

DIRECTIVE SUPPORT, NONDIRECTIVE SUPPORT, AND MORALE

KENT D. HARBER
Rutgers University at Newark

JOANNE KRAENZLE SCHNEIDER
St. Louis University

KELLY M. EVERARD AND EDWIN B. FISHER
Washington University School of Medicine

The concept of social support as being directive or nondirective may help explain why helping can either boost or impede morale. The Inventory of Nondirective and Directive Instrumental Support (INDIS) was developed to investigate this question. The directive factor concerns others' attempts to dominate coping and the nondirective factor concerns others' attempts to facilitate but not dominate coping. Studies 1 and 2 identified and confirmed these factors. Study 3 showed predicted associations between INDIS subscales and measures of morale. Nondirective support (from a family member) was positively related to hope and optimism, and directive support (from either a family member or a friend) was positively related to depression and loneliness, even after controlling for other social support measures.

Maintaining hope and morale is one of the most important and difficult challenges faced by people coping with serious problems. Events such as loss of loved ones, professional or interpersonal failure, and cata-

Kent D. Harber, Department of Psychology, Rutgers University at Newark; Joanne Kraenzle Schneider, Department of Nursing, St. Louis University; Kelly Everard and Edwin Fisher, Division of Health Behavior Research, Departments of Medicine and Pediatrics, Washington University School of Medicine.

We thank Gabrielle Highstein, Ian Brissette, Lee Jussim, Bäerbel Knauper, and Annette La Greca for their contributions to this research. We also thank Alan Lambert for his assistance.

Correspondence concerning this article should be addressed to Kent D. Harber, Department of Psychology, Rutgers University, Smith Hall, 101 Warren Street, Newark, NJ 07044; E-mail: kharber@psychology.rutgers.edu.

strophic damage to oneself or to one's prized possessions can shake victims' confidence in their self worth and self-efficacy (Epstein, 1989; Janoff-Bulman, 1989). Social support is an important buffer to these psychic costs of trauma. People coping with an array of economic, educational, and health challenges experience more hope (Yarcheski, Mahon, & Yarheski, 2001), improved esteem and worthiness (Brown, Andres, Harris, Adler, & Bridge, 1986), and less depression (Brown et al., 1986) if they have a supportive social network.

However, support is not always nurturing. In many cases social ties can fail to buttress morale, and can even exacerbate the psychological challenge of coping. Research into "negative social support" identifies a number of ways in which helping attempts can be unhelpful. Sometimes would-be supporters aggravate recovery by being critical, antagonistic, disruptive or even exploitative (Rook, 1984; Schuster, Kessler, & Aseltine, 1990). In other cases supporters may have benign intentions but lack the skills or insights to be effective (Dakof & Taylor, 1990).

One of the most common forms of failed support is not generally attributable to insufficient caring, knowledge, or skills. Instead, this form of counterproductive helping is most often and most potently delivered by those closest to copers, and by those most heavily invested in their recovery. Referred to as "over-involvement" (Coyne, Wortman, & Lehman, 1988) or "over-protectiveness" (Fiske, Coyne, & Smith, 1991), this kind of support is characterized by attempts to impose solutions or perspectives on copers; to be, in effect, back-seat drivers on the road to recovery. Over-involved support includes interfering with behavioral choices (Lewis & Rook, 1999), dictating corrective actions (Burke & Weir, 1979; Cohen & Lichtenstein, 1990), giving unwanted information or undesired advice (Lehman, Ellard, & Wortman, 1986; Revenson, Schiaffino, Majerovitz, & Gibotsky, 1991; Stuart & Davis, 1972), supplying unwanted tangible support (Lehman et al., 1986), and determining how much effort copers should exert and the degree to which they should attempt to resume full functioning (Taylor, Bandura, Ewart, Miller, & DeBusk, 1985).

By taking charge of too much, supporters may communicate through their very acts of support that copers lack the skills or strengths needed to remedy their own problems (Coyne et al., 1988). These implicit messages can make copers feel "guilty, incompetent, resentful, lacking in autonomy, or coerced" (Coyne et al., 1988, p. 307). In this way over-involvement may reinforce the sense of failure and futility that make major events so debilitating in the first place. It is therefore not surprising that over-involved helping is associated with increased feelings of dependence (Shinn, Lehman, & Wong, 1984), heightened rates of depression and distress (Burke & Weir, 1979; Helgeson, 1993), reduced self-es-

teem (DiMatteo & Hays, 1981) and ultimately lowered morale (Coyne et al., 1988).

Although the concept of over-involvement has both intuitive appeal and empirical confirmation, it lacks a single, unifying definition. As Fiske et al. (1991) point out, "over-involvement is unclearly defined, subsuming a large number of often contradictory qualities" (p. 6). These contrasting qualities include "dominance, submission, aggression, deference, excessive emotional expression, protection from emotional upset, coldness, and dependency" (Fiske et al., 1991, p. 6). In addition, although the terms "over-involvement" and "over-protectiveness" are implicitly pejorative, the saturating support to which these terms refer is not always negative. The availability of others who can direct the course of caring may be beneficial when copers are so severely burdened that they are unable to manage their own recovery (Fiske et al., 1991).

However, despite these operational difficulties, advances in social support research buttress the over-involvement framework. Cutrona, Cohen, & Igram (1990) show that support is regarded (by third-party judges) as more helpful when supporters provide help that has been determined by the recipient, rather than by the supporter. Deci and Ryan's work on autonomy support demonstrates that competence, affect, self-esteem, and health behaviors are improved when supporters respect and advance copers' exercise of agency and choice (Williams, Gagne, Ryan, & Deci, 2002). Supporters appear to meet these needs of autonomy best when they deliver help without drawing attention to themselves as helpers or to their actions as assistance, but instead supply what Bolger, Zuckerman, and Kessler (2000) describe as "invisible support." Collectively, the research on over-involvement, autonomy support, invisible support, and need-provision fit all emphasize the tension between addressing the hardships copers face without sapping their feelings of efficacy, autonomy, and dignity.

To a certain degree this tension is an inescapable dilemma of support provision. However, underlying and perhaps aggravating the copers' conflicting needs for help and for autonomy may be helpers' conflicting motives to step in and step back. These motives can be characterized by the degree to which helping is *nondirective* or *directive*. In essence, what distinguishes nondirective from directive help is whether supporters attempt to advance the copers' own recuperative agenda or instead impose an agenda of recovery upon the copers. Supporters provide nondirective support when they cooperate without assuming primary responsibility for the other person's performance. Supporters provide directive support when they assume, or attempt to assume, primary responsibility for coping (Fisher, La Greca, Greco, Arfken, & Schneiderman, 1997). Thus the same helping behavior can be either

nondirective or directive, depending on the manner in which helpers supply it. For example, a supporter who screens phone calls based on the copers' instructions would be providing nondirective support, but would be supplying directive support by screening calls either without, or against, the copers' instruction. The former advances the copers' intent, while the latter supercedes it.

It is important to emphasize that nondirective and directive support do not necessarily differ in the degree to which they meet the immediate objective needs of the copers. Screening phone calls may ultimately prove helpful or unhelpful, regardless of whether this action has been requested or not. Instead, nondirective and directive helping differ in the kinds of meta-messages they communicate to copers regarding their physical, mental, and emotional competencies. These messages, we believe, can profoundly affect copers' morale regarding their coping efforts.

NONDIRECTIVE SUPPORT VS. DIRECTIVE SUPPORT AND MORALE

Kurt Lewin defined morale as the ability to set valued goals combined with confidence in one's own ability to achieve those goals (Lewin, 1948). According to Lewin, this combination of a hoped-for future paired with confidence in one's ability to realize it was essential for overcoming adversity.¹ More recently, Charles Snyder and colleagues used this same prescription to define and measure hope. In much the same way as Lewin characterized morale, Snyder et al. define hope as consisting of both an ability to set goals and confidence in one's own capacity to achieve them. Hope serves "as a means of maintaining a fighting spirit" in the face of adversity (Snyder et al., 1998, p. 195). Snyder and his colleagues have demonstrated the contribution of hope to realizing important personal goals (Snyder et al., 1991) and to coping with serious illness (Irving, Snyder, & Crowson, 1998).

The themes of planning, agency, and control that are integral to morale are centrally implicated in the distinction between nondirective and directive support. People who receive primarily nondirective support are encouraged to identify and articulate the goals of their own recovery and, through the assistance of their supporters, to achieve the goals that they, themselves, have set. Moreover, by controlling the amount, nature,

1. Lewin explicitly associated morale with social support, stating "group 'belongingness' may increase a feeling of security, thereby raising the morale . . . of the individual" (Lewin, 1948, p. 85).

and timing of help, recipients of nondirective support may be better able to both ascertain and exercise their own coping abilities. Because nondirective support allows them to assert greater agency in their own recovery, copers who mainly receive this kind of support—at least for generally tractable problems—should experience greater morale, compared to people who receive primarily directive support, where others prescribe the nature, time-course, and degree of helping.

