Types of Social Support in African Americans With Cancer

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Purpose/Objectives: To determine the types of social support that African Americans use to cope with the experience of cancer.

Research Approach: Qualitative study using a grounded theory approach.

Setting: Participants' homes in the southeastern United States.

Participants: A purposeful sample of 13 African American men (aged 61–79 years) treated for prostate cancer and 15 African American women (aged 42–87 years) treated for breast cancer. Participants were selected according to key variables known to influence social support: age, gender, marital status, education, geographic region, and proximity to family.

Methodologic Approach: Open-ended and semistructured interviews were conducted with each participant (N = 28). Participants were interviewed until informational redundancy was achieved. Constant comparison techniques were used to identify variations of social support within and across cases.

Main Research Variables: The experience of social support during diagnosis or treatment for cancer as well as post-treatment.

Findings: Participants used types of social support not currently emphasized in the literature. The emotional support of "presence" was reported most frequently. Instrumental support included not only current conceptualizations but also offers of prayers, assistance to continue religious practices, and assistance to maintain social roles. Informational support included what to expect and how to manage symptoms, interpret information, and validate information received.

Conclusions: Findings suggest the need to reconceptualize social support for African Americans with cancer and to refine instruments to include these different manifestations of social support.

Implications for Nursing: Researchers can use these findings in the design of culturally relevant questionnaires and interventions for this population. Clinicians can use knowledge of the types of social support valued among African American patients with cancer to develop more appropriate strategies to promote healthy outcomes for this population.

Key Points . . .

➤ Researchers have acknowledged that race or ethnicity and culture affect the social support experiences of patients with cancer, yet these studies generally have focused on western, white, middle-class people.

➤ Evidence exists that African Americans may not use or benefit from types of support as typically defined.

➤ Knowledge of the role that social support plays in coping with cancer among African Americans is needed as caregivers strive to improve the health outcomes for this population.

studies generally have focused on white, middle-class people (Beder, 1995; Northouse, 1995; Reynolds et al., 1994; Rodrigue, 1997; Stewart & Tilden, 1995). When African American patients with cancer have been included in research, the discovery of presumably lower amounts of social support has led researchers to conclude that African Americans are socially isolated and lacking social support (O'Hare, Malone, Lusk, & McCorkle, 1993; Ostrow et al., 1991; Rodrigue). But what is not clear is whether lower amounts of social support actually result from a lack of resources or the failure to identify them because of cultural differences that are not taken into account.

The purpose of this article is to describe the types of social support a group of African American women and men used to cope with the experience of cancer. Using a grounded theory approach, the authors examined social support in African

Social support can have many positive benefits for patients with cancer, allowing patients to talk about their cancer-related worries and concerns, obtain information and advice about the disease and its associated treatment, and receive assistance with finances or household tasks (Helgeson & Cohen, 1996; Hoskins et al., 1996; Reynolds et al., 1994). The availability of social support has been shown to positively influence attitudes toward health care (Mishel & Braden, 1987), aid psychological adjustment to illness (Bloom & Speigel, 1984; Funch & Mettlin, 1982; Northouse, 1988), buffer stress (Speigel, 1992), and even increase survival rates (Carlsson & Hamrin, 1994; Reynolds et al.; Speigel, Bloom, Kraemer, & Gottheil, 1989; Waxler-Morrison, Hislop, Mears, & Kan, 1991).

Although the benefits of social support as a general resource for people with cancer have been investigated, these

American men treated for prostate cancer and African American women treated for breast cancer. Researchers have acknowledged that race or ethnicity and culture affect the social support experiences of patients with cancer (Makabe & Hull, 2000; Rodrigue, 1997). In addition, African Americans have the highest overall incidence of cancer compared to any other racial or ethnic group in the United States (American Cancer Society [ACS], 2003). Even though cancer deaths have declined for African Americans, the cancer mortality rates for this ethnic minority group remain higher than those for any other group (ACS). African Americans have the worst morbidity and mortality rates of any group with cancer, yet few studies have examined social support from the perspective of African Americans diagnosed with cancer.

