurred because the women saw their phy- sicians more frequently, thereby increasing opportunities for communica- tion and information exchange.

Thus, specific sources of social support for postmastectomy clients include kinship networks (spouse/partner, family members, and relatives)

social and role networks (friends, neighbors, and work associates), professional networks (health care providers and other professionals), and community networks (church, community groups, and agencies). It was found that the greatest support received in the aforementioned studies was from family, friends, and other friends who had had a mastectomy (Maguire, 1976; Norbeck, Carrieri, & Perry, 1981).

Three studies have specifically been carried out on social support and social networks as perceived by cancer clients from varied intercultural groups. These studies incorporate the overall function of social support as a buffer for stressful life events such as cancer. In so doing, the studies focus on the constructs of social support and culture. Kahn's conceptual definition of social support is used in each of the studies. He defines this as interpersonal transactions that include one or more of the following: "the expression of positive affect of one person towards another; the affirmation or endorsement of another person's behavior, perceptions, or expressed views; the giving of symbolic or material aid to another" (Kahn, 1979, p. 85).

The Norbeck Social Support Questionnaire or NSSQ (Norbeck, Lindsey, & Carrieri, 1980) was developed to measure the social support network, its properties, social support functions, and quality of that social support. Subjects are expected to rate each of their network members on a Likert scale, as to how much these members provide affect, affirmation, and aid.

In addition, network properties of social support are specified. The network properties include number in the network, frequency of contact with network members, and duration of relationship with members listed. Loss of network members and loss of support previously provided

by these lost members are also specified. Individuals listed are identified according to nine social support network categories. Persons in these categories act with the focal person, who is the client, in dyadic relationships. The sources include spouse/partner; family members/relatives; friends; work/school associates; neighbors; health care providers; counselors/therapists; religious persons; or others.

This network of persons through which social support is provided has been given the term "convoy" (Kahn, 1970), which depicts the image of movement, or the changing groups of people who may accompany a person at different stages or situations of his life. The items loss of network members and loss of support previously provided by these lost members are included to convey changes in the convoy structure over time. Thus, network properties and categories of people the network contains may vary throughout the lifetime of a person and may be influenced by the culture and society in which that person lives. Consequently, the perceived functions of social support; the social support network and its properties; and the quality of that social support may vary during a person's lifetime and may also reflect social trends within a culture and across cultures.

The collection of normative data, as well as instrument testing, were carried out during two different phases of development of the Norbeck Social Support Questionnaire with American subjects (Norbeck, Lindsey, & Carrieri, 1981; 1983). In the first phase, two groups of subjects were utilized: 75 first year Masters' in nursing students; and 60 senior nursing students enrolled in a baccalaureate program. The Masters' students were comprised of one male and 74 female nurses: their mean age was 30.3 and average level of education was 4.4 years of

undergraduate education. The ethnic composition was 92 percent White,
3 percent Asian, 1 percent Hispanic, and 4 percent other; marital status
was 43 percent single, 37 percent married, and 20 percent divorced or
separated. These students were tested during their 2nd week on campus
to prevent the development of extensive relationships among student
peers.

The Norbeck Social Support Questionnaire was administered to the 75
group one subjects initially; 67 of these subjects participated one
week later for the retest. Average ratings on each support category
for individual network members were affect, 4.14 (quite a bit); affirma-
tion, 3.81 (moderately to quite a bit); aid, 3.07 (moderately); duration
of relationships, 4.30 (2-5 years); and frequency of contact, 3.29
(monthly to weekly). Also, both high test-retest reliability (.85 to
.92) and internal consistency (.89 to .97) were demonstrated. The in-
strument also appeared to be free from the social desirability response
bias. The basis for content validity was the use of conceptual defini-
tions for social support (Kahn, 1979) and network properties (Barnes,
1972).

Since social support has been found to correlate with psychiatric
symptomatology (Lin, Simeone, Ensel, & Kuo, 1979; Schaefer, Coyne, &
Lazarus, 1983) and has been theoretically related and widely studied as
a moderating variable for life stress, these variables were studied to
determine construct validity. The Profile of Mood States (POMS) was
used with 75 subjects from Group 1 to compare its subscale with the
Norbeck Social Support Questionnaire functional subscales. None of the
mood subscales or the total negative mood score were significantly

correlated to the Norbeck Social Support Questionnaire functional subscales (.03 to .10), total functional (.03 to .16), or total network (.02 to .20) score. However, total loss showed a low but significant level of association with the depression subscale (.24) and to the confusion subscale (.26), both at the .05 Alpha level.

To study social support as a moderator of life stress, 33 subjects from the second group were given the Norbeck Social Support Questionnaire, the Sarason Life Experiences Survey, and the Profile of Mood States. When the comparison was made with the three main variables from the Norbeck Social Support Questionnaire (affect, affirmation, aid), there were no significant results. However, the instrument did demonstrate sensitivity to the differences in convoy changes that occurred as a result of losses when groups 1 and 2 were compared.

In the second phase, three studies were employed to look at normative data and construct validity; sensitivity, and stability; and concurrent and predictive validity. In the first study, the sample consisted of 136 staff employees at a large university medical center. There were 47 males and 89 females who were studied to obtain normative data and construct validity. The mean age was 35.8; the mean number of years of education was 15.9; nearly 42 percent were married; 61 percent listed their spouse or partner as their significant other; and 71.3 percent were White. The average ratings on each subscale per person were affect, 4.02 (quite a bit); affirmation, 3.71 (moderately to quite a bit); aid, 3.56 (moderately to quite a bit); duration of relationships, 4.40 (2-5 years); and frequency of contact 3.65 (monthly to weekly). These results were basically the same as those obtained in the first phase.

Social support network members listed by the greatest number of subjects were family members or relatives (97.1 percent) and friends (94.1 percent). However, approximately 90 percent of the subjects did not list anyone in the following categories: health care provider, counselor or therapist, or minister/priest/rabbi. The investigators suggested that this may have occurred because the sample was a non-clinical one. Half of the subjects included work or school associates, but only one-sixth included neighbors in their network. Mean scores reflecting the relative contribution of each network category were obtained by calculating the highest mean number of persons listed in each category. These results were: friend category - 43.7 percent and family or relatives - 35.9 percent. Frequency distributions showed that 32.4 percent of the subjects listed 6 or more friends, while 27.9 percent listed 6 or more family members or relatives.

Construct validity was demonstrated by statistically significant correlations between the Norbeck Social Support Questionnaire composite variables and 2 interpersonal needs found in the Fundamental Inter-personal Relations Orientation (FIRO-B) (Schulz, 1978). This instrument contains six 9-item subscales measuring "expressed" and "wanted" aspects for each of 3 interpersonal needs: inclusion, affection, and control. The two interpersonal needs that significantly correlated with the Norbeck Social Support Questionnaire subscales were inclusion (affect, .26; affirmation, .26; aid, .18) and affection (.26, .27, .20 respec-tively). The investigators suggested that these small to moderate correlations indicate that one's interpersonal needs for inclusion and affection are related to their self-reports of the amount of social support available to them.

Other results from the second phase dealt with sensitivity and stability of the instrument as well as concurrent and predictive validity. Study 2 examined sensitivity and stability of the Norbeck Social Support Questionnaire to changes over time. The Norbeck Social Support Questionnaire was mailed 7 months after the first phase to master's degree-seeking students, 44 of whom responded. The students were female, all White except one; had a mean age of 30.9; and had a mean educational level of 4.27 years of undergraduate education.

Thirty-eight percent were single; 40.9 percent married; and 20.5 percent divorced or separated. Stability of the Norbeck Social Support Questionnaire over a 7-month period was high, ranging from .58 to .78. The consistent pattern of a decrease in the family or relatives category ($\underline{t}$ (43) = 1.99, $\underline{p}$ = .023) in providing total functional support ($\underline{t}$ (43) = 2.036, $\underline{p}$ = .023) and in frequency of contact ($\underline{t}$ (42) = 2.80, $\underline{p}$ - .008) and an increase in the neighbor category ($\underline{t}$ (43) = 2.18, $\underline{p}$ = .035) and in frequency of contact ($\underline{t}$ (42) = 2.08, $\underline{p}$ = .044) occurred over the 7-month period. Although the mean number of persons listed in the friends category did not change, the actual composition of that network did. When network lists were compared, it was found that subjects had substituted new friends as follow-up for those who were dropped from the initial network list. The investigators suggested that these changes reflected both the substitution of new friends from the graduate peer group and the geographic relocation changes required in order to attend graduate school (decrease in family or relatives and increase in neighbors). Thus, the tool was sensitive to changes in the convoy through geographic relocation and further education.

Concurrent and predictive validity were established in the third study dealing with 55 female graduate nursing students. The majority were White (87.3 percent); the others were Asian and Hispanic (3.6 percent each); and Black, Native American, and other (1.8 percent each). Their mean age was 32.9; average level of education was 4.35 years beyond high school; and marital status was 40 percent single, 38.2 percent married; 20 percent divorced/separated, and 1.8 percent widowed. Concurrent validity was tested with a global social support questionnaire know as the Personal Resource Questionnaire (PRQ) developed by Brandt and Weinert (1981). Predictive validity was tested in relation to the stress-buffering role of social support as depicted in the literature (Cassel, 1976; Cobb, 1976; Wilcox, 1981). Correlations between the Norbeck Social Support Questionnaire and the Personal Resource Questionnaire indicated medium levels of association (.35 to .41) between the functional components of the Norbeck Social Support Questionnaire and Personal Resource Questionnaire; while lower significant levels of association between most of the network properties of both instruments were established (.24 to .32).

In order to establish predictive validity, the Norbeck Social Support Questionnaire was administered with the Negative Life Scale, a life stress measure. In so doing, the main effects and interactions of social support and life stress on the total negative mood score obtained from the Profile of Mood States were tested. Affect and aid accounted for 2 1/2 percent of the variance, but this was not significant. When the network properties were analyzed, a significant main effect was found for the duration of relationships subscale (11.7 percent) in predicting negative mood. A significant main effect was also found for the

following two significant interactions: the product of life stress and duration of relationships (7.6 percent) as well as the product of life stress and aid (13.2 percent) in predicting negative mood. The amount of variance accounted for the social support subscales and their inter- actions with life stress was 19 percent for separate functional subcales and 20 percent for separate network subscales. When the composite score for total functional support was substituted for separate scores, the results were 1.9 percent for total functional and 1.2 percent for total total composite network. Consequently, the investigators emphasized that the subscales should not be combined into a total score if the effect is 1 percent from one subscale or its interaction term.

In addition, the importance of stability of the convoy was demon- strated through the significant main effect and interaction found for duration of relationships on negative mood. This subscale accounted for a higher percentage of variance than any of the functional support variables; therefore, the inclusion of network properties is supported.

Three additional studies use the Norbeck Social Support Question- naire to investigate perceptions of social support network and quality by Taiwanese (Lindsey, Dodd, & Chen, 1985); Egyptian (Lindsey, Ahmed, & Dodd, 1985); and Swiss-German (Kesselring, Lindsey, & Lovejoy, 1986) cancer clients. Similarities were found in all three cultures. The category with the most members was the family/relatives one, which comprised 60 percent (Taiwanese), 57.5 percent (Egyptians), and 54.8 percent (Swiss-German) of the total network. In addition, this cate- gory provided very little, if any, functional support. Also, all three cultures perceived their networks as stable, since the duration of their relationships was approximately 5 years.

Differences were also reported among the three cultures when compared with the normative group (American sample). The Egyptian clients had the highest mean number of persons perceived as most supportive - 14.8 compared with 12.2 (American), 10.25 (Taiwanese), and 9.3 (Swiss-German). These numbers were reflected in mean total functional scores, which were 304 for the Egyptian clients (representing "quite a bit" of support), compared with 202 for the American sample ("moderately to quite a bit") and 169 for the Swiss-German clients. Average frequency of contact was also highest for the Egyptians (weekly or more), compared with the Swiss-German (> once/month); and the Americans (monthly to weekly). In addition, the Egyptian sample had the highest percentage of married clients (90); while the percentage of married Taiwanese was 85; and those of the Swiss and American samples were 69 and 41.9 percent respectively. These differences were reflected in the clients' perceptions of high quality support. For example, 92 percent of the married Taiwanese clients indicated the spouse as provider of the greatest amount of support; while the Egyptians perceived their spouses as providing more support than persons in the other categories. Lastly, the high percentages of widowed Swiss-German clients (21.4 versus 10 percent Taiwanese; 2.2 percent American) and older aged Swiss-German clients (58 years compared to 48 - Taiwanese; 45 - Egyptian; 34 - American) many have been related to the high percentages of past year losses (32 percent - Swiss-German; 22 percent - Egyptian; 15 percent - Taiwanese).

Social Support in the Black Culture

A few studies have been carried out to depict social support in the Black culture. One such study, by Raymond, Rhoads, and Raymond (1980),

compared family social involvement among Chicanos, Blacks, and Whites. Blacks and Chicanos attached more importance to family relationships than Whites; however, Blacks attached more significance to other social relationships than did the other two cultural groups. Also, although there was no difference in satisfaction with social relationships, Black respondents were more satisfied with family relationships than the Chicano and White respondents were.

Two other investigations, by Ball, Whorheit, Vandiver, and Holzer (1979; 1980), compared the significances of family and friend relationships for low-income Black and White females. In the first study (1979), Black females reported significantly more relatives living in close proximity and perceived themselves to be in frequent contact with those relatives. The White females, however, requested assistance from relatives significantly more often than the Black females did. The 1980 study resulted in no significant differences between the Black and White low income females with respect to having friends who lived close by, frequency of contact, or perceived helpfulness of friends in aiding with major problems.

In addition, a study by Steward and Vaux (1986), was designed to obtain information on social support network members, behaviors, and perceptions among Black and White college students. Results indicated that similar network members with high levels of support existed: each group identified approximately 18 unique members and 7 to 8 of these provided all 6 modes of support - material aid, behavioral assistance, intimate interaction, guidance, feedback, and positive social interaction (Barrera & Ainsley, 1983). In addition, the relationships

involved frequent contact; were close, balanced, and complex; and con-
sisted of more than 90 percent family and friends of the same ethnicity.
Significant differences did occur: the Black students indicated more
closeness and labeled fewer friends than the White ones. When results
were disaggregated for sex, the same results occurred, but only in
females; however, Black females had significantly less emotional sup-
port from friends. Lastly, both groups had high levels of perceived
social support: while there were no differences between the groups on
either the total scale or on the family or friend subscales among the
total sample, the Black females experienced significantly more support
from their family compared to White females.

Finally, an investigation carried out by the California Department
of Mental Health (1982) was designed to specify social support network
members and types as perceived by various ethnic groups. Results were
compared with the norm. The study indicated that multiplex support (the
multiple functions, for example, informational, material and emotional
support, that are served by a linkage between network members) in Blacks
was provided at a nominal level with support for females provided mostly
by spouse, brothers, sisters, and friends. For males, support was
primarily provided in financial emergencies and during times of stress,
such as death and relationship break-ups. It was found that support
provided during times of death occurred at levels of 75 percent for
Black males versus 62 percent (norm), while support provided during
times of relationship break-ups occurred at levels of 55 percent for
Black males versus 47 percent for the norm.

The nature of support for home chores, socializing, and cash were
near the norm for sharing hobbies, emotional support, intimacy, and

judgement support. The network composition in the Black sample (n = 112) for each support function showed a number of patterns. Friends provided support for all functions except for home chores. Spouses provided support across all functions (although the proportion of dissolved marriages was higher than the norm); while brothers and sisters provided emotional, judgemental, intimacy, and financial support. The cash provided for women was more than that provided for men. Thus, the study showed that Black men, especially if unmarried, may have only friends to turn to for help. Support was also obtained through membership in formal organizations, the percentage of which was quite high. Examples of organizations they participated in or were affiliated with included religious groups, unions, business and other professional organizations, social clubs, sports, parent-teacher-student organizations, and racial/ethnic organizations.