Research conducted by our group generally confirms these hypotheses (Fisher, La Greca, et al., 1997; Fisher, Bickle, et al., 1997). Among patients with diabetes and lupus and among women describing their response to menopause, structured interview measures of nondirective and directive support show that directive support was generally associated with poorer metabolic control among those with diabetes and increased depression, while nondirective support was associated with better diabetes control and lessened depression. However, for more severe situations such as advanced lupus or surgically induced menopause, directive support was associated with reduced depression (Fisher, Bickle, et al., 1997). This pattern is consistent with other research showing that over-involved support is debilitating for mild to moderate situations, but can be beneficial for acute situations (Burt, Cohen, & Bjork, 1988; Fiske et al., 1991).

DEVELOPMENT OF A SELF REPORT MEASURE OF NONDIRECTIVE AND DIRECTIVE SUPPORT

The distinction between nondirective and directive support may help differentiate the ways that over-involved helping depletes morale. According to over-involvement researchers, help that over-reaches can convey to copers a lack of faith in their capacity to solve their own problems (Coyne et al., 1988). However, it is also possible that those who know when to back off from problem solving, and when to abide by copers' own solutions, send morale-boosting messages that over-reaching helpers fail to convey. The sending of these morale-boosting messages, as much as the transmission of morale-depleting messages, may contribute to copers' overall levels of confidence and determination. The over-involvement concept is too general to capture these differences. The nondirective and directive support may be sufficiently differentiated to do so.

The nondirective/directive distinction has two other important advantages over "over-involvement." First, over-involvement is largely empirically derived and for this reason definitions of it vary across the studies in which it has been observed (Fiske et al., 1991). Indeed, helping can only be considered "over-involved" if it conflicts with the prefer-

ence, judgment, or need of the recipient. Nondirective support and directive support are defined a priori. They remain conceptually consistent across support situations and can be assessed independent of the recipients' preferences or situation. Second, nondirective support and directive support are not necessarily evaluative terms. Indeed there may be situations in which an emphasis on one or the other might be especially appropriate (a point we elaborate upon in the Discussion). "Over-involvement" (and "over-protectiveness"), on the other hand, carries pejorative connotations that may obscure the necessary relation between, for example, assertive helping and acute crises (see Fiske, Coyne, & Smith, 1991, for similar argument).

The nondirective/directive distinction also differs from "invisible support" (Bolger et al., 2000). Like invisible support, nondirective helping is regarded as protective of copers' self esteem. However, invisible support avoids eroding esteem by supplying help in ways undetected by the copers. Nondirective support is known to copers, but is supplied in ways that respects rather than challenges copers' autonomy and competence. Thus, "invisibility" concerns support salience, whereas the directive/nondirective dimension concerns support style. As such, these are largely orthogonal constructs.²

The present study crystallizes the concepts of directive and nondirective support by presenting them in a self-report measure of received support (cf., Wills & Shinar, 2000), which we have named the Inventory of Nondirective and Directive Instrumental Support (INDIS).³ We used the INDIS to demonstrate the relative effects of directive support and nondirective support on morale. To do so, we related INDIS responses to Snyder et al.'s "Hope" measure as well as to measures of optimism, depression, and loneliness. Hope and optimism address accretions to morale (as defined by Lewin) by indexing confidence in positive outcomes and faith in one's own ability to achieve these outcomes. Depression and loneliness address depletions to morale, in that they are states in which people are discouraged about their futures and feel bereft of internal and interpersonal resources. Collectively these four measures provide a fairly comprehensive survey of morale.

2. Indeed, there may be cases where directive and nondirective support are supplied invisibly, perhaps making the former less injurious and the latter less beneficial to esteem.

3. The adjective "Instrumental" emphasizes the more tangible and action-oriented kinds of support as reported in the over-involvement literature.

SPECIFYING SUPPORT SOURCE

Many extant measures of social support inquire about the overall quality of support people receive from their social networks. However, there is an increasing appreciation that support does not come from an undifferentiated social field. Instead, the nature and impact of support are strongly affected by support source, such as family versus friends (Brown et al., 1986; Burke & Weir, 1979). Indeed, overall support networks are not strong predictors of coping once core relationships have been considered (Brown et al., 1986). Critics of social support research therefore recommend that social support measures specify the source of support (Wills & Shinar, 2000). We followed this advice and designed two parallel versions of the INDIS, one focusing on support from a family member and another focusing on support from a friend. The items and format comprising these versions are identical, only the referent support source (family member or friend) distinguishes them from one another.

The research reported here describes three studies regarding the development of the INDIS and the testing of the nondirective/directive model. The purpose of the first study was to identify and confirm the directive and non-directive constructs. The second study was conducted to re-confirm these sub-scales. The third study used the INDIS to test whether directive support and nondirective support are differentially associated with morale.

STUDY 1

METHOD

PARTICIPANTS

The participants in this study were 353 Washington University undergraduates enrolled in an introductory psychology class. Two hundred thirteen (60.3%) were women and 140 (39.7%) were men. Participants' ages ranged from 17 to 21 ($M = 18.5$, $SD = 0.92$). The sample, in order of representation, was comprised of 250 non-Hispanic whites (70.8%), 73 Asians (20.7%), 18 African Americans (5.1%), and two Latinos (0.6%). Ten participants (2.8%) did not indicate their ethnicity. The religious composition of the sample included 100 Protestants (28.3%), 93 Jews (26.3%), 73 Catholics (20.7%), and 44 atheist or agnostic (12.5%). Forty-three participants (12.2%) did not indicate their religious affiliation. Participants completed the questionnaire as part of a class exercise.

MEASURES

Inventory of Nondirective and Directive Instrumental Support (INDIS).

A pool of 40 directive and nondirective items, emphasizing instrumental support, was generated for purposes of modified Q-sorting. These items were based upon themes that emerged from structured interviews investigating directive and nondirective support, and from general concepts of these kinds of support developed by Fisher and his colleagues (e.g., Fisher, Bickle et al., 1997; Fisher, La Greca et al., 1997). Seven colleagues who have conducted extensive interviews designed to investigate directive support and nondirective support were enlisted to complete the sorting task. Sixteen items were excluded due to low concordance (i.e., less than 75% agreement that they represented either directive or nondirective support). The remaining 24 items (12 directive and 12 nondirective) were subsequently administered in survey form. There were two parallel versions of the INDIS, one focusing on support from a family member and the other focusing on support from a friend. The items comprising these versions were the same; the difference between the versions was in the specific source (family member or friend) to which the items referred. Participants indicated how accurately each item reflected the kind of help that they received from their respective support source, using five-point Likert scales that ranged from 1 = *not at all accurate* to 5 = *extremely accurate*.

Background Questionnaire. A brief background questionnaire was prepared that sampled participants' age, race, gender, and religion. In addition, it instructed participants to indicate whether or not they had experienced any of nine major kinds of problems including personal health, romantic relationships, non-romantic relationships, bereavement, loved one's injury or illness, personal victimization, loved one's victimization, or problems in academics, jobs, or other valued area, or any other kind of problem. Two final questions asked participants to indicate which problem was the most severe, and which family member or friend (depending on INDIS version) served as their primary source of support.

PROCEDURE

Participants completed the background survey first. They then completed either the family member or the friend version of the INDIS, according to random assignment. Participants completed the INDIS in the context of the most severe problem they weathered in the past 12 months, and in reference to the individual friend or family member (de-

pending on INDIS version) who served as their primary support source in dealing with this particular problem.

RESULTS

PSYCHOMETRIC ANALYSIS OF STUDY 1

Because we had anticipated the underlying latent variable structure of the sub-scales (one directive and one nondirective latent variable), it would have been appropriate for us to immediately test the model using confirmatory factor analysis (Byrne, 1998). However the more traditional approach is to conduct exploratory factor analysis first (Bollen, 1989). Therefore, we proceeded first with exploratory factor analysis followed by confirmatory factor analysis.

We intended to develop a twin set of social support instruments that would reliably assess nondirective and directive social support from two distinct support sources, a family member and a friend. We therefore examined the factor structure for the family member version of the INDIS ($n = 172$) separately from the friend version ($n = 173$) in order to identify those items that loaded on the directive and nondirective factors across both support contexts. The same procedures and criteria were used to identify factor structures in both the family member and friend versions of the INDIS.