Literature Review

Social support has been conceived as being comprised of (a) emotional support, (b) instrumental support, and (c) informational support (Helgeson & Cohen, 1996; House & Kahn, 1985; Tilden, 1985). The most frequently studied is emotional support, which is defined as the expression of love, liking, or both and listening to worries and concerns. Although definitions of emotional support have been broad, the most frequent indicator of this type of support appears to be individuals' ability to confide in other members of their social network about health-related problems (Bloom, Stewart, Johnston, Banks, & Fobair, 2001; Helgeson & Cohen; Katapodi, Facione, Miaskowski, Dodd, & Waters, 2002; Koopman et al., 2001).

Appraisal support, a type of emotional support, has been defined as an agreement with ideas or feedback that lead to self-validation. Appraisal support is determined by the degree to which social network members provide feedback of acceptance (Goodenow, Reisine, & Grady, 1990; Gulick, 1994; Sollner et al., 1999), agreement of ideas (Gerin, Pieper, Levy, & Pickering, 1992; Gulick; Ostrow et al., 1991; Wellisch et al., 1999), empathy (Sollner et al.), and feedback that encourages positive self-validation (Gerin et al.).

The second type of social support studied is instrumental support. Also sometimes referred to as tangible support, instrumental support is assistance with material aid or finances and household tasks, goods, and services. Indicators of instrumental support have been the loaning or borrowing of money (Bloom et al., 2001; Gulick, 1994; Wellisch et al., 1999), being able to call on someone for assistance when confined to bed (Gant & Ostrow, 1993; Koopman, Hermanson, Diamond, Angell, & Spiegel, 1998), and assisting with chores and other household tasks (Bloom et al.; Hays, Saunders, Flint, Kaplan, & Blazer, 1997; Matthews, Stansfeld, & Power, 1999).

Informational support, the third category of social support, has been studied less frequently than either emotional or instrumental support (Helgeson & Cohen, 1996). When types of informational support have been examined, the focus has been on types of information available from formal educational programs or support groups (Cope, 1995; Helgeson & Cohen; Samarel et al., 1998). Research has focused on interventions to meet patients' needs for information about their cancer from computerized educational programs, physicians, and support groups (Eriksson & Lauri, 2000; Jones, Nyhof-Young, Friedman, & Catton, 2001). Types of information from informal sources are differentiated from types received from formal sources (Dirksen, 2000); however, studies examining types of information available from informal networks to patients with cancer are limited.

Social Support and African Americans

Evidence exists that African Americans may not use or benefit from types of support as typically defined (Sampter, Whaley, Mortenson, & Burleson, 1997; Strogatz & James, 1986). For example, investigators have found that African Americans were half as likely to confide in family members about personal problems as Caucasians (Strogatz & James). The emotional support of having others listen to personal problems also was not as important to African Americans as it was to Euro-Americans or Asian Americans (Sampter et al.). Researchers have acknowledged the existence of cultural influences on types of emotional support for African Americans (Bourjolly & Hirschman, 2001; Rodrigue, 1997); however, these differences have not been described fully.

African Americans have reported the receipt of types of instrumental support, such as assistance with sick care and chores (Hays et al., 1997; Strogatz & James, 1986), transportation (Taylor & Chatters, 1986; Tessaro, Eng, & Smith, 1994), and financial assistance from family and friends (Walls, 1992). Yet, this kind of instrumental support not always has resulted in positive health outcomes. For example, although a group of elderly African Americans was protected against functional decline with the support of assistance with sick care and household tasks (Hays et al.), these types of instrumental support did not have positive health outcomes for HIV-positive African American men (Gant & Ostrow, 1993). Tangible forms of instrumental support did not positively influence participation in cancer screening tests for African American women either (Kang, Bloom, & Romano, 1994).

Studies examining informational support among African Americans are even more limited and focused more on sources rather than types of support. Sources of informational support for African Americans include church-sponsored support groups and family and friends (Chatters, Taylor, & Jayakody, 1994; Matthews, Lannin, & Mitchell, 1994; Tessaro et al., 1994). Whether similarities or differences exist in the types of advice or information received from formal and informal sources is not clear. However, in the context of healthcare problems, African Americans have used the informational support of advice on whether to seek out formal healthcare services (Neighbors & Jackson, 1984). Specifics on types of information and advice are not known.

This research examining the social support experiences from the perspective of African Americans was overdue. A culturally informed understanding of social support among African Americans is needed to evaluate the utility of this concept for the care of this ethnic minority population. Knowledge of the role that social support plays in coping with cancer is critical as caregivers strive to improve the health outcomes of African Americans with cancer.