At times of stress, a number of network members provided support to the Black subjects. In times of death, spouse, brothers and sisters, friends, and parents provided support. During breakups of close relationships, parents entered the network along with brothers, sisters, and friends. There was much less support, however, during the remaining three life changes; only the spouse, if married, provided support in times of major illness or injury; the spouse and professional did so when undergoing a major job change (most received no help); and the spouse, parents, brothers, and sisters provided support during major residential changes. This last result suggests that family networks in the Black group were preserved because of low residential mobility.

According to the California Department of Mental Health (1982), reciprocation was higher in the Black sample than in any of the other

cultural groups (American Indian, Chinese/Chinese American, Japanese American, Mexican American/Lation, Filipino, White): a higher percentage (69) of Blacks were at the high reciprocation level compared with the norm (41 percent). When multiplex support was compared to the number and level of function served and to emotional support and network size, results showed that the normal level of multiplex support may have been maintained by the higher reciprocation level of females, who reciprocated significantly more so than males (77 percent versus 58 respectively).

The conclusion reached by the investigators was that reciprocation in the Black sample was higher than in any other group when multiplex support was correlated with level of reciprocation and that females reciprocated significantly more so than males. Thus, "high reciprocation is a salient feature of the networks of Black females as comprised of brothers and sisters, friends, and spouse, and is one of the 'glues' that keep the network intact (p. 193).

In summary, most studies of social support have found that the quality rather than the availability of social support is paramount for decreasing stress. Also, social support buffers/protects persons from some of the pathological effects (physiological and psychological) of stressful situations and transitions. In addition, it has varying effects on physical health. Following physical illness and/or surgeries, persons providing the most beneficial social support include spouses; relatives or family members. Also important are financial, informational, and professional support. Social support is provided most frequently to middle-aged, married, physically attractive, socially competent, socially involved women who have experienced high quality

parental involvement during childhood. Thus, persons who elicit threat and discomfort, such as cancer clients, are frequently rejected by others and therefore suffer from communication difficulties. During psychiatric illness, the presence and type of stress and network members, as well as coping responses, determine outcomes. In addition, network orientation or mobilization, low density networks, and externally induced stress foster positive outcomes.

There are a number of cultural variations of social support provisions also. For example, Egyptians have identified the highest number of support compared to Americans, Taiwanese, and Swiss-German persons. Among all these groups, the spouse and family/relatives groups have provided the greatest amount of social support. In other studies, Black persons have demonstrated higher degrees of support than other cultural groups. Blacks have demonstrated more significant and more satisfying family relationships than Chicanos and Whites and Black college students have identified a higher degree of closeness with their families and a lower degree of closeness with friends than White college students. Also, Black females receive more social support from their families and less from their friends than Whites. Lastly, reciprocation is identified as being higher in Blacks (especially females) than in American Indians, Chinese/Chinese American, Filipino, Japanese American, Mexican American/Latino, and White.

Environmental Stressors of Blacks in America

The Black family in America has tremendous socioenvironmental stressors to deal with. Such stressors are compounded by those that are inherently present during chronic illnesses such as cancer.

During the past few years in America, there has been a general shift in values. Traditional values stressing opportunity, compassion, and equality have changed to values that represent selfishness, hostility to the poor, and indifference to equality (Persons, 1987). Selfishness is depicted by proponents of easy solutions who urge self-help and voluntary efforts in a society that creates few opportunities that assist people in helping themselves (Jacob, 1987). Another paradox is seen in a government that has sought to convince Americans that today's society is colorblind and neutral while at the same time engaging in anti-civil rights' activities such as fighting extensions of civil rights' laws, and undermining affirmative action (Jacob, 1987). Such activities have had a tremendous impact on the lives of Blacks in particular, a large number of whom are at a disadvantage because they are poor and therefore powerless, Consequently, for Blacks, racism lives on. This racism, although primarily covert, has been manifested in an overt manner also. As this section unfolds, it will be seen that, for Blacks, subtle and blatant forms of discrimination permeate economically, socially, and politically.

Economic Environment

Despite modest improvement in the economic conditions of Blacks during 1985 and 1986, the deep recession that has "gripped" (Swinton, 1987, p, 49) the Black community during the past six years has continued. The present administration's leadership has increased racial inequality since the 1960's" (1987, p. 49). National data on income, poverty rates, and labor market status indicate the degree of economic distress among Blacks. During the present administration, Black family income has declined, poverty rates have increased, and difficulties in

the labor market have intensified. In addition, there has been an in-
crease in racial inequality in income, employment, and wages (Swinton,
1987).

Income data for 1985 as recorded by the Census Bureau reveal that
Blacks have made little, if any, progress and have remained consistently
below Whites in all categories. For example, in 1984, the median weekly
earnings of Black women was $242, compared to $264 for White women; $304
for Black males; and $403 for White males. Income per capita was lower
in the last five years than during the previous five years ($6,319 for
the first five years, $6,413 in the five years preceding) and the gap
between Black and White per capita incomes has increased. The smallest
gap occurred when Blacks received 58.6 percents for every dollar
attained by Whites. The median family income of Blacks reached its peak
of $16,785 during 1985; however, this level was lower than at any time
during the ten years prior to 1980 (Census Bureau, 1985) and represented
a net worth twelve times lower than that of the typical White family.
Almost one-third of all Black families have no assets at all (Census
Bureau, 1985).

In addition, the family income distribution has generally worsened
in the past few years. The percentage of Black families receiving less
than $5,000 was 13.5 percent in 1985 compared to 9.6 percent in 1978.
On the other hand, the percentage of this group with incomes greater
than $35,000 has grown from 14.5 percent (1982) to 18.8 percent (1985),
although the level was 19.0 percent in 1978 (Census Bureau, 1985).
Thus, Blacks have been more likely to be poor and less likely to have
high incomes during the past six years compared to the preceding five
years. Racial differences in income distributions have increased also,

particularly at the lower ends. For example, a 6.9 percent difference between the percentage of Black and White families with incomes less than $5,000 in 1978 rose to 9.8 percent in 1985. However, the percentage of Whites with incomes greater than $50,000 was 12.6 percent higher in 1985 compared with an 11.1 percent increase in 1978 (Census Bureau, 1985).

These low income levels are reflected in high poverty rates for Blacks. During 1985, nearly one out of every three Blacks (31.3 percent) had incomes placing them below the poverty level. The poverty rate among Black families headed by both men and women exceeds the rate of poverty among White female-headed families. Also, the poverty rate among Blacks with one year of college was higher than the poverty rate of Blacks who worked full-time and was three times that of Whites working full-time. Lastly, the poverty rate of Black households with only two persons was nearly equal to that of Whites with more than seven persons (Census Bureau, 1985).

Consequently, poverty continues to be a massive problem, especially for Blacks; however, the public is much less sympathetic now than during the last six years. The concept, the Black "underclass" (Glasgow, 1987, p. 129), is currently gaining widespread usage - in contemptuous terms for many. Thus, the underclass is accused of having created their plight and of having developed a "culture that perpetuates it (Glasgow, 1987)."

In reality, neoconservatives have "developed the rationale for vitriolic condemnation and punitive social policy proposals (Glasgow, 1987, p. 130)." Because of these proposals, federal spending on employment and training programs for the economically disadvantage have been

cut by 50 percent since 1980 (Nightingale, 1985). Other resource de-
velopment programs, such as those in education, have also been curtailed
drastically (Simms, 1984; Tidwell, 1985).

Subsequently, the Black underclass consists of the "worst-
positioned persons among the Black poor" (Glasgow, 1987, p. 131). This
group has little hope of becoming self-supporting or socially mobile.
The size of this underclass is estimated to be five to seven million
persons (The Economist, 1986). This may be an astoundingly low figure
if one factors in the unemployed; the discouraged worker population;
the almost one million Black men whose labor force status cannot be
determined because they are missed in the census; Blacks in prisons;
the three million Blacks hidden in small rural towns; and the homeless
Black poor (Glasgow, 1987).

Such high numbers of Black poor persons with low levels of income
have resulted in substantial labor market difficulties for Blacks. For
example, in 1984, Blacks earned $5,103.13 per person from wage salary
and self-employment compared to $8,497.17 per person for Whites
(Swinton, 1987). The economic disadvantage thus displayed arises from
several factors:

> there are proportionately fewer Blacks of working age;
> there are proportionately fewer males among the working
> aged Black population; Black men and Black teenage parti-
> cipation rates are lower than White male and White teenage
> participation rates; Blacks have higher rates of unemploy-
> ment; Blacks have poorer occupational distributions; Blacks
> have lower wage rates (Swinton, 1987, p. 56).

The first two factors are demographic. Smaller proportions of
Blacks (72 percent of the population over 15) than Whites (79 percent)
are working age. Thus, Blacks have approximately two million fewer
working-age persons in proportion to Whites. In addition, the ratio

of Black males to Black females among the over 15 population was 8,115 per 10,000 versus 9,161 per 10,000 for Whites in 1984 (Census Bureau, 1985). During the past five years, the percentage of working-aged Blacks continued to rise; however, the ratio of Black males to females among adults continued to decline. Consequently, the decline in the Black male working population continues to be a significant problem.

Various factors can be attributed to the decreasing number of Black males in today's society. They have a lower life-expectancy than females; many males die from homicide and suicide; many are in prison and/or are drug addicts (Poussaint, 1986; Kirk, 1986); they have a higher rate of severe mental disorder than females; and an unknown number are homosexual (Poussaint, 1986). The destructive nature of most of these factors, according to Kirk (1986), may be due to the following: "weakening of family and communal ties in the Black community, a greater sense of alienation and normlessness, a decrease in Black consciousness, and an overidentification with the White race" (p. 17). He adds that other Black psychologists and mental health professionals agree with the concept of "mentacide" (p. 7) to explain the tendency to violent behavior. The definition of this is: "the deliberate and systematic destruction of a group's mind with the ultimate objective being the extirpation of that group" (p. 7). Thus, external and internal factors have played a major role in the diminishing existence of the Black male.

In addition to the smaller numbers of working-age Blacks (Black males, in particular), the participation rate has been a factor in labor market difficulties. While the participation rate for Black females has moved up, that for males has drifted downward. Also, Black teenage

participation, although showing an upward movement, remained lower than that for White teens by approximately 12 percent (Census Bureau, 1985).

Overall, the total participation rates for Blacks have been slightly higher during the past 5 years than in the 6 years immediately preceding. This suggest that Blacks have increased efforts to obtain jobs. Trends in labor force participation for White male and female adults paralleled those for Blacks. Thus, there was a moderate decline in White male participation and somewhat sharp increase in White female participation during the same period. Subsequently, White women continued to narrow the participation gap between themselves and Black females, while the relative gap between Black males and White males remained virtually unchanged (Swinton, 1987).

Unemployment for Blacks has generally been higher during the past 5 years than in previous years (Bureau of Labor Statistics, November, 1986; June, 1985). During the first 6 months of 1986, Black unemployment averaged 12.9 percent; that for the Black female 14.1 percent (compared to 11.8 percent for the 6 years prior to 1980); and the unemployment rate for teenage Blacks increased from 38.9 percent to 43.6 percent. Black unemployment was more than 2.4 times White employment during the past year. Racial inequality in employment rates was also increased, with Black males, teenagers, and women experiencing higher declines than their White counterparts. In fact, the employment rates of White females, for the first time on record, surpassed the employment of Black females (Swinton, 1987).

The contemporary Black unemployed comprise many subgroups as can be seen in the following summary extrapolated from the Bureau of Labor Statistics (1985). Greater than half of all unemployed Blacks in 1984

lost their jobs (52 percent), including 44 percent who were permanently terminated. Only one percent of job leavers left voluntarily, while 28 percent were reentrants into the labor force and 18 percent were first-time job seekers. Black males were more likely than females to be struck by unemployment. In 1984, 52 percent of those unemployed were males. Blue collar workers were overrepresented, while white collar workers were underrepresented.

The incidence of unemployment declines with increased education. Although college graduates constituted 12 percent of the Black civilian labor force in 1984, they accounted for only 4 percent of the un-employed. On the other hand, Black high school dropouts represented 18 percent of the labor force but 29 percent of the unemployed. In terms of racial comparisons, the gap between Black and White employment rates is greater at the higher education levels: the jobless rate of Black college graduates in 1984 was 2.5 times that of their White cohorts, while the rate of Black high schools dropouts was only 1.8 times the rate of White dropouts. These findings illustrate the continued impact of racial discrimination in the labor market (Tidwell, 1987). Other evidence of employment discrimination against Blacks is found when com-paring Black and White jobless rates within different occupational categories (Tidwell, 1987). In particular, Black white-collar workers in 1984 were unemployed at 2.6 times the rate of their White counter-parts; the rate of Black unemployed blue collar workers was 1.8 times that of their White cohorts (Bureau of Labor Statistics, 1985).

These occupational distributions for Blacks indicate that there is "underutilization in better paying, high status occupations and over-utilization in the lower paying, less prestigious occupations" (Swinton,

1987, p. 64). Black males are employed at 40 percent of the rates of Whites in managerial, professional, and sales occupations. Altogether, these occupations employed approximately 10 percent of working age Black males compared to 27 percent working age White males. In technical and craft occupations, which employ approximately 13 percent of working age Black males versus 21 percent of White males, Black males were hired 60 percent of the rates that Whites were. Black males are also employed from 1.2 to 1.4 times as often as Whites in private household, other service, and laborer occupations (Bureau of Labor Statistics, January, 1986).

Similar occupational patterns exist for Black females who are heavily utilized in the least desirable female occupations (Swinton, 1987). The five occupational groups of managerial, professional, sales, clerical, and agricultural employ Black females at substantially lower rates than White females - 25 percent compared with 35 percent respectively. Black and White females are hired at roughly equal rates in technician, craft, and transport operative groups. However, private household, protective and other service, machine operators, and laborers all employ Black females at a higher rate (20 percent) than White females (12 percent) Bureau of Labor Statistics, 1986).

During the past six years, the constant dollar wages of Black full-time and salaried workers have declined (to $304 per week from $342 per week in the five years preceding) and racial inequality in wages has increased. Thus, the general labor market position of Black is lower than for Whites. In fact, for each measure of labor market status, results on average have been worse during the past six years than during the

five or year period before (Swinton, 1987). After three or four years
of this administration's recovery, Black unemployment rates are higher
and earning rates lower than they were prior to 1980 (Swinton, 1987).

Social Environment

Although major educational reform reports have attempted to deal
with the score of problems revolving around Black access, achievement,
status, and other concerns in the American educational system, these re-
ports have generally not been integrated within the "mainstream of their
recommendations (Robinson, 1987, p. 31). Thus, hundreds of thousands of
"at risk" children (A Nation at Risk, 1985) - those who are poor,
nonwhite, handicapped, or female - "are not receiving even minimal edu-
cational opportunities guaranteed under law" (Education Week, 1985,
p. 1). Thus, the problems of Black students are indicated in levels of
student achievement, dropouts, teenage pregnancies, passing rates on
teacher examinations, environmental role models, and family income:
these indicators illustrate that the "problems of Black students con-
tinue to expand in alarming and threatening proportions" (Robinson,
1987, p. 31).

High academic achievement levels among Black students are rare in
many public school systems and are threatened in Black colleges and
universities. Studies have indicated that Black students, especially
those in inner-city school districts, have demonstrated lower and
slower academic rates than their White public-school counterparts
(Moody, 1986; Darling, 1985). This discrepancy is also evident when one
compares Black inner-city students with both Black and White students
educated in suburban school districts. On the other hand, historically

Black colleges and universities have succeeded in the past in preparing
Black students for work in "prestigious graduate programs" (Robinson,
1987, p. 32) and to lead productive lives in society. This "tradition
of success" (Robinson, 1987, p. 32) was never threatened or questioned
until competition for students and resources resulted in the redistribu-
tion of both. Now, the survival of Black colleges and universities is
threatened (Robinson, 1987). Additionally, college enrollment has
generally dropped dramatically, especially among Black males who are out-
numbered by Black females in college by more than 100,000 (Census
Bureau, 1984). Thus, it is becoming increasingly difficult to create
opportunities and conditions for educational attainment of all Black
students.