The 24 survey items were entered into principal components analyses. Because we expected to find two distinct constructs, one directive and one nondirective, two factors were rotated orthogonally using Varimax rotation. For both the family member and friend version of the INDIS items were eliminated if: (1) they did not load on either factor at or above .30; (2) they cross-loaded with a difference in loadings less than .10; or (3) they failed to load on the same factor for both the family member and friend versions. Four items were eliminated through this process. The remaining 20 items accounted for 44.2% of the family version variance and 40.6% of the friend version variance. Kaiser–Meyer–Olkin Measure of Sampling Adequacies (KMO) of .86 and .82 respectively indicated that factor analysis was appropriate for these data.

As expected, two factors emerged from this analysis, for both the family and friend versions, which were respectively comprised of nondirective and directive items. The *nondirective* factor contained those items that reflected support in which the provider cooperated with the recipient without “taking over” responsibility or control. The *directive* factor contained items that reflected taking over the tasks of coping.

CONFIRMATORY FACTOR ANALYSIS

In order to determine how well individual items fit the overall model, we proceeded to confirmatory factor analysis, using structural equation modeling to evaluate the fit indices of the remaining 20 items. Confirmatory factor analysis uses a set of measured variables (e.g., questionnaire items) to form a variance/covariance matrix from which unobservable latent variables (e.g., hypothesized factors) can be tested. The loading of each questionnaire item indicates its relationship with the latent variable (i.e., construct or factor). In confirmatory factor analysis, the measurement model specifies the observed variables that define the constructs and “reflects the extent to which the observed variables are assessing the latent variables in terms of reliability and validity” (Schumaker & Lomax, 1996, p. 64). We conducted confirmatory factor analysis to detect and delete weak questionnaire items (i.e., items that detract from overall model fit). The process is iterative; after detecting and deleting a weak item, the entire model is re-analyzed in order to detect and delete additional weak items, the model is analyzed again, and so forth until the model cannot be improved with additional deletions (Hofmann, 1995). The result of this winnowing is a measure containing only those questionnaire items that most strongly reflect the underlying constructs. In addition, the more compact size of the refined measure lessens respondent burden and thereby reduces the error variance associated with fatigue or annoyance that can be aroused by more lengthy and redundant survey formats.

We applied this process of item trimming to the INDIS versions and examined a variety of fit indices to determine if our measurement model fit the sample data. These included Root Mean Square Error of Approximation (RMSEA), the Comparative Fit Index (CFI), and the Incremental Fit Index (IFI). Chi-square indicates how well the measurement model we specified fits the sample data. A non-significant chi-square (with a high probability level) would indicate that our hypothesized nondirective/directive measurement model fits the data well. However, because chi-square is sensitive to sample size, well-fitting models where chi-square approximates degrees of freedom are unrealistic in most SEM calculations (Byrne, 1998). For this reason it is common to obtain significant chi-squares and still retain the model. The RMSEA also is an indicator of how well the measurement model fits the data. Browne & Cudeck (1993) recommend an RMSEA less than .08, preferably less than .05. MacCallum and colleagues (1996) noted that RMSEA values ranging from .08 to .10 indicate moderate fit. However, Byrne (1998) recognizes that these criteria are based on subjective judgment and therefore should not be regarded as inviolable. Thus, we used the RMSEA

guidelines as aids for interpretation and not as absolute thresholds. We reported the RMSEA 90% confidence intervals as recommended by MacCallum, Browne, & Sugawara (1996). Lastly, the Comparative Fit Index (CFI) and Incremental Fit Index (IFI) were chosen because the CFI was developed to take sample size into account, thereby providing a better estimate of model fitness than other fit indices. The IFI was developed to adjust for degrees of freedom and sample size. Both are recommended to be above .90 (Byrne, 1994).

Conducting confirmatory factor analysis on the family member and friends data separately, we specified the items that reflected each latent variable, as identified by the exploratory factor analysis, and constrained their loadings to zero on the latent variables on which they did not belong. Then, by allowing the latent constructs to correlate and applying the indicators of fit to each iteration, an additional 11 items were eliminated, six nondirective and five directive. The final fit indices for the family member version ($n = 171$) were $R^2(26) = 93.2$, $p = 0.00$; RMSEA = .12, 90% CI = 0.097–0.15; CFI = .90; and IFI = .90. Final fit indices for the friend version ($n = 173$) were $R^2(26) = 96.5$, $p = 0.00$; RMSEA = .13, 90% CI = 0.099–0.15; CFI = .86; and IFI = .86. These results provide encouraging indications of model fit. The measurement model approached criterion levels for the RMSEA and the CFI and IFI for both versions of the measure. For the family member version, the CFI and IFI met the recommended values. The friend version approached but fell just shy of meeting these values. The INDIS versions also demonstrated acceptable reliability. Coefficient alphas for the nondirective and directive family member version were .79 and .81 respectively. For the nondirective and directive friend version the alphas were .74 and .76 respectively.

Study 1 satisfied most of our objectives. It demonstrated two distinct subscales within both versions of the INDIS that closely relate to the hypothesized constructs of directive and nondirective support. These subscales accounted for more than 40% of the explained response variance. Moreover, the item composition of these sub-scales was the same across both survey versions, which permitted comparisons of directive and nondirective support arising from a family member or a friend. The compact size of the final versions, which was comprised of just nine items, is likely to enhance the administration of this measure. Based on this overall pattern of results, we determined that the resulting nine-item version of the INDIS was suitable for re-confirmation with a new sample and for an examination of construct validation. This version appears in the appendix.

STUDY 2

INTRODUCTION

Study 1 provided initial confirmation of the predicted two-factor structure of the INDIS. Exploratory analyses showed that items predicted to comprise the nondirective and directive subscales did so, and confirmatory analyses demonstrated that these items generally fit the overall model. However, in order to ensure that the confirmatory results obtained in Study 1 were reliable, we conducted Study 2 to obtain a separate confirmatory test of the two-factor model.

METHOD

PARTICIPANTS

The sample consisted of 142 undergraduates recruited from Rutgers University at Newark (74%) and from Washington University (26%). Rutgers/Newark has the most culturally diverse student population in the United States (*U.S. News and World Report*, 2003) and therefore provides a unique opportunity to demonstrate the generalizability of the INDIS. Females constituted 63% of the sample, and ages ranged from 17 to 36 ($M = 19.79$, $SD = 2.25$). The sample, in order of ethnic representation, included 50 non-Hispanic Whites (35.2%), 39 Asians (27.5%), 19 Hispanics (13.4%), 18 African Americans (12.7%), and 16 other (11.2%). Participants received course credit for participation in this study, which lasted roughly 15 minutes.

PROCEDURE

Participants were tested en masse in a large introductory psychology course at Rutgers, or individually at Washington University, where the study was included as an added task to other ongoing experiments. Participants first completed the revised nine-item INDIS and then filled out a brief background questionnaire sampling gender, age, and ethnic background. Data were collected anonymously.

RESULTS AND DISCUSSION

The nine items that comprise the INDIS (as identified in Study 1) were taken into confirmatory factor analysis using LISREL. The measurement models for the family member version and the friend version were reexamined separately. As before, items were constrained to zero on latent

constructs to which they did not belong and the latent constructs were allowed to correlate. Initial fit indices for the family member version ($N = 142$) were $R^2(26) = 123.24$, $p = 0.00$; RMSEA = .16, 90% CI = 0.13–0.19; CFI = .88; and IFI = .88. Initial fit indices for the friend version ($N = 142$) were $R^2(26) = 107.40$, $p = 0.00$; RMSEA = .15, 90% CI = 0.12–0.18; CFI = .82; and IFI = .82. Item trimming indicated that the friend model would be improved slightly by deleting the weakest item, “Knows when to back off from being helpful.” However, we decided to provisionally retain this item because it fit the model in the Study 1 confirmatory analysis, it is conceptually central to the non-directive factor, and because the model demonstrated acceptable fit in Study 2 when this item was included in the friend version. We therefore decided that the final disposition of this item would be determined in confirmatory analysis conducted in Study 3.

Several directive items were allowed to covary. “Decided what kind of help I needed” covaried with “Decided who could help me” and “Organized my schedule for me.” “Solved problems for me” covaried with “Took charge of my problems.” These items were allowed to covary based on the modification indices and supported conceptually. The final fit indices for the family member version ($N = 142$) were $R^2(23) = 73.21$, $p = 0.00$; RMSEA = .12, 90% CI = 0.093–0.16; CFI = .93; and IFI = .93. Final fit indices for the friend version ($N = 142$) were $R^2(23) = 64.59$, $p = 0.00$; RMSEA = .11, 90% CI = 0.081–0.15; CFI = .91; and IFI = .91. The two factors (nondirective and directive) were negatively related – .03 in the family member version and – .13 in the friend version.