Methods

The findings reported in this article were derived from open-ended and semistructured interviews with 15 African American women with breast cancer and 13 African American men with prostate cancer recruited from the southeastern United States. Approval and informed consent for this study

were obtained from the institutional review board of the School of Nursing at the University of North Carolina at Chapel Hill.

Participants

The 28 participants interviewed for this study were sampled from lists of participants who had completed three National Institutes of Health-funded studies—Managing Uncertainty: Self-Help in Breast Cancer Study funded to Principal Investigator (PI) Merle Mishel, PhD, RN, FAAN; Promoting Self-Help: Underserved Women with Breast Cancer Study to PI Carrie Braden, PhD, RN, FAAN; and Managing Uncertainty in Stage B or Early Stage C Prostate Cancer Study to Mishel. A total of 291 women and men participated in these three studies. These studies were designed to deliver a psycho-educational intervention to women being treated for breast cancer and men being treated for prostate cancer. Of the 15 African American women interviewed for this study, 9 (60%) were in the primary study's control group and did not receive the intervention. Of the 13 men interviewed for this study, 6 (46%) were in the control group.

The 28 women and men recruited for this study were selected deliberately according to key variables identified as important from the social support literature. Among these variables were gender, age, marital status, education, geographic region, and proximity to family (House & Kahn, 1985; Kahn & Antonucci, 1980). However, as a result of restrictions imposed by sampling from an available list of participants, the authors were able to select only women and men who varied on gender, marital status, educational level, geographic location, and proximity to family. Because of missing data on income, the authors could not sample on this variable.

Procedure

The first author conducted in-depth interviews with each participant. These interviews were aimed at eliciting descriptions of their experiences with social support during the diagnosis, treatment, and post-treatment periods of their cancer trajectory. Participants were interviewed once in their homes, and each interview lasted from 45 minutes to two hours. Participants were interviewed until informational redundancy in each gender group and theoretical saturation of the typology were achieved (Sandelowski, 1995). Initially, the interviews were unstructured. Each interview started with a general question: "Tell me about your experience with cancer." Other general questions included "What helped you through that experience?" and "What has been helpful to you since your diagnosis, and why was that important to you?" As the interviews progressed, the questions became more directed so that researchers could pursue analytic lines that emerged in previous interviews.

Data Analysis

Constant comparison analysis techniques were used for an in-depth exploration and further understanding of the construct social support from the perception of African Americans with cancer (Strauss & Corbin, 1998). This in-depth exploration, along with the systematic process of simultaneous data collection and analysis, guided the formulation of a typology of social support.

The grounded theory techniques of theoretical sampling and constant comparative analysis were used for typology development (Strauss & Corbin, 1998). Although sampling was confined to people who had participated in the previously described intervention studies, theoretical sampling consisted of sampling interview data for different manifestations of social support in people who varied according to gender, educational level, marital status, geographic location, and proximity to family. The intent was to use these data in combination with concepts already in the social support literature to develop a more culturally sensitive typology of social support.

Constant comparison analysis techniques were used (Strauss & Corbin, 1998) to discern patterns and variations in the types of support within and across cases. The responses of each woman were compared to those of the other women, each man was compared to the other men, and women and men were compared to each other as a group. Types of social support that each participant described were compared to each other and to types of social support described in the literature. Intra- and cross-case displays were created showing the types of social support that each participant described. As a result of this use of constant comparison analysis, the relevance of existing concepts of social support were confirmed or extended or new concepts were added.

In a previous reporting based on the same group of participants (Hamilton & Sandelowski, 2003), the focus of analysis was on identifying reciprocal relationships among these participants. The purpose of this article is to describe the types of social support these women and men used throughout the cancer trajectory.

Findings

The average age of the African American women (N = 15) in this study was 60 years (range = 42–87), and their average educational level was 13 years (range = 8–19), with a majority having at least a high school education (n = 11, 73%); 53% of them were not married. At the time of the interviews, a majority (n = 11, 73%) were retired or on medical leave. A majority (n = 14, 93%) had a history of working in service to others as teachers, nurses, or domestic workers. Very few lived alone, but this low number can be attributed partly to family members living with them while they were recovering from their treatment. According to the U.S. classification of counties and equivalent areas, only two of these women lived in nonmetropolitan counties.