The student dropout problem is a national one that spans all ethnic
and geographic boundaries but is most evident among urban minority youth
(Robinson, 1987). Blacks are more likely to drop out than Whites, but
less likely to do so than Hispanics (McDill, Natriello, & Dallas, 1985).
Multiple causes of and reasons for dropping out fall into three cate-
gories: those related to school experiences; family conditions; and
economic factors (McDill, Natriello, & Dallas, 1985). Despite the
varied nature of these reasons, the reform movement has raised standards
across the board without considering the means to help all students
achieve those standards. This decision may adversely impact on those
students who have little control over family and economic factors (The
Association for Supervision and Curriculum Development, 1986).

Other problems are teenage pregnancy and dropouts among Black high
school students. The dropout rates among Black males are increasing

dramatically and the pregnancy and birth rates for Black teens are increasing in a "dramatic and alarming" (Robinson, 1987, p. 32) manner: there are more than 4 times higher the number of Black than White teenage pregnancies and birth rates (Teen Pregnancy Report, 1985). Black adolescents also begin childbearing at younger ages than Whites. Researchers estimate that 40 percent of today's 14-year old girls will be pregnant at least once before age twenty (Time, December 9, 1985). Because of these dropout and teenage pregnancy rates, there exists a lack of hope that is "most debilitating for today's youth" (Robinson, 1987, p. 33).

Another problem that is linked to the plight of Black students is that of Black teachers. Black educators, most of whom have served as positive role models dedicated to ensuring that Black young people continually strive for excellence, are drastically decreasing in number (Robinson, 1987). In 1980, Black teachers represented 8.6 percent of all teachers, kindergarten to twelfth grade (Baratz, 1986). Black teacher representation in the national teaching force could be reduced to less than 5 percent by 1990 (Baratz, 1986; Smith, 1986). The reduced number of teachers is especially pronounced in neighborhoods where poor Blacks predominately live because middle-class Blacks have "geographically segregated themselves from the underclass" (Robinson, 1987, p. 34). Consequently, the Black underclass have virtually no educators to call their own. These results are thought to result from low teacher compensation, status, and prestige; low passing rates on teacher preservice and inservice examinations; and increased opportunities in other professions (Robinson, 1987). In addition, both Black university and

college professors, as well as doctoral candidates, are drastically

declining (Robinson, 1987.

Finally, the implementation of school desegregation has had both

positive and negative effects on Black children. The U.S. Census Bureau

(1983-1984) reports that minority youth are staying in school longer.

The difference in the median school year for these students is less than

1 percent. Subsequently, one can understand why there is continuing

support for desegregated education from Blacks nationwide. However,

there is also increasing pessimism regarding school desgregation as a

desired goal. This discrepancy arises because of busing, which

described as "Unfair" to Blacks (The faculty and students of Furman

University, 1986, p. 47). Authors such as these cite that busing is

focused on moving Black students. For example, in Greenville, South

Carolina, in 1983, 88 percent of the children bused to achieve racial

balance were Black (Quality and Equality of Opportunity in the School

District of Greenville County, 1984).

Political Environment

The present administration has displayed ignorance of and arrogance

towards the plight of minorities, especially Blacks (Jacob, 1986). This

display has particularly been observed in its civil rights' policies.

The current government has: "tried to win tax exemptions for segregated

schools, fought extension of civil rights' laws, underminded affirmative

action . . . stacked the judiciary with right-wingers" (Jacob, 1987, p.

8). False statements, designed to convince the public that unemployment

was no longer a problem, that the poor do not want to work, and that

social programs do not help resolve but compound social problems, were

substituted in place of the existing domestic policy (Jacob, 1987). The

behaviors thus displayed are indicative of serious disorders that "plague our society . . . and stem from ideologies contemptuous of democratic processes and humane social considerations" (Jacob, 1987, p. 9)."

Jacob (1987) states that discrimination is evident when one considers the increasing number of blatant racial acts as well as other more subtle forms of racism. Overt acts of racism have been illustrated by anti-crime measures specifically directed towards Blacks in White neighborhoods; by the assault of Blacks by a lynch mob; and the harrassment of a Black student by White cadets in Ku Klux Klan dress. Examples of covert forms toward Blacks include housing discrimination, unequal busing of children to desegregated schools; discrimination towards voters; and job discrimination, among others (Jacob, 1987).

Social welfare reform policies have also failed to create a more equitable system between Blacks and Whites. Thus, policies that deliberately encourage higher unemployment and lower levels of social spending and investment have resulted in growing disparities in income and wealth (Jacobs, 1987). For example, despite the fact that the population of Blacks is 12 percent, Black income amounts to only 7.4 percent of the total U.S. money income (Census Bureau, 1985). Also, while total personal property income the U.S. is approximately $200 billion, Blacks share only $3 billion. The Census Bureau (1985) also reports that Black families have a net worth of $3,400, including house and car, while White families' net worth is $39,000. These data suggest that many middle-class families are being "squeezed into poverty" (Persons, 1987, p. 194): this small group is increasingly threatened by cuts in government jobs, downsizing of corporations, and an environment hostile to civil rights' enforcement (Persons, 1987). Thus, the Black middle-class

is more vulnerable to the threat of downward mobility than is the White middle-class (Billingsley, 1987).

One study that implies that stress is experienced by middle-class Black families was carried out by Gary and Beatty (1983). These investigators studied a group of 50 strong, stable, achieving Black families in the Washington, D.C. area. Their strength was perceived as such because they had high salaries, high levels of education, occupational status, small numbers of children, and were highly religious. Despite these characteristics, a number of problems and dissatisfactions were expressed: they all complained of financial, marital, and child problems and most were more dissatisfied with their jobs than anything else.

The failure of social welfare policies can perhaps best be illustrated by the plight of the 3.5 million homeless (National Coalition for the Homeless, 1985). The bulk of the homeless are individuals and families too poor to afford available housing (Henderson, 1987). Federal funds have been slashed for subsidized housing by 78 percent since 1980 (National Coalition for the Homeless, 1985). Thus, discouragement of real estate investments, curtailment of capital gains, and stricter rules on income losses for rental property tend to discourage low-income housing development in Black communities (Henderson, 1987). The new Gramm-Rudman-Hollings Act and Tax Reform provisions are fiscally regressive for Black individuals and households; only the lowest individuals in this community benefit and approximately 25 percent of all Black households will most likely be eliminated from the tax rolls (Burbridge, 1986).

Regardless of the overwhelming socioeconomic and political stres-
sors that exist in the United States today, the majority of Black
families manage to avoid poverty and deprivation (Billingsley, 1987).
Most Blacks live within the family structure. Husband/wife families
tend to earn above the poverty levels. While a third of Black families
have attained middle-class, another third is steadily employed in the
blue collar working class. Substantial progress has been achieved by
married couple families where both partners are educated and employed
(Billingsley, 1987). Such families, who constitute a third of all Black
families, had median incomes that were 80 percent of White family income
in 1982 (Census Bureau, 1984). Thus, achieving Black families exist in
all socioeconomic groups (Billingsley, 1987). In the midst of even the
worse conditions in the inner city, Billingsley (1987) states:
"achieving Black families seem to rise out of the ash heap of history
and contemporary conditions to develop high levels of family stability
and capacities to meet the needs of their children for ecconomic
support, for nurturance, and for guidance" (p. 103).

Thus, the Black family continues to succeed in caring for its own
despite extreme internal and external stressors. Consequently, the
Black family whose member has cancer, has tremendous forces against it
but also potentially has great support resources.

The Black Family

Despite the many hardships experienced in American throughout the
years, the Black family remains intact and "resilient" (Suggs, 1986).
The strong kinship bonds among Black families today can be traced his-
torically to Africa (Nobles, 1974; Gutman, 1976; Nobles & Nobles, 1976;

Staples, 1976; Martin & Martin, 1978; McAdoo, 1978; Lantz, 1980; Thompson, 1981; Hinds & Boyd-Franklin, 1982; Bloch, 1983). The basis of African life was this extensive kinship group, which was "bound together by blood ties and the common interest of corporate functions" (Staples, 1976, p. 220): thus, there was a strong sense of family and community (Staples, 1976; Martin & Martin, 1978; Nobles, 1980; Bloch, 1983). Franklin (1982) specifies the importance of the African family by stating that it provided the basis for economic and political life in Africa and exerted considerable influence over its members.

Slavery temporarily disrupted the close family ties, broke down the sense of community, and alienated Africans from an "authentic identity with a God, a land, and a people" (Martin & Martin, 1978, p. 93). It was difficult for slaves to maintain communication with kin because slave owners refused to choose large numbers of slaves from the save tribe; hence, culture and language were different among the slave group members (Martin & Martin, 1978).

Plantation life was one of extreme hardship for the family in bondage. Because slaves were not allowed to enter into binding contractual relationships, there was no legal basis to most of the marriages that were performed between them (Boyd-Franklin, 1982). Consequently, many marriages were initiated and dissolved by slave owners. When these nuptial unions were permitted, they frequently occurred between slaves of the same plantation in order to enhance prospects of breeding future slaves and to deter slaves from fleeing (Boyd-Franklin, 1982).

Despite separation of some family members by their master's choice, death, or sale, the family institution was one of the most important survival mechanisms for slaves (Blassingame, 1972; Gutman, 1976). The

social support provided by the family was made manifest in different ways: affection, respect, discipline, companionship, love and empathy were provided; and members were taught how to maintain cultural morals, to avoid punishment, to resist authority, and to cooperate with fellow slaves (Gutman, 1976; Staples, 1976). Consequently, members were able to retain vestiges of self-esteem and rely on a kinship network for coping that was not necessarily drawn alone blood lines (Gutman, 1976; Hines & Boyd-Franklin, 1982).

Once freedom had been granted, some former slaves adopted to remain on plantations for two major reasons: one, they hoped that lost family members might return; and two, they chose to remain "in a local familial and social setting" with "extended kin networks" (Gutman, 1976, p. 209). Others, however, fled to former plantations or advertised for love ones in newspapers before fleeing to the North with the help of fellow former slaves and the Freedman's Bureau (Gutman, 1976).

Thus, quasi-kin or extended family relationships existed as "networks of mutual obligation that extended beyond formal kin obligations dictated by blood and marriage" (Gutman, 1976, p. 222). Community ties emerged from such relationships, "flowing upward and outward from the adaptive domestic arrangements and kin networks that had developed over time among the slaves themselves" (p. 222). Social obligation, defined by Gutman (1976) as "a concern among slaves for nonkin" (p. 224) was continued following emancipation. Donations such as time, food, money, nursing care, shelter, and child care, especially for orphans, were provided by both slaves and ex-slaves (Gutman, 1976).

Consequently, Blacks today have descended from a rich heritage of shared loyalty, determination, and strong kinship bonds. Such loyalty

and kinship have been exhibited in behaviors resulting in the "survival of the tribe" - doing whatever is necessary to maintain the family, such as ascribing interchangeable roles for male and female; and existing in a "oneness of being" mode (Nobles, 1974, p. 12). Thus, group unity or togetherness and oneness in nature are prevalent.

Several investigators have indicated that the Black family today is resilient, flexible, adaptable, and all encompassing. Stack (1975), in her study of impoverished Blacks in a neighborhood known as "The Flatts," emphasized the reciprocal nature of family/kin support as: "the domestic cooperation of close adult females and the exchange of goods and services between male and female kin" (p. 9). Martin and Martin (1978) added the concepts of multigenerationality and stability in their definition of the Black extended family as:

   a multigenerational, interdependent kinship system held
   together by a sense of obligation to relatives; organized
   around a "family base" household; guided by a "dominant
   family figure;" extended across geographical boundaries
   connecting family units to the extended family network;
   and having a built-in mutual aid system for maintaining
   individual members and the entire family (p. 1).

Thus, in their eyes, the "extended family network" (p. 1) is a combination of the extended family base; the subextended family; and the mutual support system. Subextended families are connected to one another and to an extended family base household; they are kept to-gether by the leadership of the dominant family figure as well as by a sense of obligation to dependent family members (Martin & Martin, 1978). These subextended families give rise to new extended families once the former have grown independent and have become multigenerational. The new extended family maintains ties with the old, but is centered around its own extended base household (Martin & Martin, 1978). Because of the

extent to which families can grow, they can consist of a complex network of blood and nonrelated persons that may include mother, father, children's father(s), brothers, sisters, "adopted" brothers and sisters, aunts, uncles, cousins, grandparents, great-grandparents, nieces, nephews, neighbors, ministers, and friends (Stack, 1975; Branch & Paxton, 1976; Gutman, 1976; Smith, 1976; Staples, 1976; Martin & Martin, 1978; Kennedy, 1980; Ross, 1981; Henderson & Primeaux, 1981; Thomas, 1981; Hinds & Boyd-Franklin, 1982; McGoldrick, Pearce, & Giordano, 1982; Bloch, 1983).

Gutman (1976) emphasizes the strength of kin ties among extended family network members as he traces the naming of children from pre-slavery times to postemancipation. He states that these naming practices supply evidence about the "adaptation of West African kinship beliefs" (p. 196) and about "how enlarged slave kin networks became the social basis for developing slave communities" (p. 185). Children were named for blood relatives within immediate families, including dead or sold siblings, and for blood kin outside immediate families, including aunts, uncles, great-aunts, and great-uncles (Gutman, 1976). Wimberley (1982) has a different perspective of the Black family: he states that movement from the multigenerational extended family to two-generational or one-generational nuclear families is occurring today. He adds that this change is leading to discontinuity of traditional values and supports.

Two functions of the extended family have been identified by Martin and Martin (1978). The first, leadership, provides a sense of security, sense of family, and a sense of group direction and identity. The second function is to "promote the welfare of dependent family members: to deal with crisis situations, to provide family members with the

basic necessities of life, and to have them have some feeling of econo-
mic security" (p. 10). These functions are evident when one looks at
the numerous studies depicting Black family members' close ties with,
support of, and loyalty to one another, especially during times of
stress and crisis (Martin & Martin, 1978).

One crisis situation that families are frequently involved in is
chronic illness, more specifically, cancer. Although research has not
been done in this area, the literature indicates that Blacks prefer
family-centered care during illness. This may be due to a long-standing
distrust of the establishment, such as health care professionals (Hays
& Mindel, 1973; Jackson, 1978; Wimberley, 1982), a fear of hospitals
(McCabe, 1960), or the increased stress that is associated with hospi-
talization (Ahmadi, 1985). In addition, these ill individuals prefer
most to remain at home during illness (McCabe, 1960; Ross, 1981; Bloch,
1983). Nobles (1976) illustrated this family support, finding that
Black American family members and friends will often "sit up" (p. 192)
with clients to assist them in meeting their needs and are less likely
to view illness as a burden. Billingsley (1968) found that Black fami-
lies cope by banding together to form a network of intimate mutual aid
and social interaction with neighbors and kin, while Hill (1972) dis-
covered that the entire family steps in at crucial times to provide
support for its members.

In their exploratory study, Hays and Mindel (1973) interviewed 25
Black and White families matched on the basis of socioeconomic and mari-
tal status. They found that the extended network formed a more salient
structure for Black families than for White families. Blacks reported

seeing more of their kin more often than Whites in all family relation-

ship categories except parents. Martin and Martin (1978) discovered

that the functions of the Black family were carried out by the extended

rather than the nuclear family unit.

McAdoo (1978) carried out a study to ascertain the impact of mobi-

lity on relationships in the Black community. In her study, she found

that reciprocal kinship-help patterns remain strong after individuals

have achieved upward mobility. She also found that helping networks

were much more active among Black families than among Catholic and

Jewish immigrant families and that the Black families preferred to

handle problems within the family. As a matter of fact, many family

members felt that they would have been unable to obtain a college educa-

tion without extensive kin support (McAdoo, 1978).

Consequently, the Black family has for centuries provided contin-

uous support for its members. It is thus important for ill individuals,

specifically those with cancer, to identify family and/or social support

members in order for culture-sensitive and family-oriented nursing care

to the provided.