Cumulatively, these fit indices show that the hypothesized constructs of the INDIS are supported by the data reasonably well, and that they support the findings obtained in the prior study. Coefficient alphas were satisfactory. For the family member version, alpha coefficients were .78 for Nondirective Support and .84 for Directive Support. For the friend version they were .75 for Nondirective Support and .79 for Directive Support. Consistent with the fit indices, subscale alphas also supported the strength of the measures.

In sum, confirmatory analyses of the INDIS in Study 2 provided further evidence that both the family member and friend versions of the INDIS are psychometrically sound measures. Notably, this reconfirmation was obtained even after sampling from a population largely distinct from the one sampled in the initial test of the two-factor INDIS.

STUDY 3

INTRODUCTION

Studies 1 and 2 indicated that the INDIS nondirective and directive subscales represent psychometrically satisfactory constructs. The primary purpose of Study 3 was to test the construct validity of the INDIS by relating it to several measures of morale, including hope, optimism, depression, and loneliness. We predicted that nondirective support would be positively related to morale, and directive support would be negatively related to morale, and that these relations would be reliable even after controlling for other measures of social support. In addition, Study 3 afforded a third opportunity to reconfirm the factor structure of the INDIS, and to also test the convergent validity of these subscales by relating them to established omnibus measures of social support.

METHOD

PARTICIPANTS

The sample consisted of 343 Washington University undergraduates who participated for course credit. The sample closely resembled the one that participated in Study 1. It included 223 women (65%) and 120 men (35%). Participants' ages ranged from 17 to 24 ($M = 19.6$, $SD = 0.30$). The sample, in order of representation, was comprised of 235 non-Hispanic whites (68.5%), 68 Asians (19.8%), 19 African Americans (5.5%), and 7 Latinos (2.0%). Fourteen participants (4.1%) did not indicate their ethnicity. The religious composition of the sample included 102 Protestants (29.7%), 74 Jews (21.6%), 67 Catholics (19.5%), and 55 atheist or agnostic (16.0%). Forty-five participants (13.3%) did not indicate their religious affiliation.

MEASURES

Directive and Nondirective Support Instrument (INDIS). Participants completed both the family member and the friend versions of the INDIS. Participants indicated how accurately each item reflected the kind of help they received from their respective support source using five-point Likert scales that ranged from 1 = *not at all accurate* to 5 = *extremely accurate*. Participants completed the measure in relation to a particular problem that occurred during the previous twelve months and in reference to the individual family member (family version) or friend (friend version)

who served as their primary support source in dealing with that problem.

Ways of Responding. The Ways of Responding scale (Snyder et al. 1991), also known as the Hope scale, is a measure of confidence in one's own ability to discern methods of reaching goals, and to successfully apply these methods to furthering one's own aims. The measure consists of eight items plus four filler items with response options ranging from 1 = "definitely false" to 4 = "definitely true." The measure consists of two subscales. The "Pathways" subscale assesses confidence in one's own ability to find solutions to personal problems and to set meaningful goals, and the "Agency" subscale assesses confidence in one's own ability to enact solutions and achieve goals. The subscales are considered additive and can be collapsed into a composite measure of hope. The total measure shows good reliability across several studies ($\alpha = .74-.84$). The Hope Scale is positively correlated to measures of optimism, perceived control, and esteem and negatively correlated to depression and hopelessness. It is distinct from negative affectivity, life stress, optimism, and locus of control. We use only the composite hope score in this study.

Revised Life Orientation Test (LOT-R). The Revised Life Orientation Test (Scheier, Carver, & Bridges, 1994) is a frequently used measure of optimism. It consists of six items plus four filler items, with 5-point response options that range from 0 = "strongly disagree" to 4 = "strongly agree." The LOT-R has acceptable internal consistency ($\alpha = .76$). It is positively correlated to self-mastery and self-esteem, and negatively related to trait anxiety and neuroticism (Scheier & Carver, 1985). An earlier version of the LOT (Scheier & Carver, 1985) is negatively related to depression and number and intensity of physical symptoms, and is positively related to active coping and planning.

Beck Depression Inventory (BDI). The BDI (Beck, Ward, Mendelsohn, Mock, & Erbaugh, 1961) is one of the most widely used self-report measures of depression. It consists of 21 items relating to feelings of sadness, negative thoughts about the self, and self-destructive impulses. Respondents are provided four response options with values ranging from 0 to 3, with "0" generally designating never feeling or thinking a particular way, and the remaining three indicating increased propensity to have the indicated thoughts and feelings. The highest scores assigned to items are added together, and the resulting sum represents respondents' BDI scores. The psychometric properties of this instrument have been extensively documented (see Beck, Steer, Garbin, 1988 for a review).

Revised UCLA Loneliness Scale (RULS). The RULS (Russell, Peplau, & Cutrona, 1980) is an established measure of loneliness with high internal consistency ($\alpha = .94$). It consists of 20 items rated on a four-point scale

where 1 = "I have never felt this way" and 4 = "I have felt this way often." The RULS is positively correlated to depression, anxiety, and rejection concerns, and is negatively correlated to self-esteem, assertiveness, and sociability.

Medical Outcomes Study Social Support Survey (MOS). The MOS (Sherbourne & Stewart, 1991) is a 19-item measure of social support, with response options ranging from 1 = "none of the time" to 5 = "all of the time." Although relatively brief, the MOS is designed to capture the primary domains of support. These are represented in the following four subscales: emotional support, tangible support, positive social interaction, and affectionate support. The subscales are additive (inter-correlating at $r = .69$ to $r = .82$), permitting a single comprehensive support measure. Internal consistency for the subscales range from $\alpha = .91$ to $\alpha = .96$. The internal consistency of the entire measure is $\alpha = .97$ (Sherbourne & Stewart, 1991). The overall measure is positively related to family functioning, mental health, physical health, energy and social activity. It is negatively related to loneliness, physical and social role limitations, and several symptom indices. The MOS Support inventory is not focused on medical contexts, and only three of the 19 items make explicit reference to illness.

Social Provisions Scale (SPS). The SPS (Cutrona & Russell, 1987) is a widely used, multi-factor measure of social support. The measure consists of 24 items with response options ranging from 1 = "strongly disagree" to 4 = "strongly agree." The six subscales that comprise the SPS include attachment, social integration, reassurance of worth, reliable alliance, guidance, and opportunity for nurturance. Subscale internal consistency ranges from $\alpha = .65$ to $\alpha = .76$, but the intercorrelations between subscales are high and range from $r = .55$ to $r = .99$ (Cutrona & Russell, 1987). The subscales can be combined to form a composite measure of support (Cutrona, 1986). The SPS has been used with a wide variety of adult populations.

Background Measure. A brief general background questionnaire was prepared for purposes of surveying participant demographics. The questionnaire gathered information on participants' age, sex ethnic background, religion, and degree of religious observance. An additional set of questions concerned the most serious problem participants encountered over the previous 12 months, the severity of this event, and the nature of the support source that respondents relied on most heavily in coping with this problem (i.e., which family member, and what type of friend). A final question asked participants to rate their satisfaction with the support that they received from their primary source of family support or friend support, depending on the INDIS version they completed.

PROCEDURE

Participants were tested in groups of 30 to 50. Participants first completed informed consent forms and were instructed that the study concerned experiences with personal problems. They next completed the background measure and then, according to random assignment, completed either the family member version of the INDIS followed by the friend version, or the friend version of the INDIS followed by the family member version. They then completed the remaining measures, were debriefed and dismissed.

RESULTS AND DISCUSSION

CONFIRMATORY TESTS

The nine items that comprise the INDIS (as identified in Study 1) were taken into confirmatory factor analysis using LISREL. The measurement models for the family member version and the friend version were reexamined separately. As before, items were constrained to zero on latent constructs to which they did not belong and the latent constructs were allowed to correlate. The model could not be improved by deleting additional items, thereby supporting the nine-item resolution obtained in Study 1. Our decision to retain "Knows when to backoff" was supported, as this item demonstrated satisfactory fit.