The average age of the African American men (N = 13) was 67 years (range = 61–79). The majority were married (n = 11, 85%) and well educated; nine (69%) had college degrees and three of those had graduate degrees. At the time of interview, a majority (n = 10, 77%) were retired or on medical leave. Their working histories were similar to the women, with a majority (n = 9, 69%) having worked in service roles, primarily as teachers or ministers. Five of the men lived in nonmetropolitan counties.

Table 1 summarizes the key findings of this study. Participants described types of social support that have not been a primary focus of research. In this section, the authors will discuss these types of support and how they relate to existing conceptualizations of emotional, instrumental, and informational support.

Emotional Support

Emotional support was available to a majority of these women (n = 14, 93%) and men (n = 12, 92%). The authors

Table 1. Types of Support

Support Type	Women (N = 15)		Men (N = 13)		Total (N = 28)	
	n	%	n	%	n	%
Emotional	14	93	12	92	26	93
Presence of others	14	93	12	92	26	93
Encouraging words	11	73	11	85	22	79
Distracting activities	11	73	9	69	20	71
Protecting and monitoring	11	73	9	69	20	71
Instrumental	15	100	13	100	28	100
Offers of prayers	10	67	3	23	13	46
Assistance to maintain social roles	3	20	8	62	11	39
Assistance to continue religious practices	5	33	1	8	6	21
Assistance to live at home	4	27	–	–	4	14
Informational	12	80	11	85	23	82
Getting information about what to expect	9	60	6	46	15	54
Validating information received	4	27	5	38	9	32
Assistance to understand information	3	20	4	31	7	25

identified four kinds of emotional support: presence of others, encouraging words, distracting activities, and protecting and monitoring.

Presence of others: In contrast to the most frequently mentioned type of emotional support in cancer research—confiding in others—the most frequent type of emotional support for women (n = 14, 93%) and men (n = 12, 92%) in this study was the presence of others, a type of emotional support observed in other patients with cancer (Dakof & Taylor, 1990; Ferrell, Grant, Funk, Otis-Green, & Garcia, 1998; Makabe & Hull, 2000). Referred to as the support of "being there" (Helgeson & Cohen, 1996), presence as a type of emotional support occurs when network members communicate that they are available and willing to help in whatever way needed (Sarason, Sarason, & Pierce, 1990). Makabe and Hull described presence as a form of companionship, not involving conversations about cancer.

One man described how his wife and children were there for him. His four daughters all lived in distant towns and were not able to visit frequently. Yet, this father still believed that his children were "there" for him during his cancer treatments. "They would come here sometimes and just sit with us. They would come and sit with us at the cancer center sometimes."

Another man with adult children living close by described how his wife and children were there for him. "They let me know they were there for me, through thick and thin. Anything that I wanted or asked, anything I wanted them to do for me, they would."

Encouraging words: A second type of emotional support included verbal expressions that were perceived as positive, motivating, and uplifting and used by family members to convince the person with cancer that he or she did not look sick. The majority of women (n = 11, 73%) and men (n = 11, 85%) received this type of support.

As a type of emotional support, encouraging words are intended to reassure or to encourage positive self-evaluation (Helgeson & Cohen, 1996). In research with other patients

with cancer, encouraging words from family members and friends communicated optimism about patients' prognoses or their ability to survive with cancer (Dakof & Taylor, 1990). Similarly in this study, encouraging words included comments to praise the women and men for having the courage to get treated for cancer. Encouraging words also were intended to inspire and motivate participants to endure cancer treatments. At other times, comments were intended to validate that patients' appearances had not changed—essentially, that they still looked healthy.

A married woman who was very active in church groups described the encouraging words that she received from her church family.

They always said I looked good. I looked well. Said, "You sure do look well," you know. And they said, after the chemo, that I looked better. They would say, "You don't look sick." They would always tell me I didn't look sick. Those encouraging words sure did help.

The receipt of encouraging words is not always viewed as helpful (Helgeson & Cohen, 1996), which was also a finding of this study. One woman with advanced breast cancer told how she felt about encouraging words from friends.

Well, I really was sick, and they thought I wasn't gonna live, okay; people would look at me with these eyes, these pity eyes. And no matter what came out of their mouth, the good encouraging words, behind the good encouraging words, I could see really what was going on. I could see what they were really saying. I didn't need that.