CHAPTER THREE

METHODOLOGY

The purposes of this study included describing the perceived social support network of Black cancer clients regarding its properties, functions, and quality (as specified by Likert-style ratings of affect, affirmation, and aid) and comparing these descriptions to normative social support data as found in Norbeck's, Lindsey's, and Carrieri's (1981; 1983) studys of employed a adults. In addition, selected demographics of the sample were described and examined to see if there were related differences in in reported social support networks. The following describes the setting, sample, duration, design, study variables, extraneous variables, data collection, and data analysis.

Setting

Once the study was approved by the Clemson University Committee for the Protection of Human Subjects (see Appendix A), the participants for the study were selected from three hospital clinic sites housed within two teaching medical center and in one rural hospital in the northwestern area of South Carolina. These sites house three of South Carolina's State-sponsored Cancer Clinics. The three State-sponsored clinics coordinate care for cancer clients from several counties in the area. Clients are referred by local oncologist or other physicians in the area, as well as medical, surgical, and/or gynecological teaching staff. The majority of these clients either are in financial need, have

fixed incomes, or have incomes below the national poverty line of $10,000. They are treated and seen primarily in the Cancer Clinics, whose services include medical services, clinic visits, all outpatient diagnostic tests, treatments, medications, and nutritional supplements specifically related to the cancer diagnosis. A small group of clients are cared for in the home and/or are enrolled in the local county's Hospice programs. Cancer Clinic is held one or two days per week, depending on the health care facility in question.

Clients are seen by the Surgical Teaching Staff, Medical Teaching Staff, Gynecological Teaching Staff, and/or by Oncologists rotating through the clinics. Other persons who care for the clients include full-time and part-time registered and licensed nurses and office staff persons.

<div align="center">Sample</div>

Once consents were obtained to use the State Cancer Clinics (see Appendices B and C), a convenience sample of twenty cancer clients were selected from the population of adult Black residents of northwestern South Carolina who were being followed in the State Cancer Clinics. This sample was obtained through referrals from three State Cancer Clinics in the nearby counties. The following were criteria for inclusion in the sample group:

1. subjects had been admitted to the State Cancer Clinics,

2. subjects were Black, 50 years or older, who had been diagnosed as having cancer,

3. subjects had been informed of the cancer diagnosis,

4. subjects were alert and able to respond to questions
   on the Orientation Questionnaire designed for use in
   this study (Appendix D);

5. subjects were English-speaking and able to hear the
   spoken word and/or were able to read and write.

The investigator assisted Black cancer clients to complete the
Orientation Questionnaire (see Appendix D) when they entered the State
Cancer Clinics on the days of their scheduled visits. This information
was used to select subjects who fulfilled the criteria for inclusion for
the study. Those clients who met the criteria were approached by the
investigator and asked to participate in the study.

The investigator informed subjects that they had the right to re-
fuse to participate at any time; that there were no known risks; and
that their answers would be confidential. Benefits associated with the
study of social support, to help nurses and other health care workers to
identify those close to Blacks who should be included when planning and
providing care and when developing future programs, were also described.
This information, along with the remainder of the Informed Consent
Agreement (see Appendix E), was provided verbally in a private area
within the clinic. Subjects were then asked if they had any questions
and/or needed help reading and completing the Informed Consent Agree-
ment. If they required no assistance, they were asked to sign the
agreement. Those requiring help signed after the consent had been read
aloud a second time and they indicated that they understood it. The
complete protocol is included as Appendix F.

Data Collection

Data was collected during regularly scheduled clinic visits during
the fall of 1987. The time to complete the Norbeck Social Support

Questionnaire (see Appendix G) and the Information Questionnaire (see Appendix H) took approximately 15 to 25 minutes. An approval letter from Norbeck has been received and is indexed in Appendix I. Norbeck provided no data on the reading level required for the questionnaire or any cultural biases of the wording of questions.

To assess these factors a pilot test was carried out. Four older Black adults (> 50 years old) who reside in northwestern South Carolina, who had not been diagnosed with cancer, and who had had no college education took the Norbeck Social Support Questionnaire. The investigator encouraged each individual to share in verbal and/or in written form any thoughts, feelings, questions, comments, suggestions, and uncertainties he or she had about the questions. Confusion was ver- balized regarding the word "confide" in Question 3, "moderately" in the Likert responses, and "significant" and"relationship" in the original instructions. Based on this feedback, confide was changed to "know that what you tell them stays with them and does not get told to anyone else;" "moderately" was restated as "in between;" "significant" was stated as "important,' and "relationship" was "what they are to you." In addition, the pilot subjects suggested that the number 2 rating for question 7 be changed to 1 year instead of 12 months, that the list of personal network members and their relationships be switched from the right-hand side to the left-hand side and that the instructions and questions be switched from the left-hand side to the right-hand side for ease in reading. These suggestions were carried out. The pilot ques- tionnaires and discussion of the questions took an average of 37.5 minutes to complete. All were self-administered except one. All four subjects stated that they would have preferred for the investigator to

have administered the tool rather than themselves. Advice was also given on how best to clarify the instructions; this advice was followed also.

Design of the Study

The study was exploratory. Self-reports of subjects' social support network properties, social support functions, and quality of social support were described according to selected demographic variables. In addition, the subjects' social support data were compared with that of normative support data as reported by Norbeck, Lindsey, and Carrieri (1983).

Study Variables

Conceptual Definition of Social Support

Social support is provided through the convoy, which is the set of persons who are involved in the giving and receiving of social support as they move through life (Kahn, 1979). Formal properties of convoys are measured according to social networks, which is a symbol used to organize thinking about the set of relationships experienced by an individual and the others with whom he or she interacts (MacElveen, 1978). These properties can be measured of the convoy as a whole and of the separate dyadic links between each of the convoy members and the focal person. Social networks can be described according to their size, density, frequency of contact, duration, and type of relationship.

Social support involves the assistance received through interpersonal transactions with convoy members. Functions of social support include affect, affirmation, and/or aid. Affective transactions are

expressions of liking, admiration, respect, or love. Transactions of affirmation are specified as expressions of agreement or acknowledgement of the appropriateness or rightness of some act or statement of another person. Transactions in which direct aid or assistance is given include the donation of money, information, time, and entitlements (Kahn, 1979).

The perception of social support is the meaning that things have or the mental association ascribed to things by a person (Paterson & Zderad, 1976). The quality of this social support is dependent upon the amount of caring or understanding that a person perceives from his or her convoy members. The humanistic nursing experience best denotes the high degree of quality required. This is described as "a responsible searching, transactional relationship whose meaningfulness demands con-ceptualization founded on a nurse's existential awareness of self and of the other" (Paterson & Zderad, 1976, p. 3).

Operational Definition of Social Support

The Norbeck Social Support Questionnaire (NSSQ) was used to measure the subject's perception of social support (see Appendix G). This 9-item tool is based on Kahn's (1979) definition of social support. The respondents listed or had the name and the type of relationship (for example, husband, sister, friend, etc.) listed for each significant person in his or her life. Then the subject rated each of these network members on a Likert scale according to the amount of affect, affirma-tion, and aid support functions that they provided. This provided the score for social support quality. The scale was as follows: 1 re-presented "a little;" 3 represented "moderately" or "in between';" 4 represented "quite a bite;" and 5 represented "a great deal" (Norbeck,

Lindsey, & Carrieri, 1981, p. 265). Questions 1 and 2 measured affect information, questions 3 and 4 measured affirmation information, and questions 5 and 6 measured aid information. These three subscales were totaled to yield individual subscale scores for each affect, affirmation, and aid function. These three results were then totaled to yield the total functional variable (Norbeck, 1980).

Number in the network, frequency of contact, and duration of relationships comprised the social network properties. Number in the network was obtained by calculating the total number of listed network members and coding the type of relationship for each. Scores for the duration of the relationship and frequency of contact were obtained from questions 7 and 8 respectively, which yielded answers to Likert scales. The scale for duration was: 1 = less than 6 months; 2 = 6 months-1 year; 3 = 1-2 years; 4 = 2-5 years; 5 = more than 5 years. Frequency of contact was coded as: 5 = daily; 4 = weekly; 3 = monthly; 2 = a few times a year; 1 = once a year or less. These subscales of number in network, duration, and frequency of contact were summed to yield a score for the variable called total network variable.

Loss of network members were also accounted for in questions 9, 9a, and 9b. Question 9 asked if the respondent had lost important relationships within the past year. If "yes," question 9a elicited the number and type of network members that were not longer available. Question 9b evaluated the amount of social support that was once provided by the lost members according to a Likert scale with 0 as none at all; 1 as a little; 2 as a moderate or in between amount; 3 as quite a bit; and 4 as a great deal. These three variables of recent losses; loss quantity,

and loss quality were totaled to yield a score known as total loss variable (Norbeck, 1980).

Responses for questions 1 through 8 ranged from 1 to 5 points. A total possible score for deciding whether a subject had a high or low amount of support is not provided the author of the tool. Therefore, the mean total social support score used as the dividing point between high and low amounts of social support. This same procedure was used for determining high and low scores of the social support subscales (affect, affirmation, aid) and the total network properties score. The total loss score was reported as an average of all study participants.

The instrument was tested by Norbeck, Lindsey and Carrieri in two phases (1981; 1983). In phase 1 (1981), 75 graduate students completed the Norbeck Social Support Questionnaire and were then retested one week later. Pearson correlations were obtained for all the Norbeck Social Support Questionnaire items. The affect, affirmation, and aid subscales had high test-retest reliability with a range of .85 to .92. Kendall Tau B correlations for test-retest scores on the number of network members lost and amount of lost support was .83 ($p < .0001$) and .71 ($p < .0001$) respectively. Correlations between individual items were .97 for affect items, .96 for affirmation items, and .86 for aid items. Network properties for size of network, duration, and frequency of contact had correlations ranging from .88 to .96 (Norbeck, Lindsey, & Carrieri, 1981). Thus, there was high internal consistency. The instrument also appeared to be free from social desirability response bias as determined by the low correlations (from .01 to .17) obtained from the concurrently administered Marlow-Crowne Test of Social Desirability (1960) and the Norbeck Social Support Questionnaire.

Validity data was reported from Phase Two only. Concurrent validity was obtained by comparing the results of the Norbeck Social Support Questionnaire with the Personal Resource Questionnaire developed by Brandt and Weinert (1981). Medium levels of association (.35 to .41) were found between the functional components of Norbeck Social Support Questionnaire and Personal Resource Questionnaire. Lower but significant levels of association were found between most of the network properties of both instruments (.24 to .31). The number listed in the network subscale was not significantly related to the Personal Resource Questionnaire because of the different formats of the two instruments. While the Norbeck Social Support Questionnaire is based on ratings for previously listed network members, the Personal Resource Questionnaire is based on global evaluations of support.

Phase Two of the testing established construct validity by examining correlations between the Norbeck Social Support Questionnaire subscales for function, network, and loss, as well as total variables in each of these and related and nonrelated constructs and Schutz's (1978) Functional Interpersonal Relations Orientation (Firo-B). The related constructs included the need for inclusion (network and functional subscales - .17 to .26; loss subscales - .10 to .19; total variables - .15 to .24) and affection (network and functional subscales - .15 to .27; loss subscales - .05 to .18; total variables .13 to .24). The unrelated construct was the need for control (network and functional subscales = - .09 to .02; loss subscales = .09 to .11; total variables = - .04 to .11). Pearson correlation coefficients were small but significant between the Norbeck Social Support Questionnaire subscales and the related construct (Norbeck, Lindsey, & Carrieri, 1983).

Extraneous Variables

The perception of social support could have been affected by certain identified variables that could have had an undesirable effect on the variable being studied (Polit & Hungler, 1981). Such variables as sex (Lowenthal & Haven, 1968; Hirsch, 1979; Sarason, Levine, Basham, & Sarason, 1983); marital status (Lowenthal & Haven, 1968); enrollment in social groups (Weiss, 1976; Cronenwatt, 1980; Knight, Wollert, & Levy, 1980); educational preparation, occupation, number of children, place of residence, participation in religious and social activities, and birthplace might have had an effect on data collected on social support; therefore, they were included on the demographic questionnaire. Disease-related variables, such as site of cancer, time since diagnosis, concurrent medical conditions, treatment modalities at the time of data collection, and activity in cancer-related programs could also have undersirably affected the social support variable. This information was accounted for in data analysis. Age, another extraneous variable, according to Sarason, Levine, Basham, and Sarason (1983) and Norbeck (1981), was partially controlled for by limiting the sample to persons aged 50 years and above. Income level was also partially controlled for because subjects who are State Cancer Clinic clients are primarily in the low or fixed income brackets.

Recognition of the influence of all these factors were accounted for by recording and taking them into account in data analysis. Types of agencies involved in care, such as Home Health or Hospice could also have impacted on data collection; these factors, therefore, were controlled for using statistical analysis described in the data analysis section.

Data Collection

The environment in which data was collected could have had an effect on data collection since actual social support network members may have accompanied the clients to the clinic and therefore may have been present during the time of data collection. To help control for this, subjects were taken to a private area in the clinics while the questionnaires were being answered. Only the investigator was present during the actual data collection period.

Once the subjects were chosen on the basis of the Orientation Questionnaire and Criteria for Inclusion and had signed the Informed Consent Agreement, the investigator explained how Norbeck Social Support Questionnaire and the Information Questionnaire were to be completed and answered any questions that the clients had. Those requiring no assistance were directed to complete the two questionnaires. For those who required assistance, the questions were asked verbatim and answered according to the subjects' directions. The questionnaires took 15 to 25 minutes to complete.

Data Processing

Responses from the tools were coded for computer utilization. The Norbeck Support Questionnaire was scored according to the tool's specifications. The demographic questionnaire allowed for reporting certain extraneous variables such as sex, marital status, age, enrollment in social groups, education level, occupation, number of children, place of residence, participation in religious and social activities, birthplace and for examining data for differences related to these factors. The demographic questionnaire also provided additional information, such as cancer site, concurrent medical conditions, treatment modalities, and

activity in cancer-related or other disease-related groups. Each subject's responses received the following scores:

1. social support functions - a) affect subscale, b) affirmation subscale, c) aid subscale, d) total functional support variable (sum of previous subscales),

2. network properties - a) number in network, b) duration of relationship, c) frequency of contact, d) total network variable,

3. loss variables - a) recent losses, b) loss quantity, c) loss quality, d) total loss variable.

Data Analysis

After the data were collected, descriptive, correlational and ANOVA statistical methods were used for analysis of the social network properties, social support functions, and quality of social support using the SAS statistical format. Responses from the tool were examined to determine if any relationship to selected demographic characteristic of the sample existed. Finally, the quality of social support was compared with normative social support data by a t-test to answer the question as to whether or not the quality of social support in Blacks was different from that of the normative group and, if different, what the direction of the difference was. An alpha level of .05 was utilized.

The purpose of this study included describing the perceived social support network of Black cancer clients regarding its properties, functions, and quality (specified by Likert-style ratings of affect, affirmation, and aid social support subscales) and comparing these descriptions to normative social support data as found in Norbeck's, Lindsey's, and Carrieri's study of employed adults (1983). In addition, demographics of the sample were described and examined to see if they were related to differences in reported social support. Twenty subjects were selected from Black cancer clients attending three State-sponsored Cancer Clinics housed within two teaching medical centers and one rural hospital in the northwestern area of South Carolina.

Subjects completed three instruments: the Orientation Questionnaire, the Norbeck Social Support Questionnaire, and the Information Questionnaire. The Orientation Questionnaire was used to select subjects for participation. The Norbeck Social Support Questionnaire measured the subjects' perceptions of social support according to Kahn's (1979) definition. The third instrument, the Information Questionnaire, obtained socioeconomic, disease-related, and activity-related data that could influence social support. All data were collected by the investigator during the months of September and October, 1987; questionnaires were completed by the investigator as directed by the clients. Correlation and analyses of variance statistics were used to determine associations between in demographic and social support variables. The Alpha level was set at .05.