The final measurement models, with and without allowing items to covary, resulted in very similar fit indices. Thus, we provide the most parsimonious models here. The final fit indices for the family member version ($n = 344$) were $R^2(26) = 114.1$, $p = 0.00$; RMSEA = .10, 90% CI = 0.081–0.12; CFI = .96; and IFI = .96. Final fit indices for the friend version ($n = 344$) were $R^2(26) = 105.1$, $p = 0.00$; RMSEA = .09, 90% CI = 0.076–0.11; CFI = .95; and IFI = .96. Cumulatively, these fit indices show that the hypothesized constructs of the INDIS are supported by the data reasonably well, and that they are as strong or stronger than those obtained in Studies 1 and 2. Coefficient alphas were satisfactory. For the family member version, alpha coefficients were .80 for nondirective support and .83 for directive support. For the friend version they were .71 for nondirective support and .81 for directive support. Consistent with the fit indices, subscale alphas also supported the strength of the measures.

In sum, confirmatory analyses of the INDIS in Study 3 provided a third, and stronger, indication that both the family member and friend versions of the INDIS are psychometrically sound measures. Table 1 presents the items that comprise the two versions of the INDIS and the standardized factor loadings, error variances, and squared multiple correlations for each item in the measurement model for each version. The

four nondirective items, and the five directive items, were summed and averaged to compute a nondirective scale score and a directive scale score, respectively.

COMPARISON OF SUPPORT FROM FAMILY MEMBER AND FROM FRIEND

Nondirective support from a family member was moderately related to nondirective support from a friend, $r(334) = .25, p < .001$, and directive support from a family member was moderately related to directive support from a friend, $r(334) = .40, p < .001$. Although related in valance, the amounts of directive and nondirective support differed by support source. Participants reported higher levels of nondirective support from friends ($M = 3.68, SD = .74$) than from family members ($M = 3.37, SD = .85$), $t(333) = 5.80, p < .001$, and more directive support from a family member ($M = 1.89, SD = .89$) than from a friend ($M = 1.62, SD = .71$), $p < .001$.⁴

Overall, participants reported nondirective support than directive support from both family members $t(334) = 19.71, p < .001$, and from friends $t(334) = 36.78, p < .001$.

The relation between directive and nondirective support differed by support source. When the supporter was a family member nondirective support was negatively related to directive support, $r(334) = -.25, p = .001$. When the support source was a friend the two support modes were unrelated, $r(342) = -.04, p = .ns$. The difference between these sets of correlations is significant, $z = 2.63, p = .004$. This suggests that support from a family member is likely to have a generally directive or nondirective character, while support from a friend is less likely to emphasize one or the other of these support modes.

DEMOGRAPHIC DIFFERENCES IN DIRECTIVE AND NONDIRECTIVE SUPPORT

The amounts of directive and nondirective support that participants received from a family member and from a friend were also examined in relation to participants' gender, race, and religion (see Table 2).⁵

4. Analyses were conducted using paired sample t-tests, two-tailed.

5. Significance levels reported in this table, and throughout this paper, are computed as two-tailed values.

TABLE 1. Standardized Factor Loadings, Error Variances, And Squared Multiple Correlations For Each Item In Study 3 (N = 344)

Measurement Items	Family Member			Friend		
	Factor Loadings	Error Variances	R ²	Factor Loadings	Error Variances	R ²
Directive Support Subscale						
Decided what kind of help I needed.	0.82	0.33	0.67	0.70	0.51	0.49
Solved problems for me.	0.74	0.45	0.55	0.72	0.49	0.51
Decided who could help me.	0.71	0.49	0.51	0.77	0.41	0.59
Organized my schedule for me.	0.80	0.36	0.64	0.85	0.28	0.72
Took charge of my problem.	0.85	0.28	0.72	0.86	0.25	0.75
Nondirective Support Subscale						
Knew when to back off.	0.72	0.48	0.52	0.57	0.68	0.32
Helped me without making me feel helpless.	0.59	0.65	0.35	0.65	0.57	0.43
Tried not to take over.	0.85	0.27	0.73	0.71	0.49	0.51
Helped out without taking over.	0.80	0.36	0.64	0.81	0.34	0.66

TABLE 2. Mean Nondirective and Directive Support from a Family Member and from a Friend, by Respondent Characteristics

Characteristic	Nondirective		Directive	
	Family Member <i>n</i> = 312	Friend <i>n</i> = 317	Family Member <i>n</i> = 312	Friend <i>n</i> = 317
Gender				
Female	3.43(.89) ^a	3.73(.75) ^b	1.85(.90) ^a	1.55(.63) ^b
Male	3.28(.77) ^a	3.59(.71) ^b	2.00(.89) ^a	1.72(.82) ^b
Race				
African American	3.41(.96) ^a	3.89(.80) ^a	1.68(.80) ^a	1.47(.47) ^a
Asian	3.15(.80) ^a	3.54(.73) ^b	2.15(.92) ^a	1.92(.83) ^b
Latino	3.04(.78) ^a	3.61(.73) ^a	1.83(.84) ^a	1.40(.60) ^a
White	3.45(.86) ^a	3.71(.73) ^b	1.82(.88) ^a	1.55(.66) ^b
Other	3.20(.99)	3.69(.84)	2.07(1.01)	1.40(.71)
Religion				
Atheist/Agnostic	3.46(.91) ^a	3.80(.62) ^b	1.90(.86) ^a	1.63(.86) ^a
Catholic	3.35(.90) ^a	3.62(.71) ^a	1.76(.84) ^a	1.53(.60) ^b
Jewish	3.25(.90) ^a	3.73(.74) ^b	2.05(.97) ^a	1.53(.63) ^b
Protestant	3.56(.77) ^a	3.65(.79) ^a	1.78(.86) ^a	1.60(.68) ^b
Other	3.05(.76)	3.60(.83)	2.07(.94)	1.85(.78)

Notes. Comparisons are restricted to family vs. friend, and do not compare nondirective support to directive support. Means that do not share superscripts differ at $p < .05$. The "other" categories in race and religion were not analyzed because they were insufficiently specified.

Gender. Men and women did not differ in the degree of nondirective and directive support they received from family members, nor in the nondirective support received from friends. However, men were more likely than women to receive directive support from a friend.

Ethnicity. The four ethnic groups that represented 95% of our sample generally did not differ in nondirective or directive support from family members. The notable exception was between Asians and Whites. Tukey tests of multiple comparisons show that Asians reported greater directive support from friends, $p < .001$, and marginally more from family, $p < .06$, than did Whites. Also, Asians reported marginally lower levels of nondirective support from family than did Whites, $p < .09$.

Religion. Support type did not differ by religion, regardless of support source.

CONVERGENT VALIDITY

Table 3 shows correlations between the INDIS subscales and two established social support measures, the MOS and the SPS. Correlations were computed separately for support from a family member and support

TABLE 3. Correlations between Nondirective and Directive Subscales and Other Social Support Measures (MOS & SPS), by Support Source (Family Member or Friend)

Support Measure	Nondirective		Directive	
	Family Member <i>n</i> = 312	Friend <i>n</i> = 317	Family Member <i>n</i> = 312	Friend <i>n</i> = 317
SPS				
Reliable Alliance	.27***	.28***	-.08	-.13*
Reassurance of Worth	.25***	.26***	-.16**	-.22***
Attachment	.22***	.32***	-.05	-.13*
Guidance	.26***	.32***	-.08	-.12*
Opportunity to Nurture Others	.13*	.24***	.13*	.08*
Social Integration	.24***	.26***	-.07	-.13*
Total Measure	.28***	.35***	-.04	-.13*
MOS				
Tangible Support	.24***	.20***	-.11	.02
Affectionate Support	.22***	.28***	-.01	-.01
Positive Interaction	.23***	.31***	-.09	-.01
Emotional/Informational	.25***	.36***	-.07	-.01
Total Measure	.28***	.36***	-.08	-.01

p* < .05. *p* < .01. ****p* < .001.

from a friend. The results show nondirective support is moderately related to these other social support measures, both in terms of their aggregate scores and in terms of their respective subscales. This is equally true for support from a family member and support from a friend. Nondirective support is expected to reflect supporters' sensitivity to copers' need for autonomy. It is therefore appropriate that nondirective support would be positively related to the SPS and MOS, which address the emotional and self-worth aspects of support.

Directive support from a friend was negatively related to the overall SPS. Directive support from either a family member or a friend was negatively related to the "reassurance of worth" subscale of the SPS. This result is consistent with our conception of directive support as challenging feelings of competence and morale. For support from a friend, directive support was also negatively related to the reliable alliance, attachment, guidance, and social integration subscales of the SPS. These negative correlations suggest that friends who are overly directive may be undermining rather than enhancing support. In addition, directive messages may reflect "pseudo-supportive communications" (Coates & Wortman, 1980) that indicate reduced commitment to genuine helping. Directive support was unrelated to MOS scores.

TABLE 4. Correlations between Nondirective and Directive Subscales and Measures of Morale, by Support Source (Family Member or Friend)

Coping Measure	Nondirective		Directive	
	Family Member <i>n</i> = 312	Friend <i>n</i> = 317	Family Member <i>n</i> = 312	Friend <i>n</i> = 317
Hope	.31***	.23**	-.13*	-.09
Optimism (LOT)	.26***	.12*	-.06	-.09
Depression (BDI)	-.20***	-.08	.18**	.19***
Loneliness (RULS)	-.24***	-.28***	.14*	.18***

* $p < .05$. ** $p < .01$. *** $p < .001$.

Unexpectedly, directive support was mildly related to the “Opportunity to Nurture Others” subscale of the SPS, for both family and friends. Perhaps directive support is more common in relationships with a history of reciprocal helping, where the license to advise and shape the course of coping has been earned through a history of giving and receiving help.

DIRECTIVE AND NONDIRECTIVE SUPPORT AND MORALE

Correlations Between INDIS and Morale Measures. Table 4 shows the relationship between the nondirective and directive subscales and hope, optimism, depression, and loneliness. The overall pattern of these correlations is consistent with the predicted effects of directive and nondirective support on morale. Nondirective support, from both a family member and from a friend, was positively related to hope and optimism, and negatively related to loneliness and (from family member only) depression. Directive support was negatively related to hope, and positively related to depression and loneliness.

The Unique Contributions of Nondirective and Directive Support to Morale.

The correlations between nondirective and directive support, and the several measures of morale, are consistent with our predictions. Are these associations significant after controlling for extant social support measures? In other words, does the directive/nondirective distinction add anything unique to our understanding of social support and coping? The regression results presented in Table 5 show that they do. When a family member supplies support the INDIS subscales predict hope, optimism, depression, and loneliness even after controlling for the SPS and the MOS individually and jointly.⁶

6. The change in R^2 for optimism was marginally significant at $p .08$.

TABLE 5. Standardized Regression Coefficients Relating Nondirective and Directive Support to Morale By Support Source (Family Member Or Friend), Controlling for General Measures of Support (SPS And MOS)

Morale Indices	Family Member		Friend	
	Non-directive <i>n</i> = 312	Directive <i>n</i> = 312	Non-directive <i>n</i> = 317	Directive <i>n</i> = 317
Hope (unadjusted)	.30**	-.06	.23**	-.08
Controlling for SPS	.15**	-.05	.05	-.04
Controlling for MOS	.18**	-.06	.09	-.09
Controlling SPS + MOS	.13*	-.04	.03	-.07
Optimism (unadjusted)	.26**	-.01	.12*	-.09
Controlling for SPS	.14*	-.03	-.05	-.04
Controlling for MOS	.18**	.01	.03	-.09
Controlling SPS + MOS	.13*	-.02	-.04	-.05
Depression (unadjusted)	-.17**	.14**	-.07	.19**
Controlling for SPS	-.05	.13**	.09	.14**
Controlling for MOS	-.06	.14**	.01	.19**
Controlling SPS + MOS	-.01	.13*	.06	.14**
Loneliness (unadjusted)	-.22**	.09	-.27**	.17**
Controlling for SPS	-.02	.10*	-.02	.10**
Controlling for MOS	-.07	.11*	-.07	.17**
Controlling SPS + MOS	.00	.11**	-.01	.11**

Note. Nondirective support and directive support were entered simultaneously in all steps. **p* < .05. ***p* < .01.

Nondirective support was consistently related to enhanced morale (hope and optimism) but unrelated to depleted morale (depression and loneliness). For directive support, just the opposite pattern emerged. Directive support from a friend did not make a unique contribution to enhanced morale. However, directive support remained significant in predicting depression and loneliness, even after controlling for the separate and conjoint effects of the SPS and the MOS. There were no significant interactions between directive support and nondirective support in any of these analyses.

SUPPORT SATISFACTION

The relationship between directive and nondirective support and satisfaction with support differed by support source. Nondirective support was strongly and positively related to support satisfaction when the source was a family member, *r* (317) = .56, *p* < .001, but it was only marginally related to satisfaction when the support source was a friend, *r* (317) = .10, *p* < .10. Directive support was unrelated to satisfaction when

TABLE 6. Standardized Regression Coefficients Relating Nondirective and Directive Support to Support Satisfaction by Support Source, Controlling for General Measures of Support (SPS And MOS)

	Non-directive <i>n</i> = 312	Directive <i>n</i> = 312	Non-directive <i>n</i> = 317	Directive <i>n</i> = 317
Satisfaction (unadjusted)	.58*	.06	.08	-.19**
Controlling for SPS	.54**	.08	-.01	-.17**
Controlling for MOS	.48**	.07	.03	-.20**
Controlling SPS + MOS	.53**	.09	.00	-.17**

Note. Nondirective support and directive support were entered simultaneously in all steps. * $p < .05$. ** $p < .01$.

the support source was a family member, $r(317) = .09, p = .11$, but it was negatively related to satisfaction when the support source was a friend, $r(317) = -.20, p < .001$. Table 6 shows that even after controlling for the SPS and the MOS, nondirective support predicted satisfaction when a family member was the support source, and directive support predicted satisfaction (negatively) when a friend was the support source.

DISCUSSION

This research had two objectives: to develop a psychometrically sound measure of nondirective and directive social support and, using this measure, to show that the nondirective/directive aspects of social support differentially affect morale. We believe that both objectives were met.

THE PSYCHOMETRIC PROPERTIES OF THE INDIS

The two-factor INDIS meets conventional standards of reliability and validity. The directive and nondirective factors that comprise the INDIS represent orthogonal constructs, both of the INDIS factors demonstrate adequate internal consistency across three separate undergraduate samples, and both factors are equally reliable for support from a family member and from a friend. The INDIS is grounded in actual events occurring within a fixed time frame, and therefore reflects the actual circumstances of received support rather than general impressions of prospective support. The convergent validity of the INDIS was demonstrated by moderate correlations between it and two well-established omnibus measures of social support, the SPS and the MOS. The nondirective factor was positively related to both of these measures, and

the directive factor was negatively related to the SPS but was unrelated to the MOS.

The criterion validity of the INDIS was demonstrated by correlations between nondirective and directive support and several measures of morale. Nondirective support, which was expected to advance morale, was positively related to hope and optimism and negatively related to depression and loneliness. Directive support, which was expected to depress morale, was negatively related to hope and optimism and positively related to depression and loneliness. These associations between the two INDIS factors and morale measures were evident when the support source was either a family member or a friend.

Hierarchical regressions, controlling for the SPS and the MOS (separately and conjointly), showed that the INDIS uniquely accounted for all four morale indices when the support source was a family member, and for depression and loneliness when the support source was a friend. The SPS and the MOS are themselves multi-dimensional measures designed to assess a broad swath of benign helping. The fact that the INDIS captured effects of helping above and beyond the conjoint effects of these other measures is strong confirmation that the nondirective/directive dimension represents a distinct aspect of social support.

THE DIFFERENTIAL EFFECTS OF NONDIRECTIVE SUPPORT AND DIRECTIVE SUPPORT ON MORALE

The over-involvement research (e.g., Coyne et al., 1990) demonstrated that helpers might inadvertently depress morale by trying to dominate coping. The correlations between the INDIS factors and the morale indices, as well as the regression analyses, reinforce this basic point. As the over-involvement research would predict, the meta-messages of nondirective and directive support can, themselves, profoundly affect feelings of hope, optimism, depression and loneliness—an ensemble of psychosocial states that comprehends morale in its broadest sense.

However, the directive/nondirective framework not only supports the over-involvement research, but the bi-dimensional nature of this concept also allows it to establish whether overly assertive helping depresses morale by conveying discouraging messages or by failing to send encouraging ones. The present research suggests that both kinds of communication matter, but in different ways. Directive support, where helpers assert their own agendas on the course of coping, was uniquely related to measures of depleted morale, i.e., depression and loneliness. Nondirective support, where helpers demonstrate respect for copers' autonomy, was uniquely related to measures of enhanced morale, i.e., hope and optimism. These relationships appear to be mutually inde-

pendent; after accounting for the more general effects of social support, directive support did not uniquely detract from hope and optimism, and nondirective support did not uniquely lessen depression and loneliness.

The complementary associations between directive support and morale, and nondirective support and morale, may correspond to the different meta-messages they respectively send. Directive support, where helpers attempt to assert control over coping, may convey to copers that they are perceived as helpless, inept, or dependent. If these messages are internalized, they become the classic recipe for depression (Seligman, 1975). Directive support may also exacerbate loneliness by focusing so much on the extrinsic features of copers' problems that copers feel neglected or discounted as individuals. In an inversion of the fundamental attribution error (Ross, 1977), this fixation on problems may convey to copers that helpers are more concerned with the exigencies of their problems rather than with themselves as people.