The Subjects

Thirteen females and 7 males participated in the study. Selected
socioeconomic characteristics of the subjects are listed in Tables 1 and
2. In addition to these data all clients stated a religious preference.

TABLE 1

SELECTED DEMOGRAPHIC CHARACTERISTICS

	Males $\underline{n} = 7$	Females $\underline{n} = 13$	Total $\underline{N} = 20$
Age in years			
Range	51-76	53-95	51-95
Mean	62.7	67.2	65.7
S.D.	7.9	13.0	10.8
Education in years			
Range	5-13	5-13	5-13
Mean	7-3	10.1	9.1
S.D.	2.8	2.3	2.7
Number of Children			
Range			1-5
Mean			2.9
S.D.			1.8
Number of Grandchildren			
Range			2-20
Mean			6.0
S.D.			5.1

TABLE 2

FREQUENCY DISTRIBUTION OF DEMO-GRAPHIC CHARACTERISTICS

	Males		Females		Total	
	n	%	n	%	N	%
Marital Status						
Single	1	5	2	10	3	15
Married	2	10	0	0	2	10
Divorced	2	10	3	15	5	25
Widowed	2	10	8	40	10	50
Income Level						
9,999	4	20	9	45	13	65
10 - 14,999	1	5	1	5	2	10
35 - 39,999	0	0	1	5	1	5
Unknown/not reported	2	10	2	10	4	20
Employment						
Full-time	0	0	2	10	2	10
Part-time	1	5	0	0	1	5
Retired	3	15	6	30	9	45
Disabled	3	15	5	25	8	40

The majority of clients (n = 15) were Baptist: of these, 2 subjects belonged to the Freewill Baptist church while 5 subjects specified the Missionary Baptist Church as their preference. Those of the Baptist churches indicated greater participation in church activities than did

members of other churches. A frequency distribution of religious parti-

cipation is shown in Table 3.

TABLE 3

RELIGIOUS PARTICIPATION OF CLIENTS

Religious Preference	Total N	%	1-2 times/year n	%	Monthly n	%	Weekly n	%
Baptist	8	40	1	5	4	20	3	15
Freewill Baptist	2	10					2	10
Missionary Baptist	5	25			3	15	2	10
United Methodist	2	10	1	5	1	5		
Holiness	1	5					1	5
New Zion Holiness	1	5			1	5		
Church of Christ	1	5			1	5		

Clients lived in four counties in the northwestern area of South

Carolina: 10 subjects lived in Anderson, 6 lived in Greenville, and 2

each lived in Pickens and Spartanburg counties. Eighteen clients were

born in the northwestern area of South Carolina, one client was born in

Mississippi, the other in Georgia. The majority of the clients in this

sample were born in Anderson County (n = 9). Of those born in South

Carolina, none had relocated more than 30 miles from their home of

birth. Clients had lived at their current residence for a mean of 27.3

years (range of .1 to 85 years) and had a range of 1 to 3 persons living

with them (mean = 1.6). Persons living with the clients were composed

primarily of spouse/partners and family members. Of the thirteen female clients, 8 lived with family members, while 5 lived alone. Of the male clients, two lived alone, 2 with family members, and two lived with a spouse/partner. One male client lived with a friend.

Breast cancer (n = 4) followed by colon cancer (n = 3) were the most frequent sites of cancer (see Table 4). Clients had had cancer for

TABLE 4

DISTRIBUTION OF CANCER DIAGNOSIS BY COUNTY

Cancer Diagnosis	Greenville n	%	Anderson n	%	Pickens n	%	Spartanburg n	%	Total N	%
Breast	2	10	2	10					4	20
Colon	1	5	1	5			1	5	3	15
Lung	2	10							2	10
Uterus	1	5	1	5					2	10
Bone			1	5	1	5			2	10
Neck					1	5			1	5
Neck/Arm			1	5					1	5
Breast/ Colon							1	5	1	5
Leukemia			1	5					1	5
Stomach			1	5					1	5
Throat			1	5					1	5
Tonsil			1	5					1	5
Total	6	30	10	50	2	10	2	10	20	100

a mean of 4.3 years. Six clients were receiving no form of cancer treatment at the time of data collection. None had had surgery within the past three months. A frequency distribution of the treatment types is presented in Table 5.

TABLE 5

FREQUENCY DISTRIBUTION OF TREATMENT MODALITIES

Treatment Modality (N = 20)	n	Percent
Chemotherapy	3	15
Radiation therapy	2	10
Pain therapy	2	10
Chemotherapy, Blood	2	10
Radiation therapy, Blood, Pain Therapy	2	10
Chemotherapy, Pain Therapy, Blood	1	5
Radiation therapy, Pain Therapy	1	5
No treatment	1	5
No response	6	30

The majority (n = 5) of clients had 2 concurrent illnesses (see Tables 6 and 7). Only one person, a female, participated in a cancer-related program (a hospital-based support group). Eight clients identified the American Cancer Society, hospital auxiliary, and/or church volunteers as providing help, one client identified home health

TABLE 6

FREQUENCY DISTRIBUTION OF CLIENTS'
NUMBER OF CONCURRENT ILLNESSES

Number of Concurrent Illness	n	Percent
0	4	20
1	4	20
2	5	25
3	4	20
4	1	5
5	2	10

TABLE 7

TYPES OF CONCURRENT ILLNESSES

Other Illness ($\underline{N}$ = 20)	n	Percent
Hypertension	12	60
Arthritis	9	45
Heart Disease	6	30
Anemia	6	30
Diabetes	4	20
Lung Disease	2	10
Kidney Disease	1	5

personnel, and two identified the health department visiting nurisng
personnel as providing help to them. Twelve clients indicated that they
received no help from other groups.

Nine clients reported participating in other community, job re-
lated, or social groups. The number of groups involved in ranged from 1
to 5 with a mean of 3 for this group of clients.

Social Support Results

The first question addressed in the study was: what were the
social support functional and network properties as perceived by Black
cancer clients. To answer this, Norbeck Social Support Questionnaire
responses were summed to provide scores for affect, affirmation, and
aid, total mean functional support, number of network members, cate-
gories of network members, frequency of contact, duration of relation-
ships with network members, total network, network support provided by
network category, functional support provided by network category,
recent losses, loss quantity, loss quality, and total loss. Group means
for the affect, affirmation, and aid subscales were 66.28, 57.19, and
52.23 respectively. The mean total social support functional score was
175.70 with scores ranging from 18-204. When these figures were separ-
ated out for male and female clients, male clients had less total
functional support than females clients (M = 186.0, S.D. = 9.8, range =
69-477 for males, M = 343.8, S.D. = 26.7, range = 78-441 for females)
and less total network support than females (M = 69.8, S.D. = 8.6,
range = 30-173 for males; M = 122.8, S.D. = 17.9, range = 32-221 for
females). In addition, males had a total loss score that was higher

than that for females ($\underline{M}$ = 5.2, S.D. = 7.11, range = 0-16 for males; $\underline{M}$ = 2.9, S.D. = 4.87, range = 1-14 for females). These figures are depicted in Table 8.

TABLE 8

MALE AND FEMALE SOCIAL SUPPORT SCORES

	Mean		S.D.		Range	
	Male $\underline{n}$ = 7	Female $\underline{n}$ = 13	Male $\underline{n}$ = 7	Female $\underline{n}$ = 13	Male $\underline{n}$ = 7	Female $\underline{n}$ = 13
Affect	67.3	124.7	.9	4.4	27-160	30-204
Affirmation	64.0	115.8	2.1	4.4	24-157	30-121
Aid	54.7	103.3	6.8	17.8	18-160	18-116
Total Functional Score	186.0	343.8	9.8	26.7	69-477	78-441
Number in Network	6.6	7.5	4.5	5.1	3-16	3-23
Duration of Re- lationships	34.8	61.8	.71	3.9	15-80	15-115
Frequency of Contact	28.4	53.5	3.4	8.9	12-77	14-83
Total Network Score	69.8	122.8	8.6	17.9	30-173	32-221
Recent Losses	.4	.4	.51	.51	--	--
Loss Quantity	4.1	1.3	5.5	2.7	0-13	0-10
Loss Quality	.7	1.2	1.2	1.7	0-3	1-4
Total Loss Vari- able	5.2	2.9	7.1	4.9	0-16	1-14

The total mean loss score was 5.1 and consisted of the sum of the mean number of recent losses (.4), mean loss quantity (2.3), and mean loss quality (2.4). Table 9 displays the mean, standard deviation, and score range for the scales, subscales, and variables of the Norbeck Social Support Questionniare.

TABLE 9

DESCRIPTIVE STATISTICS FOR THE NORBECK SSQ SCALES SUBSCALES AND VARIABLES

	Mean	S.D.	Range
Affect	66.28	5.39	27-204
Affirmation	57.19	6.51	24-175
Aid	52.23	24.63	18-160
Total Functional	175.70	36.53	69-521
Number in Network	7.15	5.05	3-23
Duration of Relationships	33.63	4.55	15-115
Frequency of Contact	27.31	12.34	12-83
Total Network Variable	68.09	21.92	30-221
Recent Losses	0.40	.50	--
Loss Quantity	2.30	4.11	0-13
Loss Quality	2.43	1.51	0-14
Total Loss Variable	5.13	6.12	0-17

Total network property scores were made up of the number of the network, duration of relationships, and frequency of contact. The number of social support network persons ranged from 3 to 23 with a mean of 7.15 persons and a standard deviation of 5.05 persons. Most of the Black cancer clients had known their network members longer than 5 years (M = 4.78, on a scale where 4 = known 2-5 years, 5 = known more than 5 years). The total mean for duration of relationships was 33.63 with females reporting mean durations nearly twice that of males. The majority of these clients had had contact with their network members daily, with a mean frequency of contact of 3.99, on a scale where 3 = monthly, 4 = weekly, and 5 = daily. The total mean for frequency of contact was 27.31. The total network score was 68.09 with scores ranging from 30 to 221.

In scoring the questionnaire, social support network members were coded into nine categories. All the Black clients listed family members/relatives in their network. Expressed as a proportion of the total number lised in the support network, this category represented 61.5 percent. The friend category was listed by 55 percent of the subjects and represented 17.5 percent of the total number listed in the network. Conversely, 80 percent of the subjects did not list anyone in the categories of health care provider or neighbor, while 90 percent did not list anyone in the categories of spouse/partner or work/school associate. One fourth of the subjects listed ministers/priest/pastors and none listed counselor/therapist as a category or other as a category (see Table 10).

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TABLE 10

NETWORK PROPERTIES BY SOCIAL
SUPPORT NETWORK CATEGORY

Social Support Network Category	Number in Network	Number of Clients	Frequency of Contact		Duration of Contact	
			Mean	S.D.	Mean	S.D.
Family/Relatives	2-4 5-10 11-13	16 1 3	4.78	1.00	4.91	.48
Spouse/Partner	2	2	4.79	.54	5.00	0
Friends	1 2-3 4-5	5 3 3	3.78	1.09	4.95	.27
Work/School Associates	2	2	3.47	1.09	4.68	.73
Neighbors	9	4	3.66	.91	4.93	.37
Health Care Providers	1-2 3-4 5-6	3 0 1	3.38	1.18	4.23	1.08
Counselor/ Therapist	--	--	--	--	--	--
Minister/Priest/ Pastor	6	5	4.05	1.08	4.93	.33
Other	--	--	--	--	--	--

[a]5 = daily contact; 4 = weekly contact; 3 = monthly contact

[b]5 = more than 5 years; 4 = 2 to 5 years

Other network properties by social support network category are shown in Table 10. Clients had most frequent contact with their spouses/partners and family/relatives - weekly or more. They also saw their minister/priest/pastor approximately weekly. They had contact

with all other network members more than once each month. The duration

of relationships or length of time known was approximately five years

for all network categories except work/school associates and health care

providers, who had been known for two to five years.

The proportion of total functional support and total frequency of

contact provided by the nine network categories varied a great deal

also. Family members provided the highest proportion of function and

contact, while friends provided the next highest proportions of func-

tional support and contact. Health care providers were rated next,

followed by neighbors. The minister/priest/pastor category made up 4.2

percent of the network and provided this proportionate amount of func-

tional support and contact. The spouse/partner and work/school

associates provided the least proportion of functional support and

contact (see Table 11).

The second question in this study was: what was the quality of

social support as perceived by Black cancer clients. Average ratings

for individual network members indicated high quality support as per-

ceived by Black cancer clients. These scores were obtained by dividing

the mean score of a subscale by the number in the network and correcting

for the number of questions in each subscale, for example, the affect

score was calculated by totalling the mean scores for affect 1 and

affect 2 and dividing by 2 times the mean number listed in the network.

Average scores for the Black subjects were: affect, 4.63 (quite a bit

to a great deal); affirmation, 4.00 (quite a bit); aid, 3.65 (in between

to quite a bit); duration of relationships, 4.70 (5 years and more); and

frequency of contact, 3.82 (monthly to weekly).

TABLE 11

SOCIAL SUPPORT NETWORK CHARACTERTICS

Social Support Network Category	Mean	Range	Proportion of Total Number Listed in Network	Proportion of Total Funct- tional Support	Proportion of Total Frequency of Contact
Spouse/partner	0.10	0-1	1.4	1.5	1.7
Family/relatives	4.40	2-13	61.5	63.3	67.4
Friends	1.25	0-5	17.5	16.5	15.2
Work/School Associates	0.10	0-1	1.4	1.2	1.0
Neighbors	0.45	0-5	6.3	5.3	6.0
Health Care Providers	0.55	0-6	7.7	7.7	4.7
Counselor/Therapist	--	--	--	--	--
Minster/Priest/ Pastor	0.30	0-2	4.2	4.5	4.0
Other	--	--	--	--	--

The determination of whether or not a client had high or low scores on the Norbeck Social Support Questionnaire scales and subscales was made by comparison with the group means. This procedure was described previously in the methodology section. Clients had high scores on all the subscales. However, clients reported a low number in network score and received a low total network score. Table 12 displays the frequency distribution of high and low scores on the Norbeck Social Support Questionnaire subscales and scales.

TABLE 12

FREQUENCY DISTRIBUTIONS BASED ON HIGH AND
LOW SCORES FOR NORBECK SOCIAL SUPPORT
SCALES AND SUBSCALES

Scales and Subscales	Score	Frequency N	%
Affect	High	14	70
	Low	6	30
Affirmation	High	16	80
	Low	4	20
Aid	High	13	65
	Low	7	35
Frequency of Contact	High	15	75
	Low	5	25
Duration of Contact	High	14	70
	Low	6	30
Social support	High	17	85
Function	Low	3	15
Social Support	High	7	35
Network	Low	13	65

Comparison with Normative Data

The third question asked in this study was whether the quality of Black cancer clients' social support was different from that of the subjects in Norbeck's, Lindsey's, and Carrieri's (1983) study. Data were separated out for males and females to answer this question. Two-tailed t-tests were computed with the alpha level set at .05. There were no significant differences in social support quality for the Black versus the subjects in the reported normative data (Tables 13 and 14). However, there was a significant difference in the means for numbers of total network members reported by females in the two data sets. The mean total number of network members for the 13 females Black was 7.5 and that for the reported normative data set of 89 employed adult females was 12.4. The t value of -3.47 (df = 12) was significant at the .05 alpha level (Table 13). However, there was no significant difference in means for the total network scores of both groups (see Table 13 and 14). There was also a significant difference in means for loss quantity in males for the two groups. The group of 7 male Black clients had a mean loss quantity score of 4.1 compared to .6 for the reported normative data set of 47 males. The t value was 10.1 (df = 6) at the alpha level of .05 (Table 14). Lastly, a significant difference was found for the total loss score for the two groups of males. In this case, the mean loss score was 5.3 for the Black males and 1.8 for the reported normative data for males. The t value was 3.65 (d = 6; p < .05) (Table 14).