Nondirective support, by implicitly endorsing copers' autonomy and agency, may reinforce the copers' confidence in their capacity to find and enact solutions to problems—the elements that Snyder and his colleagues identify as defining hope (Snyder et al., 1991). Nondirective support may similarly bolster optimism by conveying to copers faith in positive outcomes. That is, through their willingness to “back off” from supplying support helpers may imply that the problem itself is tractable and the odds of a positive outcome are good.

DIFFERENCES IN SUPPORT FROM FAMILY AND FROM FRIENDS

Participants in our studies reported receiving less nondirective support, and more directive support, from a family member than from a friend. However, although family were less likely than friends to supply nondirective support, the nondirective support that they did supply uniquely contributed to hope, optimism, and support satisfaction, while nondirective support from friends was unrelated to these outcomes after controlling for other sources of support. It is not surprising that nondirective support may carry more weight when communicated by family. Family members, especially those in care-taking roles, can profoundly shape people's feelings about their ability to effectively manage problems (Parker, 1979). The impact of family on one's sense of personal competence may be particularly powerful among an undergraduate college sample, comprised of people making the final transition from adolescent dependency to adult autonomy. For this reason undergraduates may interpret nondirective messages from family as an important vote of confidence in their own capacities.

Friends typically do not occupy the guardianship roles that family members do. In addition, nondirective support may be normative from peers, and therefore seen by students as less diagnostic of their own coping abilities. Therefore, friends may be less able to reinforce morale through their nondirective support. However, they may be able to depress it through their directive support, which may represent a violation of friendship norms. The positive associations between friend-based directive support and depression and loneliness, and the negative association between it and support satisfaction, are consistent with this interpretation.

SUPPORT TYPE AND PARTICIPANT CHARACTERISTICS

The directive and nondirective support that respondents reported receiving from a family member or from a friend did not differ as a function of respondent gender or religion. However, an unexpected ethnic difference emerged between Asians and Whites, such that Asians reported receiving more directive support from family and friends, and less nondirective from friends. This difference may reflect differences between Asians and whites in their attitudes towards disclosing psychological distress and in the merits of focusing on the instrumental rather than emotional aspects of personal problems (Sue, Wagner, Ja, Margullis, & Lew, 1976).

THE INTERPRETIVE LIMITS OF CROSS SECTIONAL DATA

Results from Study 3 reveal the predicted associations between measures of morale and nondirective and directive support. However, these results are based on cross sectional data and therefore causality cannot be definitively inferred. Our conceptions of directive and nondirective support, and allied research in over-involved helping, suggest that the directive/nondirective dimension of support influences levels of morale. However, it is also possible that respondents' levels of morale evoke different kinds of support from their respective caregivers. For example, those who interact with the chronically depressed can become increasingly prescriptive in response to the persistent inertia of their depressed contacts (Blumberg & Hokanson, 1983).

IS NONDIRECTIVE SUPPORT GOOD AND IS DIRECTIVE SUPPORT BAD?

The current research proposed that directive support undermines morale by conveying lack of confidence in coper's capacities. Our results, showing that directive support is uniquely associated with depression

and loneliness, are consistent with this prediction. However, despite these associations between directive support and reduced morale we do not characterize directive support as uniformly negative. When copers are overwhelmed or incapacitated, it may be appropriate for caregivers to take charge of coping. Failing to do so might endanger the coper. In addition, supporters' reticence about supplying comprehensive help during extreme situations may in itself be demoralizing, as it may be perceived by copers as a lack of caring.

Even during periods of moderate stress, some degree of directive support may be appropriate or at least benign. For example, Fisher, Heins et al. (2002) found that participants in a diabetes prevention program reported that the amount of directive support they received from staff during treatment was greatest during the first year of treatment.⁷

This was when they were acquiring new dietary habits and exercise skills, and directive support may have facilitated these behavioral shifts. It may be that directive support only saps morale when it is the dominant mode of support, when it is disproportionate to the exigencies of the copers' problems, or when it is insensitive to copers' capacities. The degree and manner in which any particular blend of directive and nondirective help affects morale is probably determined by the demands of the situation, the intentions of helpers, and the perceptions of the recipients.

APPLICATIONS OF THE INDIS

The constructs of directive and nondirective support introduce a range of important questions regarding the nature and effects of social support. For example, to what degree are these aspects of support determined by the personalities of supporters and copers, by the relationship between supporters and copers, or by differences between copers and supporters in social status, seniority, or other markers of power? Do the relative amounts of directive and nondirective support shift as copers' problems evolve, and how does flexibility in this regard affect the course of coping? Do cultures differ in the degree to which directive and nondirective support are endorsed and supplied, and the degree to which they are welcomed and prove beneficial or deleterious? The INDIS supplies a psychometrically sound, compact measure that may prove useful in exploring these and other questions.

7. Participants reported receiving more nondirective support compared to directive support overall, throughout their program involvement.

**APPENDIX.
THE DIRECTIVE NONDIRECTIVE INSTRUMENT
OF SOCIAL SUPPORT (INDIS)**

This survey concerns the kinds of help you received from a family member (or friend) during a recent and important personal problem. First, think of the family member (friend) who you turned to the most in regards to that problem. Complete this questionnaire in regards to that family member (friend).

To what degree do each of the following statements describe the kind of help you received from this family member (friend)?

THIS FAMILY MEMBER (FRIEND):	Not at All	Slightly	Somewhat	A Lot
1. Decided what kind of help I needed. D	1	2	3	4
2. Solved problems for me. D	1	2	3	4
3. Knew when to back off from being helpful. N	1	2	3	4
4. Helped me without making me feel helpless. N	1	2	3	4
5. Organized my schedule for me. D	1	2	3	4
6. Helped without taking over. N	1	2	3	4
7. Decided who could help me. D	1	2	3	4
8. Tried not to take over. N	1	2	3	4
9. Took charge of my problem. D	1	2	3	4

Note. **D** = Directive, **N** = Nondirective. Directive and nondirective subscales should be computed separately by summing and averaging across their respective items. The directive and nondirective subscales are mutually independent and a cumulative score should not be computed for this measure.

REFERENCES

- Beck, A.T., Steer, R.A., & Garbin, M.G. (1988). Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluation. *Clinical Psychology Review, 8*, 77-100.
- Beck, A.T., Ward, C.H., Mendelsohn, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry, 4*, 53-63.
- Blumberg, S.R., & Hokanson, J.E. (1983). The effects of another person's response style on interpersonal behavior in depression. *Journal of Abnormal Psychology, 92*, 196-209.
- Bollen, K.A. (1989). *Structural equations with latent variables*. New York, NY: Wiley.
- Bolger, N., Zuckerman, A., & Kessler, R.C. (2000). Invisible support and adjustment to stress. *Journal of Personality and Social Psychology, 79*, 953-961.