Despite the result that there were no signficant differences in social support quality, the average ratings for individual network members indicated that minor differences were evident between the normative

TABLE 13

T-TESTS OF SOCIAL SUPPORT SCORES FOR FEMALE BLACK VERSUS NORMATIVE SUBJECTS

Social Support Score	Black Clients		Normative Subjects		
	Mean	Standard Error of Mean df = 12	Mean	Standard Error of Mean df = 88	t
Affect	124.7	1.22	101.48	12.37	1.88
Affirmation	115.8	1.23	92.52	11.25	2.07
Aid	103.3	4.95	87.18	11.06	1.46
Total Function	343.8	7.40	281.18	33.66	1.86
Number in Network	7.5	1.42	12.39	1.41	-3.47*
Duration of Relationships	61.8	1.08	54.70	6.29	1.13
Frequency of Contact	53.5	2.48	44.84	5.07	1.71
Total Network	122.8	4.98	111.93	12.39	.88
Recent Losses	.4	.13	.44	.14	.43
Loss Quantity	1.3	.74	1.09	.44	.5
Loss Quality	1.2	.48	1.16	.43	.16
Total Loss	2.9	1.35	2.69	.94	.24

Note: The critical value for t at p = .05 and 2 df is 2.179. *Indicates significance

TABLE 14

T-TESTS OF SOCIAL SUPPORT SCORES FOR MALE BLACK VERSUS NORMATIVE SUBJECTS

Social Support Score	Black Clients		Normative Subjects		
	Mean	Standard Error of Mean df = 6	Mean	Standard Error of Mean df = 46	t
Affect	67.3	.37	91.51	19.07	-1.27
Affirmation	64.0	.78	86.94	19.48	-1.31
Aid	54.7	2.55	86.36	17.10	-1.85
Total Function	186.0	3.71	263.26	51.12	-1.51
Number in Network	6.6	1.70	11.85	2.35	-2.23
Duration of Relationships	34.8	.25	51.81	11.03	-1.55
Frequency of Contact	28.4	1.28	44.02	9.02	-1.73
Total Network	69.8	3.23	107.68	21.75	-1.74
Recent Losses	.4	.18	.37	.18	.33
Loss Quantity	4.1	2.06	.61	.35	10.1 *
Loss Quality	.7	.44	.80	.48	-.19
Total Loss	5.3	2.68	1.78	.96	3.65 *

Note: The critical value for t at p = .05 and df is 2.447. *Indicates significance

group and the Black clients. These results indicated that Black clients
had higher average scores than the reported normative data for all
subscales (see Table 15).

TABLE 15

AVERAGE SOCIAL SUPPORT SCORES OF BLACK
CLIENTS AND NORMATIVE SUBJECTS

Subscale	Black Clients $\underline{N}$ = 20	Normative Clients $\underline{N}$ = 136
Affect	4.63	4.02
Affirmation	4.00	3.71
Aid	3.65	3.56
Duration of Relationships	4.70	4.40
Frequency of Contact	3.82	3.65

Normative data subjects perceived "quite a bit" of affect compared to
Black clients, who perceived "quite a bit" to "a great deal." Affirma-
tion was percieved as being provided "quite a bit" by the Blacks versus
"in between" to "quite a bit" for the reported normative data. Aid was
listed as being provided at an "in between" amount by both groups, while
the duration of contact was 2 to 5 years for both. Subjects in both
data sets perceived themselves as having contact with members of their
networks weekly to monthly.

Comparison of Social Support to Demographic Variables

In addition to the three questions addressed in this study, one of
the purposes was to examine the demographics of the sample to see if

they were related to differences in reported social support. Correlation coefficients were used to examine the relationships between the Norbeck Social Support Questionnaire subscales and variables and demographic characteristics of the sample. Subscales included affect, affirmation, aid, frequency of contact, and duration of relationships. Number listed in the network, loss quantity, and quality of support lost were the variables correlated. Demographic characteristics chosen for correlation included number of grandchildren, number of great-grandchildren, length of time live at present residence, number of persons lived with, involvement in social groups, and time since diagnosis. The alpha level was set at .05.

Significant positive correlations were found between the groups on the number listed in the network and quantity of lost social support members, and between the number listed in the network and the number of grandchildren, and between the quantity of last social support members and the number of grandchildren. No other significant correlations existed. These correlations are shown in Table 16.

Several one-way analyses of variance computations were done to determine if significant differences occurred when various demographic variables were paired with the following social support variables: network number listed, number lost, affect, affirmation, aid, duration of relationships, frequency of contact, quantity lost, and quality of support lost. Paired analyses were carried out between these and sex, marital status, and religious participation. One significant finding resulted: there was a significant difference in perceived frequency of contact when religious participation was accounted for (see Table 17).

TABLE 16

PEARSON CORRELATION COEFFICIENTS COMPARING
SELECTED DEMOGRAPHIC AND SOCIAL
SUPPORT VARIABLES

	Mean	r	p
Quantity Lost	5.75	.778*	.02
Number in Network	7.15		
Quantity Lost	5.75	.866*	.01
Number of grand-children	6.0		
Number in Network	7.15	.647*	.02
Number of grand-children	6.00		

*Significant at p < .05

TABLE 17

ONE-WAY ANALYES OF VARIANCE FOR PAIRING SELECTED
DEMOGRAPHIC VARIABLES WITH SOCIAL
SUPPORT VARIABLES

Variable	Sum of Squares	df	Mean Square	F	Pr F
Religious participation	2.615	2	1.308	3.65*	.048
Frequency of Contact	6.085	17	.358		
Sex	73.63	1	73.663	4.17	.087
Quantity Lost	105.87	6	17.644		
Marital Status	144.75	3	48.250	5.55	.066
Quantity Lost	34.75	4	8.688		

*Significant at p < .05

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The relationships of marital status and sex and quantity lost approached significance (p = .066).

Discusssion

In providing information about and attempting to understand differences and similarities which characterize the cultural diversity of various client populations, it is helpful to compare findings between cultural groups (Lindsey, Ahmed, & Dodd, 1985). Several demographic characteristics of this sample of Black cancer clients were different from those reported in the normative data by Norbeck, Lindsey, and Carrieri (1983).

Demographic comparisons between the two groups showed that the mean age of the normative data set was 35.8 years (range = 22-67 years), while that of the Black clients was 65.7 years (range = 51-95 years) Thirty-five percent of both groups were male and 65 percent were female. Ten percent of the Black clients versus 42 percent of the normative data group were married; 15 percent compared to 46 percent were single, 25 versus 10 percent were divorced, and 50 versus 2 percent were widowed respectively. The mean number of years of education was 15.9 (range = 10-22 years) for the normative data set and 9.1 (range 5-13 years for the Black clients. The differences are reflective of the age differences and culture of the two groups. Carnevali and Patrick (1986) state that 50 percent of persons over 65 have less than a tenth-grade education, while the reported median number of years of education is 8 years for Blacks (American Association of Retired Persons, 1984). The religious preference for the Black clients was totally Protestant; however, the preferences for the normative group were Catholic, 24.3

with the Black cancer clients who all had such an affiliation. Blacks have traditionally affiliated with churches, in this sample the subjects continued to do this.

Black clients in this study were older, less educated and poorer than the subjects in Norbeck's data. In addition, only three of the Black subjects were employed, one of these part-time. Even more significantly, only two subjects were married at the time of the study, although seventeen, or 75% of the sample had been married. The high rate of marriage within this group contrasts with the popular myth that Black do not seek long-term legalized relationships.

The first question asked in this study was what were the social support functional and network properties as perceived by Black cancer clients. This question as well as question 2 will be discussed by comparing social support functions and networks of the Black clients with those reported in the normative data. The mean total social support functional score for the Black clients was 175.70. This was lower than that of the reported normative data, which was 275.52. Norbeck provided the total social support functional scores only by sex. Therefore the differences between these scores for the total group could not be calculated. However, male and female scores did not significantly differ.

The second question asked in this study was: what was the quality of social support as perceived by Black cancer clients. The Black cancer clients perceived a high quality of social support. When average ratings for affect, affirmation, aid, duration of relationships, and frequency of contact were compared for the black and the normative data sets, the Black clients had higher scores in all categories. The normative group's mean number of network persons was 12.2, while that for

frequency of contact were compared for the black and the normative data sets, the Black clients had higher scores in all categories. The normative group's mean number of network persons was 12.2, while that for this study was 7.15, even though both data sets reported from 3-23 members in their networks. Thus, although the Black clients had a smaller network than that found in the normative study, they reported a high quality of support. The smaller network size may also be related to the age and nonworking status of the sample. Work offers the opportunity to make more social contact.

The functional support scales perceived to effect more support were those depicting affect and affirmation rather than aid. The relatively low importance of aid may be reflective of the limited economic resources available to these clients and their network. They may not have had much to share. In addition it may reflect the willingness of these clients to "make do" with what they have. Elderly persons, especially those who have lived lives boardening on poverty, probably do not focus as much on material aid as on affirmation and affect needs. The importance of affect and affirmation emphasizes the needs of Black clients for these types of social support. The findings suggest that nurses should incorporate affect and affirmation support in their transactions with persons from culturally diverse groups. Affective transactions depict liking, admiration, respect, and love of clients by nurses: nurses transmit such caring messages through their doing with and for clients. Affirmative transactions incorporate expressions of agreement or acknowledgement of clients' appropriateness or rightness: essentially, nurses transmit the message that they are with their clients, who are accepted for who they are and for what they have done.

When the results were broken down by categories of social network members, both data sets indicated that the family/relatives accounted for the greatest amount of social support. The Black clients also reported the family/relatives as making up the highest proportion of their network; however, the normative data indicated that friends comprised the largest proportion of the support network.

In addition, the Black clients listed the family/relatives category as providing the greatest proportion of functional support and contact while the normative group reported friends to do so. Several authors have alluded to the strong kinship bonds among Black families that have existed since slavery times (Blassingame, 1972; Nobles, 1974; Gutman, 1976; Nobles & Nobles, 1976; Staples, 1976; Martin & Martin, 1978; McAdoo, 1978; Lantz, 1980; Thomas, 1981; Hinds & Boyd-Franklin, 1982; Bloch, 1983; Suggs, 1986). Also, one function of the Black family has been specified by Martin and Martin (1978) as promoting the welfare of dependent family members by dealing with crisis situations such as major illness. Other authors have corroborated this claim (Billingsley, 1968; Hill, 1972; Nobles, 1976; Ball, Worheit, Vandiver, & Holzer, 1979; 1980; Raymond, Rhoads, & Raymond, 9180; Stewart & Vaux, 1986).

On the other hand, the California Department of Mental Health (1982) reported mixed findings for the Black subjects in their study: while they stated that brothers and sisters provided emotional, judgmental, intimacy, and financial support, they reported no support from this category during major illnesses. This 1982 study also indicated that reciprocation was highest in the Black cultural group, as compared with five other culturally diverse groups. Thus, perceptions of a high proportion of family/relative network members who provide a high degree

of functional support and contact by Black cancer clients is consistent
with that found in the majority of the literature.

While friends were reported by 94.1 percent of the normative data
set as comprising the highest percentage of network members (35.9 per-
cent), this category made up 17.5 percent for 55 percent of the Black
clients. In addition friends provided 44 percent of the functional
support and 43.2 percent of contact in the normative group. These
figures for the Black clients were 16.5 percent and 15.2 percent res-
pectively. In the Black clients, these figures represented the next
highest proportions, compared to the family/relative category, of
functional support and contact. The literature provides contradictory
explanations for this finding in Blacks. Nobles (1976) and the
California Department of Mental Health (1982) found that friends provide
a great deal of support. However, Stewart and Vaux (1986) found that
Black college females had little emotional support from friends and
labelled fewer friends than White females. The Blacks in this study
were older and nonworking; thus their contacts were more restricted.
Low income level may also have affected these results: friends may more
frequently participate in activities which cost that do family members.
Thus, the different results may be more related to social situation than
to culture.

In contrast to the small percentage of network members in the
health care provider category reported by the normative group (.9) the
Black cancer clients reported health care providers as comprising 7.7
percent of their network. Although this percentage is comparatively
small when one compares it to other network categories, this figure is
most likely greater in the Black clients as a result of their cancer;

all the Black cancer clients were under continued medical supervision
during the time of this study.

In the State Cancer Clinics, doctors were involved primarily in
examining and prescribing. Because of clinic flow, very little time was
devoted to the visits themselves. Nurses in the clinics assisted the
doctors and coordinated the clinic activities unless the clients were
receiving chemotherapy. Chemotherapy was given to 30 percent of these
clients by the nurses during the clinic visit, usually after all the
doctors had completed their examinations. Administration of chemo-
therapy required that nurses stay with clients approximately 30 minutes.
This required contact did provide opportunity for a supportive
relationship.

Larger numbers of health care providers as well as a larger pro-
portion of functional support might have resulted had more time been
made available for emotional support. During clinic visits, social
workers were not in attendance although they were on call if needed.
Whether or not clients were aware that these persons were available to
them was not clear. Most clients spent at least one hour waiting for
the physician to see them. This time was spent alone or with accompany-
ing network members in the waiting rooms. Volunteers were present with
refreshments in these waiting rooms. Thus, clients received primarily
aid support from the health providers. Hirsch (1979) and Kapferer
(1969) stated that multidimensional relationships, or those involving at
least two different kinds of activities or behaviors, were perceived as
being stronger and more reliable sources of support. If the health pro-
fessionals in this study, then, had provided social support other than
and in addition to aid support, the clients may have perceived them to

provide a greater proportion of functional support. The question also arises as to the amount of support attributed to the volunteers in the waiting room. It is possible that contact with these volunteers was reported as support from health care professionals since, potentially, they spent the greatest amount of time with the clients. If this were so, then the actual support from health professionals would be greatly smaller.

One possible explanation for the time spent alone in waiting rooms by clients is avoidance behavior on the part of the health care providers. Several authors have stated that health providers often avoid cancer clients (Pinkerton & McAleer, 1976; Schulz, 1978), especially when the client's condition is deteriorating (Glaser & Strauss, 1967; Kastenbaum & Aisenberg, 1972; Artiss & Levine, 1973; Fosson, 1980). The average length of time since diagnosis for the Black cancer clients was 4.3 years. The effect of this time period is unknown.

Another possible explanation for the smaller proportion of perceived functional support from these health providers compared to that from family/relatives and friends is that these Black clients may not have felt as comfortable sharing their thoughts and feelings with them. A study by Ahmadi (1985) showed that Black hospitalized clients experienced more stress thought to be related to environment and/or nurse/client interaction, while several authors stated that Blacks may distrust the predominantly White health professionals (Hays & Mindel, 1973; Jackson, 1978; Wimberley, 1982).

The spouse or partner category, while comprising 6.8 percent of the network for the normative data set, made up only 1.4 percent of that in

the Black clients and provided a proportionate amount of functional support and contact. These findings are partially explained by the result that only 2 of the Black cancer clients were married. A secondary explanation for the spouse/partner category providing such a small proportion of social support may lie in the clients' condition as having cancer. Cancer clients frequently have problems in interpersonal relationships that arise because of communication difficulties (Cooper, Alpert, & Kipnis, 1980; Dunkel-Schetter & Wortman, 1982). These Black cancer clients may have avoided their spouse/partner for fear of hurting or upsetting them (Harker, 1972; Bean, Cooper, Alpert, & Kipnis, 1980). Spouses/partners may also have avoided the clients (Dyk & Sutherland, 1956; Greenleigh & Associates, 1979). However, the literature also shows that in some situations the spouse was the only person who provided support in times of major illness (California Department of Mental Health, 1982). When overall mean scores were looked at, the spouse was perceived as providing "a great deal" of affect, "quite a bit" to "a great deal" of affirmation, "quite a bit" to "a great deal" of aid, and having almost daily contact.

The minister/priest/pastor category comprised 4.2 percent of the social support network of the Black clients and 1 percent of that reported in the normative data. Twenty-five percent of the former compared to only 10.3 percent of the latter listed this category, which provided a small proportion of functional support to the Black cancer clients. This is surprising because all the Black clients stated a religious preference compared to 66.2 percent of the normative group. Participation in religious activities by the Black clients was fairly high, with 50 percent participating monthly and 40 percent participating

weekly. The functional support provided by the ministers/priests/ pastors consisted of higher percentages of affect and affirmation support than aid support. When overall mean scores were looked at, this category was perceived as providing high quality support consisting of "quite a bit" to "a great deal" of affect, affirmation, and aid and weekly contact with clients.

In the Black culture, religion has played two major roles. Since the time of slavery, religion gave Blacks a psychological or spiritual advantage and an emotional outlet through feelings of hope, security, and a sense of power (Martin & Martin, 1978). In fostering unity, the church itself offered "social contacts, recreation, and an opportunity for leadership roles" (Blackwell, 1975, p. 91). In addition, the black church has emphasized the pastoral roles of the laity, supporting lay visitation and provision of nursing care by the church. Thus, the low percentage of social support provided by ministers as reported by the Blacks in this study may not be an accurate indication of the meaning that religion and the church have in providing social support. Further study incorporating additional questions regarding the importance of religion in perceiving social support may be warranted.

Neighbors also provided a larger proportion of functional support and contact and comprised a larger proportion in the Black clients than that reported in the normative data. Seventy-five percent of the Black clients were in the lower income group and the majority had lived at their current home longer than 25 years. Many of these clients may either have lived in subsidized housing with neighbors living close by or may have had long durations of relationship with their neighbors. According to Stack (1975), neighbors frequently provide several types

of high quality social support. Thus, proximity and/or duration of re-
lationships may explain the perception of high support from neighbors.
The literature indicates that ministers, friends, and neighbors comprise
a portion of the complex network of blood and nonrelated persons of
Black families (Stack, 1975; Branch & Paxton, 1976; Gutman, 1976; Smith,
1976; Staples, 1976; Martin & Martin, 1978; Kennedy, 1980; Ross, 1981;
Henderson & Primeaux, 1981; Thomas, 1981; Hinds & Boyd-Franklin, 1982;
McGoldrick, Pearce, & Giordano, 1982; Bloch, 1983).

Work/school associates made up a much smaller proportion of the
Black than the normative data sets' social support networks and provided
very little, if any, functional support and contact. This can be ex-
plained by the sample characteristics: the normative data set consisted
of employed adults and only 15 percent of the Black clients were
employed.

When the identified categories were separated out for male and
female Black clients, only males identified their spouse/partner as pro-
viding support. Females identified neighbors, health providers, and
associates, while both sexes listed family members/relatives, friends,
and ministers. Friends and ministers were perceived as providing
proportionately more functional support by males than by females.
Several of the men in this study reported to the investigator that dea-
cons in the church and ministers were close friends of theirs.
Lowenthal and Haven (1968) have corrorborated the finding that males
perceive a higher proportion of support from friends than do females.
Males may feel more comfortable admitting that they perceive support
from friends than from family members and other social support cate-
gories. Yet the support reported by males in the subscales of affect,

affirmation and aid were consistently lower than that reported by fe-
males. This, and the range of the support scores, was especially true
in the subscale for affect, when compared to males' smaller network size
this finding may indicate that the males have greater difficulty in
seeking support from others. This interpretation raises the issue of
whether clients, especially Black male clients, perceive that they re-
ceive the support which they desire or need.

The third question asked was whether the quality of Black cancer
clients' social support was different from that reported in the
normative data. Although there were no significant differences in
quality of social support for the Black clients versus that reported in
the normative data (see Tables 13 and 14), the finding that quality of
support in the Black clients, who were much older than the subjects in
the normative study, approached that of the normative group is an impor-
tant finding because younger persons usually perceive more social
support than older ones (Lowenthall & Haven, 1968). Thus, these Black
clients in reality experienced a very high quality of support.

There was a significant difference in the means for numbers of
total network members reported by females (t = -3.47; df = 12; p < .05),
with the Black females reporting fewer network members. An explanation
for this may be that many of the Black clients reported persons
immediately nearby as their support network members. Several persons
commented that they had other relatives who lived far away. It appears
as though such persons were not perceived as being important to some of
the clients. In addition, for many of the network members, demographic
information indicated that other family members, such as grandchildren
and great-grandchildren, were in evidence but were not reported as being

important sources of support. This may be explained by the common expectation that elderly Blacks provide support to younger generations rather than receive it from them.

The significant differences in loss quantity ($\underline{t}$ = 10.1; df = 9; $\underline{p}$ < .05) and total loss scores ($\underline{t}$ = 3.65; df = 6; $\underline{p}$ < .05) for the two groups of males reflect the large numbers of members lost to the Black male clients during the past year. Persons lost to these men were family members/relatives and friends. Mortality rates due to certain chronic diseases such as cancer and cardiovascular disease that are higher in Black males, especially in the older age group, than in other culturally diverse groups, especially Whites, who comprised the majority of the sample in the normative study, may account for this difference. The finding that 60 percent of the clients suffered from hypertension adds weight to this. The subjects in this study thus adhere to the common epidemiological finding that hypertension and probably its complications, is prevalent in Blacks.

A final purpose of this study was to report whether or not significant correlations existed between selected social support and demographic variables. The significant positive correlation between the number of grandchildren and the number listed in the network was .647 ($\underline{p}$ <.05). This result may be explained by low residential mobility of the grandchildren. The clients may have perceived more members to be in their networks because of the close proximity of grandchildren to them. Also, the finding may be explained by the importance of intergenerationality in the Black culture. Having increased numbers of grandchildren signifies that the family is thriving and that relationships between generations are important. In view of the perception that these

people might be important but not a source of support suggests that

further investigation is needed. Another significant correlation was

found between the number listed in the network and the quantity lost,

r = .778, p < .05). This result may have been directly related to the

age of the clients. In older adults, losses are frequently due to

death; thus, once persons are lost, they are not replaced. A final

significant positive correlation was found between the number of grand-

children and the quantity lost. This may signify a lack of perceived

support from these grandchildren and may explain why granchildren were

included on the Information Questionnaire but not as social support net-

work members. This warrants further investigation.

A significant association was found between the perceived frequency

of contact and religious participation (F = 3.65, p = .05). This is

explained by the demographic results indicating the high degree of

church participation and the importance of religion in the Black cul-

ture. This finding is also supported by the study done by the

California Department of Mental Health (1982).

Several correlations and one-way analyses of variance indicated no

relationships among social support function, properties, network, and

demographic variables. This differs from prior studies (Lowenthal &

Haven, 1968; Weiss, 1976; Burke, 1978; Kahn, 1978; Hirsch, 1979;

Cronewatt, 1980; Sarason, Levine, Basham, & Sarason, 1983). In the pre-

sent study, these results are likely explained by the small sample size.

Failure to demonstrate differences in perceived social support

quality as well as in correlations and analyses of variance between

demographic and social support variables may have been related to the

small sample size, sample bias, or the completion of the questionnaire. Clients requested that the investigator complete the questionnaires for them and this was done at their direction. Clients may have not felt comfortable completing the questionnaires. In some cases, persons reported as living with them on the Information Questionnaire were not included on the Norbeck Social Support Questionnaire. Whether or not this was related to fatigue, comprehension level, the cancer diagnosis, the presence of one or more concurrent illnesses, treatment effects, or perhaps that persons living with them did so for economic reasons and not support, is not certain. A less complex adaptation of this questionnaire might be necessary for clients with limited education.

In addition to collection of data, the investigator made these observations about the study. The tool was helpful to the clients in some ways. In conducting the study, several clients with a perceived quality of low support were referred to the nurses and/or social workers for follow-up interventions of social support. In addition, clients utilized the interaction with the investigator to share their thoughts and feelings regarding their cancer experience, thus obtaining affect and affirmation support.

Summary

Several social support functional and network properties of the Black cancer clients were found that were different from those reported in the 1983 normative study by Norbeck, Lindsey, and Carrieri. There was no significant difference in the quality of Black clients' social support as compared to that reported by the normative data. However, the average scores for social support for the two data sets indicated

that the Black clients had a higher quality of social support and that they perceived the overall quality of social support as high. There was a significant difference in the means for numbers of total network members and number of grandchildren. There was a significant positive correlation between the number of grandchildren and the quantity lost. Lastly, there was a significant association between perceived frequency of contact and religious participation.

It is possible that these differences may have occurred more as a result of the socioeconomic characteristics of the sample, such as age, income level, education level, and sex, rather than culture. The small and homogeneous sample may account for the inability to explain results based on culture alone. Thus, future studies that utilize larger, matched samples should be carried out.

CHAPTER FIVE
CONCLUSIONS AND RECOMMENDATIONS
Conclusions

In this study of social support in Black clients who have
cancer, the demographic statistics provided a beginning profile of older
Black adults, particularly those who have cancer and who reside in the
northwestern area of South Carolina. This, in addition to reported
social support data, provides added information on this seldom studied
group both for research and for practice purposes. Health care pro-
fessionals can utilize the data to facilitate and augment Black elderly
clients' social support functions and networks so that the quality of
life of such persons can be improved. Nurses in particular can employ
the preferred socially supportive behaviors eliciting feelings of affect
and affirmation as they provide humanistic care to persons of culturally
diverse groups.

Although there was no significant difference in the social support
quality of Black cancer clients and that of subjects in the normative
study, findings were important from the perspective of the Black cul-
ture. Commonly held beliefs that the Black family in America today is
vanishing (Moyers, 1986) were not borne out by this study, which in-
dicated that this group of Black clients had not only a high quality of
support but that this high quality support was provided primarily by the
family. The author's assumption that the Black clients would report a
higher quality of support than subjects in the normative study was
therefore supported.

The finding that religious participation was associated with frequency of contact indicates the importance of religion in the experience of Blacks. Added to this is the finding of high participation in religious activities. The church in the Black culture continues to be a viable source of social support.

Health professionals were perceived as being more supportive to this group of clients than to previously studied cancer clients (Lindsey, Ahmed, & Dodd, 1985; Lindsey, Ahmed, & Chen, 1985; Kesselring, Lindsey, & Lovejoy, 1986). This may be explained by the commonly held low expectations by Blacks of White professionals. Throughout history, Blacks, especially lower income Blacks, have learned to expect little in the way of social support from these persons; thus, the support provided may have been perceived as higher simply because of the appreciation for any amount and type of social support provided.

Recommendations

Based on the results of this study the author makes the following recommendations.

1. That the study be replicated using random sampling methods and a larger sample.

2. That the study be replicated using persons from varied culturally diverse groups, socioeconomic levels, ages, and in various stages of cancer.

3. That a study be conducted to explore the relationship between cancer clients' social support and outcomes from cancer.

4. That a study be conducted to explore the social support available to and utilized by networks of the cancer clients.

5. That a study be conducted to explore further the inter-generational significance of social support.

6. That the Norbeck Social Support Questionnaire be adapted to include questions on religion for further studies, especially on the Black culture.

7. That a study be conducted to compare the perceptions of the recipients of social support to those network members identified as providers of social support.

8. That nurses be taught to incorporate affect and affirmation social support in their care of culturally diverse groups.

APPENDICES

Appendix A

Human Rights Approval

CLEMSON UNIVERSITY

COMMITTEE FOR THE PROTECTION OF HUMAN SUBJECTS

CERTIFICATION OF REVIEW AND APPROVAL

Date_____10/1/87_____

TO: _____Lynette M. Richardson_____

FROM: The University Committee for the Protection of Human Subjects

CONCERNING: Committee Review of Activity/Proposal Entitled_____

An Exploratory Study of Social Support Functions,

Network, and Quality as Perceived by Black Cancer

Clients

This notice certifies that the above described activity/proposal
identified by OUR No.___N/A_, has been reviewed by the Committee and approved
for submission to_____College of Nursing_____
or for unsponsored implementation.

_____
G. Jay Gogue, Chairman, CPHS and
Associate Director of University Research

Appendix B

State Cancer Clinic Approval A

South Carolina Department of Health and Environmental Control

September 25, 1987

Ms. Lynette Richardson
925 Cleveland Street
Aot. J 307
Greenville, SC 29601

Dear Ms. Richardson:

Your proposal for an exploratory study of social support functions, networks; and quality as perceived by black cancer clients has been approved by DHEC staff. The cancer clinic staff at Greenville Memorial Hospital, Spartanburg Regional Medical Center and Anderson Memorial Hospitals have been notified of your study. Please contact the individual for each hospital (list attached) to schedule a time for you to discuss with them your proposal and arrange dates for you to administer the questionnaires.

If you need further assistance, please contact Margaret Senn at 734-4790.

Sincerely,

Fran Wheeler

Frances C. Wheeler, Ph.D.
Director
Division of Chronic Disease

mbc
Attachment

Appendix C

State Cancer Clinic Approval B

SPARTANBURG HOSPITAL
101 East Wood Street • Spartanburg, South Carolina 29303

SYSTEM
Tel.: (803) 591-6000

October 16, 1987

Ms. Lynette Richardson, RN, BSN
Medical Education Department
Spartanburg Regional Medical Center

RE: "An Exploratory Study of Social Support Functions, Network, and Quality
as Perceived by Black Cancer Clients"

Dear Ms. Richardson:

The Spartanburg Regional Medical Center Institutional Review Board at their
meeting of October 15, 1987 approved your request to conduct research in the
State Aid Cancer Clinic as part of the requirement for your Masters of Science
degree in nursing.

This approval is for a 12-month period of time. If adverse effects occur
to patients as a result of participating in this study, or if you discontinue
this research, please notify this committee promptly. If you continue to do
this research beyond the 12-month period of approval, a timely request for renewal
should come to this committee.

Sincerely,

John H. McCulloch, M.D.
Chairman

JHM/sdp

Appendix D

Orientation Questionnaire

Dear Sir/Madam,

Lynette M. Richardson is doing research about what people do that is
helpful to someone with an illness. If you would be willing to help, please
answer these questions and return the form to _____
Some people will then be asked to answer some additional questions after
further explanation. Thank-you for your time.

Please make a ✓ in the appropriate space or fill in the best answer.

     Your age (in years) is between: 40-49 ....
                                                 50-59 ....
                                               60-69 ....
                                               70-79 ....
                                               80-89 ....
                                               90-99 ....

Do you live in a city? .... surrounding town? ....
               more that 10 miles from here? ....

What time is your clinic visit? ....

Did you drive yourself to the clinic? Yes ..... No .....

If not, who brought you? ....

Do you have cancer? Yes ..... No .....

Appendix E

Informed Consent Agreement

College of Nursing
GRADUATE PROGRAM

As part of her requirements for a Master of Science Degree, with a major in nursing at Clemson University: Lynette M. Richardson is conducting a study concerning the people and things that are helpful to those who are ill with cancer. The information obtained can be used to improve the nursing care of Black clients by increasing nurses' knowledge of the opportunity to work more closely with those people that they consider to be most helpful to them. There is no known risk associated with this study.

I understand that by participating in this study I will answer questions about the people who are helpful to me and some questions about myself. I understand that the information collected will be coded with a number and my name will not be used or connected with the study in any way. I understand that I am free to withdraw my consent and stop participating at any time and that my withdrawal will not in any way affect the care that I am receiving in the State Cancer Clinic.

I have been informed that I may call the Clemson University Committee for the Protection of Human Subjects at (803)656-2375, the Department of Health and Environmental Control (DHEC) at (803)734-4790, a member of the Institutional Review Board at Spartanburg Regional Medical Center at (803) 591-6000, or I may call Lynette M. Richardson at (803)591-6280 between the hours of 8:30 a.m. and 3:00 p.m., Monday through Friday, if I have unanswered questions.

I have understood the above explanations and descriptions, have had all my questions answered, and freely give this consent.

_____   _____
Lynette M. Richardson   Date

_____   _____
Witness   Signature of Subject

Appendix F

Protocol

Orientation Questionnaire

The investigator at the State Cancer Clinics invited clients to complete the Orientation Questionnaire as they arrived for scheduled clinic visits. Those unable to read/write were approached by the investigator who offered to complete the form as they directed her to. Those persons fulfilling the criteria for inclusion were then invited to participate in the study.