- Brown, G.W., Andrews, B., Harris, T., Adler, Z., & Bridge, L. (1986). Social support, self-esteem, and depression. *Psychological Medicine*, *16*, 813–831.
- Browne, M. W., & Cudeck, R. (1993). Alternative ways of assessing model fit. In K. A. Bollen & J. S. Scott (Eds.), *Testing structural equation models* (pp. 136–162). Newbury Park, CA: Sage.
- Burke, R.J., & Wier, T. (1979). Helping responses of parents and peers and adolescent well-being. *The Journal of Personality*, *102*, 49–62.
- Burt, C.E., Cohen, L.H., & Bjorck, J. (1988). Perceived family and environment as a moderator of young adolescents' life stress adjustment. *American Journal of Community Psychology*, *16*, 101–122.
- Byrne, B. M. (1994). *Structural equation modeling with EQS and EQS/Windows: Basic concepts, applications, and programming*. Thousand Oaks, CA: Sage.
- Byrne, B.M. (1998). *Structural equation modeling with LISREL, PRELIS, and SIMPLIS: Basic concepts, applications, and programming*. Mahwah, NJ: Erlbaum.
- Coates, D., & Wortman, C.B. (1980). Depression maintenance and interpersonal control. In A. Baum & J.E. Singer (Eds.), *Advances in environmental psychology: Vol 2. Applications of personal control* (pp. 149–182). Hillsdale, NJ: Erlbaum.
- Cohen, S., & Lichtenstein, E. (1990). Partner behaviors that support quitting smoking. *Journal of Consulting and Clinical Psychology*, *58*, 304–309.
- Coyne, J.C., Ellard, J.H., & Smith, D.A.F. (1990). Social support, interdependence, and the dilemmas of helping. In Sarason, B.A., Sarason, I.G., & Pierce, G.R. (Eds.) *Social support: An interactional view* (pp. 129–150). New York: Wiley & Sons.
- Coyne, J.C., Wortman, C.B., & Lehman, D.R. (1988). The other side of support: Emotional overinvolvement and miscarried helping. In B.H. Gottlieb (Ed.), *Marshalling social support: Formats, processes, and effects*. (pp. 305–330). Thousand Oaks, CA: Sage.
- Cutrona, C.E. (1986). Behavioral manifestations of social support: A microanalytic investigation. *Journal of Personality and Social Psychology*, *51*, 201–208.
- Cutrona, C.E., Cohen, B.B., & Igram, S. (1990). Contextual determinants of the perceived supportiveness of helping behaviors. *Journal of Social and Personal Relationships*, *7*, 553–562.
- Cutrona, C.E., & Russell, D. (1987). The provisions of social relationships and adaptations to stress. In W.H. Jones and D. Perlman (Eds.), *Advances in personal relationships* (vol. 1, pp. 37–67). Greenwich, CT: JAI.
- Dakof, G.A., & Taylor, S.E. (1990). Victims' perceptions of social support: What is helpful from whom? *Journal of Personality and Social Psychology*, *58*, 80–89.
- DiMatteo, M.R., & Hays, R. (1981). Social support and serious illness. In B. Gottlieb (Ed.), *Social networks and social support* (pp. 117–148). Beverly Hills, CA: Sage.
- Epstein, S. (1989). The self concept, the traumatic neurosis, and the structure of personality. In D. Ozer, J.M. Healy, Jr., & A.J. Steward (Eds.), *Perspectives in personality, Volume 3*. Greenwich, CT: JAI Press.
- Fisher, E.B., Bickle, M.A., Harber, K.D., Hughes, C.R., Jeffe, D.B., Kahl, M.D., & La Greca, A.M. (1997). *Benefits of directive and nondirective support are moderated by severity of circumstances*. Poster session presented at the annual meeting of the Society of Behavioral Medicine, San Francisco, CA.
- Fisher, E.B., Heinds, J.M., Todora, H.M.S., White, N.H., Marrero, D.G., McNabb, W.L., Quinn, M.T., & Walker, E.A. (2002). *Social support from staff in diabetes prevention program*. Poster presented at the annual meeting of the American Diabetes Association, San Francisco, CA.
- Fisher, E.B., La Greca, A.M., Greco, P., Arfken, C., & Schneiderman, N. (1997). Directive and nondirective social support in diabetes management. *International Journal of Behavioral Medicine*, *4*, 131–144.

- Fiske, V., Coyne, J.C., & Smith, D.A. (1991). Couples coping with myocardial infarction: An empirical reconsideration of the role of overprotectiveness. *Journal of Family Psychology*, 5, 4–20.
- Helgeson, V.S. (1993). Two important distinctions in social support: Kind of support and perceived vs. received. *Journal of Applied Social Psychology*, 23, 825–845.
- Hofmann, R. (1995). Establishing factor validity using variable reduction in confirmatory factor analysis. *Educational and Psychological Measurement*, 55, 572–582.
- Irving, L.M., Snyder, C.R., & Crowson, J.J. (1998). Hope and coping with cancer by college women. *Journal of Personality*, 66, 195–214.
- Janoff-Bulman, R. (1989). Assumptive worlds and the stress of traumatic events: Applications of the schema construct. *Social Cognition*, 7, 113–136.
- Jöreskog, K. G. (1993). Testing structural equation models. In K. A. Bollen & J. S. Scott (Eds.), *Testing structural equation models* (pp. 294–316). Newbury Park, CA: Sage.
- Lehman, D.R., Ellard, J.H., & Wortman, C.B. (1986). Social support for the bereaved: Recipients' and providers perspectives on what is helpful. *Journal of Consulting and Clinical Psychology*, 54, 438–446.
- Lewin, K. (1948). *Resolving social conflicts*. New York: Harper & Row.
- Lewis, M.A., & Rook, K.S. (1999). Social control in personal relationships: Impact on health behaviors and psychological distress. *Health Psychology*, 18, 63–71.
- MacCallum, R. C., Browne, M. W., & Sugawara, H. M. (1996). Power analysis and determination of sample size for covariance structure modeling. *Psychological Methods*, 1(2), 130–149.
- Parker, G. (1979). Parental characteristics in relation to depressive disorders. *British Journal of Psychiatry*, 134, 138–147.
- Revenson, T. A., Schiaffino, K. M., Majerovitz, D., & Gibofsky, A. (1991). Social support as a double-edged sword: The relation of positive and problematic support to depression among rheumatoid arthritis patients. *Social Science and Medicine*, 33, 807–813.
- Rook, K.S. (1984). The negative side of social interaction: Impact on psychological well-being. *Journal of Personality and Social Psychology*, 46, 1097–1108.
- Ross, L. (1977). The intuitive psychologist and his shortcomings. In L. Berkowitz (Ed.), *Advances in experimental social psychology*, (Vol. 10). New York: Academic.
- Russell, D., Peplau, L.A., & Cutrona, C.E. (1980). The revised UCLA Loneliness Scale: Concurrent and discriminant validity evidence. *Journal of Personality and Social Psychology*, 39, 472–480.
- Scheier, M.F., & Carver, C.S. (1985). Optimism, coping, and health: Assessment and implications of generalized outcome expectancies. *Health Psychology*, 4, 219–247.
- Scheier, M.F., Carver, C.S., & Bridges, M.W. (1994). Distinguishing optimism from neuroticism (and trait anxiety, self-mastery, and self-esteem): A reevaluation of the Life Orientation Test. *Journal of Personality and Social Psychology*, 67, 1063–1078.
- Schumacker, R. E., & Lomax, R. G. (1996). *A beginner's guide to structural equation modeling*. Mahwah, NJ: Lawrence Erlbaum.
- Schuster, T.L., Kessler, R.C., & Aseltine, R.H. (1990). Supportive interactions, negative interactions, and depressed mood. *American Journal of Community Psychology*, 18, 423–438.
- Seligman, M.E.P. (1975). *Helplessness: On depression, development, and death*. San Francisco: Freeman.
- Sherbourne, C.D., & Stewart, A.L. (1991). The MOS social support survey. *Social Science and Medicine*, 32, 705–714.
- Shinn, M., Lehmann, S., & Wong, N.W. (1984). Social interaction and social support. *Journal of Social Issues*, 40, 55–76.
- Snyder, C. R., Harris, C., Anderson, J.R., Holleran, S.A., Irving, L.M., Sigmon, S.T.,

- Yoshinobu, L., Gibb, J., Langelle, C., & Harney, P. (1991). The will and the ways: Development and validation of an individual-differences measure of hope. *Journal of Personality and Social Psychology, 60*, 570-585.
- Stuart, R.B., & Davis, B. (1972). *Slim chance in a fat world*. Champaign, IL: Research Press.
- Sue, S., Wagner, N., Ja, D., Margullis, C., & Lew, L. (1976). Conceptions of mental illness among Asian and Caucasian-American students. *Psychological Reports, 38*, 703-708.
- Taylor, C.B., Bandara, A., Ewart, C.K., Miller, N.H., & DeBusk, R.R. (1985). Exercise testing to enhance wives' confidence in their husbands' cardiac capabilities soon after clinically uncomplicated myocardial infarction. *American Journal of Cardiology, 55*, 635-638.
- U.S. News & World Report (2003). Campus diversity: National universities—doctoral. America's best colleges, 2003. http://www.usnews.com/usnews/edu/college/rankings/brief/natudoc/natudoc_campdiv_brief.php
- Willaims, G.G., Gagne, M., Ryan, R.M., & Deci, E.L. (2002). Facilitating autonomous motivation for smoking cessation. *Health Psychology, 21*, 40-50.
- Wills, T.A., & Shinar, O. (2000). Measuring perceived and received social support. In S. Cohen, L.G. Underwood, & B.H. Gottlieb (Eds.) *Social support measurement and intervention*. New York: Oxford University Press.
- Yarcheski, A., Mahon, N.E., & Yarcheski, T.J. (2001). Social support and well-being in early adolescence: The role of mediating variables. *Clinical Nursing Research, 10*, 163-181.

Copyright of Journal of Social & Clinical Psychology is the property of Guilford Publications Inc.. The copyright in an individual article may be maintained by the author in certain cases. Content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.