Statement of Participants' Rights

Chosen subjects were taken to a private room in the clinic. The following statement was made by the investigator: you have the right to refuse to participate at any time. There are no know risks and your answers will be confidential (no one will know what your answers are). Benefits of the study are to help nurses and other health care workers to identify those close to Black cancer patients who should be included when planning and providing care and when developing future programs. Whether or not you choose to participate, your care at the State Cancer Clinic will not be affected. You will find on the table the Consent Form, the Norbeck Social Support Questionnaire, and an Information Questionnaire. I will now read in your hearing the Informed Consent Agreement and answer any questions you have regarding the questionnaires. If you need help reading and completing the Informed Consent Agreement, please let me know. I will be glad to read it aloud again before you sign it. Please read the Informed Consent Agreement and sign it if you choose to.

Completion of Questionnaires

Please complete the questionnaires that you have in front of you. One is the Norbeck Social Support Questionnaire or NSSQ. The other is an Information Questionnaire. I will now read the instruction for the Norbeck Social Support Questionnaire. Please list each important person in your life on the left under "Personal Network" (list only first name or letters of first and last name). Then, fill in the relationship or what they are to you, for example, brother or husband, using the list given on the first page. Use as many spaces as you need to in order to cover all the important people in your life. Turn to page 2 and answer the questions according to the numbers (1 to 5) at the top of the page, for example, 1 = not at all, for each of the people you listed on page 1. Line up each page like this (will show how to line up forms). Answer question 1 to 8 like this. After that, answer questions 9, 9a, and 9b on the last page of the questionnaire.

Once the Norbeck Social Support Questionnaire is complete, please answer the Information Questionnaire. For those of you who need help completing the forms, I will be glad to help you. Thank-you very much for taking part.

Appendix G
Norbeck Social Support Questionnaire

Number _____

Date _____   (1-4)

SOCIAL SUPPORT QUESTIONNAIRE

*PLEASE READ ALL DIRECTIONS
ON THIS PAGE BEFORE STARTING.*

PERSONAL NETWORK

Please list each important person in your life on the left. Consider all the persons who provide personal support to you or who are important to you.

Use only first names or initials, and then indicate what they are to you as in the following example:

First Name or Initials	What they are to you
1.	_____ (32)
2.	_____ (33)
3.	_____ (34)
4.	_____ (35)
5.	_____ (36)
6.	_____ (37)
7.	_____ (38)
8.	_____ (39)
9.	_____ (40)
10.	_____ (41)
11.	_____ (42)
12.	_____ (43)
13.	_____ (44)
14.	_____ (45)
15.	_____ (46)
16.	_____ (47)
17.	_____ (48)
18.	_____ (49)
19.	_____ (50)
20.	_____ (51)
21.	_____ (52)
22.	_____ (53)
23.	_____ (54)
24.	_____ (55)

(5-6)

Example:

First Name or Initials	What they are to you
1. MARY T.	FRIEND
2. BOB	BROTHER
3. M.T.	MOTHER
4. SAM	FRIEND
5. MRS. R.	NEIGHBOR

etc.

Use the following list to help you think of the people important to you, and list as many people as apply in your case.

— spouse or partner
— family members or relatives
— friends
— work or school associates
— neighbors
— health care providers
— counselor or therapist
— minister/priest/pastor
— other

You do not have to use all 24 spaces. Use as many spaces as you have important persons in your life.

WHEN YOU HAVE FINISHED YOUR LIST, PLEASE TURN TO PAGE 2.

Number _____ [1-4]

Date _____

For each person you listed, please answer the following questions
by writing in the number that applies.

1 = not at all
2 = a little
3 = in between
4 = quite a bit
5 = a great deal

PERSONAL NETWORK

First Name or Initials	What they are to you	Question 1: How much does this person make you feel liked or loved?	Question 2: How much does this person make you feel respected or admired?
1. _____	_____ [32]	1. _____	1. _____
2. _____	_____ [33]	2. _____	2. _____
3. _____	_____ [34]	3. _____	3. _____
4. _____	_____ [35]	4. _____	4. _____
5. _____	_____ [36]	5. _____	5. _____
6. _____	_____ [37]	6. _____	6. _____
7. _____	_____ [38]	7. _____	7. _____
8. _____	_____ [39]	8. _____	8. _____
9. _____	_____ [40]	9. _____	9. _____
10. _____	_____ [41]	10. _____	10. _____
11. _____	_____ [42]	11. _____	11. _____
12. _____	_____ [43]	12. _____	12. _____
13. _____	_____ [44]	13. _____	13. _____
14. _____	_____ [45]	14. _____	14. _____
15. _____	_____ [46]	15. _____	15. _____
16. _____	_____ [47]	16. _____	16. _____
17. _____	_____ [48]	17. _____	17. _____
18. _____	_____ [49]	18. _____	18. _____
19. _____	_____ [50]	19. _____	19. _____
20. _____	_____ [51]	20. _____	20. _____
21. _____	_____ [52]	21. _____	21. _____
22. _____	_____ [53]	22. _____	22. _____
23. _____	_____ [54]	23. _____	23. _____
24. _____	_____ [55]	24. _____	24. _____

GO ON TO NEXT PAGE

Number _____ (1-4)

Date _____

1 = not at all
2 = a little
3 = in between
4 = quite a bit
5 = a great deal

PERSONAL NETWORK

Question 3:

Question 4:

How much can you know that what you tell this person stays with him or her and does not get told to anyone else?

How much does this person agree with or support your actions or thoughts?

First Name or Initials

What they are to you

First Name or Initials	What they are to you		Question 3	Question 4
1. _____	_____	(32)	1. _____	1. _____
2. _____	_____	(33)	2. _____	2. _____
3. _____	_____	(34)	3. _____	3. _____
4. _____	_____	(35)	4. _____	4. _____
5. _____	_____	(36)	5. _____	5. _____
6. _____	_____	(37)	6. _____	6. _____
7. _____	_____	(38)	7. _____	7. _____
8. _____	_____	(39)	8. _____	8. _____
9. _____	_____	(40)	9. _____	9. _____
10. _____	_____	(41)	10. _____	10. _____
11. _____	_____	(42)	11. _____	11. _____
12. _____	_____	(43)	12. _____	12. _____
13. _____	_____	(44)	13. _____	13. _____
14. _____	_____	(45)	14. _____	14. _____
15. _____	_____	(46)	15. _____	15. _____
16. _____	_____	(47)	16. _____	16. _____
17. _____	_____	(48)	17. _____	17. _____
18. _____	_____	(49)	18. _____	18. _____
19. _____	_____	(50)	19. _____	19. _____
20. _____	_____	(51)	20. _____	20. _____
21. _____	_____	(52)	21. _____	21. _____
22. _____	_____	(53)	22. _____	22. _____
23. _____	_____	(54)	23. _____	23. _____
24. _____	_____	(55)	24. _____	24. _____

GO ON TO NEXT PAGE

Number _____

Date _____ [1-4]

PERSONAL NETWORK

First Name or Initials	What they are to you	
1. _____	_____	[32]
2. _____	_____	[33]
3. _____	_____	[34]
4. _____	_____	[35]
5. _____	_____	[36]
6. _____	_____	[37]
7. _____	_____	[38]
8. _____	_____	[39]
9. _____	_____	[40]
10. _____	_____	[41]
11. _____	_____	[42]
12. _____	_____	[43]
13. _____	_____	[44]
14. _____	_____	[45]
15. _____	_____	[46]
16. _____	_____	[47]
17. _____	_____	[48]
18. _____	_____	[49]
19. _____	_____	[50]
20. _____	_____	[51]
21. _____	_____	[52]
22. _____	_____	[53]
23. _____	_____	[54]
24. _____	_____	[55]

1 = not at all
2 = a little
3 = in between
4 = quite a bit
5 = a great deal

Question 5:

If you needed to borrow $10, a ride to the doctor, or some other immediate help, how much could this person usually help?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____

Question 6:

If you were confined to bed for several weeks, how much could this person help you?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16 _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____

GO ON TO NEXT PAGE

Number _____ [1-4]

Date _____

Question 7:

How long have you known this person?

Question 8:

How frequently do you usually have contact with this person? (Phone calls, visits, or letters)

PERSONAL NETWORK

1 = less than 6 months
2 = 6 months to 1 year
3 = 1 to 2 years
4 = 2 to 5 years
5 = more than 5 years

5 = daily
4 = weekly
3 = monthly
2 = a few times a year
1 = once a year or less

First Name or Initials	What they are to you			

1. _____ _____ [32] 1. _____ 1. _____
2. _____ _____ [33] 2. _____ 2. _____
3. _____ _____ [34] 3. _____ 3. _____
4. _____ _____ [35] 4. _____ 4. _____
5. _____ _____ [36] 5. _____ 5. _____
6. _____ _____ [37] 6. _____ 6. _____
7. _____ _____ [38] 7. _____ 7. _____
8. _____ _____ [39] 8. _____ 8. _____
9. _____ _____ [40] 9. _____ 9. _____
10. _____ _____ [41] 10. _____ 10. _____
11. _____ _____ [42] 11. _____ 11. _____
12. _____ _____ [43] 12. _____ 12. _____
13. _____ _____ [44] 13. _____ 13. _____
14. _____ _____ [45] 14. _____ 14. _____
15. _____ _____ [46] 15. _____ 15. _____
16. _____ _____ [47] 16. _____ 16. _____
17. _____ _____ [48] 17. _____ 17. _____
18. _____ _____ [49] 18. _____ 18. _____
19. _____ _____ [50] 19. _____ 19. _____
20. _____ _____ [51] 20. _____ 20. _____
21. _____ _____ [52] 21. _____ 21. _____
22. _____ _____ [53] 22. _____ 22. _____
23. _____ _____ [54] 23. _____ 23. _____
24. _____ _____ [55] 24. _____ 24. _____

PLEASE BE SURE YOU HAVE RATED EACH PERSON ON EVERY QUESTION. GO ON TO THE LAST PAGE.

[5-6]   [25-27]   [28-30]

9. During the past year, have you lost any important relationships due to moving,
a job change, divorce or separation, death, or some other reason?

(57)

_____ 0. No

_____ 1. Yes

IF YES:

9a. Please indicate the number of persons from each category who are *no longer available* to you.

_____ spouse or partner (58)

_____ family members or relatives (59-60)

_____ friends (61-62)

_____ work or school associates (63-64)

_____ neighbors (65-66)

_____ health care providers (67)

_____ counselor or therapist (68)

_____ minister/priest/pastor (69)

_____ other (specify) _____ (70) (71-72)

9b. Overall, how much of your support was provided by these people who are no longer available to you? (73)

_____ 0. none at all

_____ 1. a little

_____ 2. a moderate amount

_____ 3. quite a bit

_____ 4. a great deal

Appendix H

Information Questionnaire

College of Nursing
GRADUATE PROGRAM

Client Code Number _____

Date _____

1. What year were you born? _____

2. Sex: _____ Male _____ Female

3. Marital Status:

_____ Single, never married _____ Married

_____ Divorced or separated _____ Widowed (husband/wife dead)

4. Number of children _____ Grandchildren _____

Great-grandchildren _____

5. Where do you live? (Please fill in)

City _____

Surrounding town _____

County _____

How long have you lived there? (In years) _____

Who lives with you? (Please complete) _____

_____

Where were you born? (Please fill in)

City _____ County _____

Surrounding Town _____

6. Occupation (job) _____ Yes _____ No (Please check ✓)

If yes, Full-time? _____ Part-time? _____

If no, Retired? _____

7. Do you participate in social groups or organizations? Please ✓ any that apply.
_____ A job-related group   _____ A charity or welfare group
_____ Urban League   _____ NAACP
_____ Fraternity or Sorority   _____ Sports Club

Information Questionnaire (cont'd)

Client Code Number _____

Date _____

7. (cont'd)

_____ Neighborhood Club   _____ Lodge
_____ Church-related group(s)   _____ Social club, card playing, music
_____ Professional organization   club or hobby group
_____ PTA or other school related group
_____ Other

8. What is your household income per year? (Please ✓)

_____ $9,999 or less   _____ 25,000 - 29,999
_____ 10,000 - 14,999   _____ 30,000 - 34,999
_____ 15,000 - 19,999   _____ 35,000 - 39,999
_____ 20,000 - 24,999   _____ 40,000 - 44,999
_____ 50,000 or above

9. Educational level: Please circle the highest grade of regular school that
   you have completed:

   Elementary   Highschool   College   Graduate School

   1 2 3 4 5 6 7 8 9 10 11 12   1 2 3 4 5 1 2 3 4 5 6

10. Religious preference (What church do you attend? Please ✓ the one that applies

    _____ Protestant (circle one)

    AME   CME   AME ZION   BAPTIST   UNITED METHODIST   PRESBYTERIAN

    PRESBYTERIAN   LUTHERAN   EPISCOPALIAN   CHURCH OF CHRIST   SEVENTH DAY ADVENTIST

    CHURCH OF GOD   CHURCH OF GOD IN CHRIST   HOUSE OF PRAYER   ASSEMBLY OF GOD

    FREEWILL BAPTIST   MISSIONARY BAPTIST   HOLINESS   PENTECOSTAL   WESLEYAN

    _____ Catholic   _____ Bahai

    _____ Black Muslim   _____ Ethiopian Orthodox

    _____ Jewish   _____ Jehovah's Witness

    _____ None   _____ Other (Specify) _____

11. Participation in religious activities: (Please ✓)

    _____ Not active
    _____ Very little participation (1-2 times a year)
    _____ Some participation (about monthly)
    _____ Regular participation (at least weekly)

Information Questionnaire (cont'd)

Client Code Number _____

Date _____

12. Location of cancer (in the body): (Please fill in)

_____

13. Length of time since diagnosis _____

13. Other illnesses: Please ✓ those that apply:
_____ arthritis
_____ sugar (diabetes)
_____ high-blood pressure (hypertension)
_____ lung trouble (e.g. emphysema, asthma, bronchitis)
_____ heart trouble (heart attack, heart block, pacemaker)
_____ low blood (anemia)

14. Cancer treatments you are receiving now (Please ✓ the right one(s))

_____ chemotherapy (cancer drugs)
_____ radiation therapy
_____ surgery
_____ pain control
_____ blood treatments (new blood)
_____ other (please name)

15. Participation in cancer-related programs: (Please ✓)

_____ I Can Cope   _____ Mastectomy Group
_____ Ostomy Club   _____ Hospital-based Support Group
_____ Laryngectomy Club   _____ Other (Please name) _____

16. Are you presently receiving help from the following groups? (Please ✓)

_____ Hospice
_____ Home Health Care
_____ Health Department Visiting Nurses and/or Aides
_____ Other volunteers (e.g. church - please specify) _____
_____ Other (Please specify) _____

Appendix I

Permission for Norbeck Social
Support Questionnaire

I request permission to copy the Norbeck Social Support Questionnaire (NSSQ) for use in research in a study

entitled: <u>Social Support: Network, Functions, Properties, and Quality</u>

<u>As Perceived by Black Cancer Clients.</u>

_____

In exchange for this permission, I agree to submit to Dr. Norbeck a copy of the one-page scoring sheet for each subject tested. These data will be used to establish a broad normative database for the instrument for clinical and non-clinical populations. Aside from use in the pooled data bank, no other use will be made of the data submitted. Credit will be given to me in reports of normative statistics that make use of the data I submitted for pooled analyses.

Lynette M. Richardson
Lynette M. Richardson, RN, BSN
June 17, 1987 (Signature)
June 17, 1987.
(Date)

Position and _Masters' Candidate, Clemson University,_
Full Address
of Investigator: _926 Cleveland St., Apt. #J307,_

Greenville, S. C., 29601

_____

Permission is hereby granted to copy the NSSQ for use in the research described above.

Jane S. Norbeck
Jane S. Norbeck
6/29/87
(Date)

Please send *two signed* copies of this form to:
Jane S. Norbeck, D.N.Sc.
Department of Mental Health and Community Nursing
University of California, San Francisco
N505-Y
San Francisco, California 94143

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