Although a few of these patients also viewed encouraging words negatively, feeling that those words of encouragement were expressions of insensitivity or forced cheerfulness or that they minimized their cancer diagnosis (Helgeson & Cohen, 1996), the majority of these patients felt that the encouraging words they received were comforting and positive.

Distracting activities: Discussions around topics that did not involve cancer-related worries were a type of support for these women (n = 11, 73%) and men (n = 9, 69%). Forms of diversion included engaging in activities such as walking, shopping, or just getting out of the house. Many women talked about distracting activities as a form of support received from dependent children or grandchildren. One woman was a caregiver for her 80-year-old invalid mother and her 9-year-old grandson. She talked about how her grandson was a source of distraction from her worries. ". . . If I get depressed, I talk to him, and it don't take him long to bring me out of it because he keeps me busy doing something all the time." In this instance, caregiving was a vehicle for social support.

Protecting and monitoring: Protecting and monitoring was a type of support intended to guard or shield the person with cancer or to protect the person from further harm. Women (n = 11, 73%) and men (n = 9, 69%) had family members and friends check on them to make sure that they were "okay" during their experiences with cancer treatments. This type of support was also a finding in other patients diagnosed with life-threatening illnesses. HIV-positive patients also felt supported when a network of friends, also HIV positive, checked on each other (Barroso, 1997).

One type of protection came from a family member acting to shield the patients with cancer from disturbing visitors and phone calls. One divorced mother talked about her son's efforts

to protect her. "Some of those ladies, they think you're going to die . . . and my son said [to them on the phone], 'don't call,' because the phone would get on my nerves sometimes."

Instrumental Support

All of these women (n = 15, 100%) and men (n = 13, 100%) received types of instrumental support. Participants discussed types of instrumental support similar to existing conceptualizations, but they also described intangible types of support that were without apparent monetary value yet invaluable to them. These types of help may represent support that is available when financial resources are scarce. Family members, friends, and fellow church members prayed for them and assisted them to continue certain religious practices, remain in their homes when ill, and maintain their roles in the family, workplace, or church.

Offers of prayers: Women (n = 10, 67%) discussed this kind of support more than twice as often as men (n = 3, 23%). One 69-year-old retired schoolteacher, very active in her church, community, and social organizations, discussed having the support of her church family who prayed for her. According to this woman, "They prayed for me because they knew that I was going through this." The inclusion of prayer as a type of support and coping strategy has been reported in other research with African American populations (Ayele, Mulligan, Gheorghiu, & Reyes-Ortiz, 1999; Helm, Hays, Flint, Koenig, & Blazer, 2000; Stolley & Koenig, 1997).

Assistance to maintain social roles: Women (n = 3, 20%) were less likely than men (n = 8, 62%) to receive this type of support. One retired man described himself as the housekeeper and cook in the home. He was a deacon and teacher in his church. He had this to say about the support from others to maintain his roles in his home and church.

We maintained the same friendships. There was no casting-aside thing because I work in the church quite often and I maintained my same status in the church. So that didn't change any. . . . I teach a class called New Members Class, [and] they waited until I got well before they started another class.

This man talked about how it helped when his jobs in the church were postponed until he could return. He said,

Well, to me, I felt like I was needed then. It's funny if something happens to you and they go on without you; you think, well, you're not needed anymore. But that way [when they hold your job for you], you felt you were needed then. In other words, there was a place for me in the church, besides just "being there." So that made you feel better about your congregation, the people around you.

In one study with older African American and Caucasian participants, being able to maintain social roles made them feel needed (Zauszniewski & Wykle, 1994). Research on the benefits of maintaining social roles has focused primarily on marital and work roles (Broman, 1991; Eagly & Crowley, 1986; Malson, 1983), but little has been written about the importance of maintaining social roles, such as those assumed in churches and other social organizations.

Assistance to continue religious practices: The social support literature has emphasized the importance of religious beliefs and activities. However, few studies focus on types of support given to assist patients in continuing these activities

when they are ill. More women (n = 5, 33%) than men (n = 1, 8%) reported receiving this type of support.

Participants received audiotapes of services that allowed them to listen to religious services and continued religious practices such as Holy Communion. One woman summarized this type of support from her church family: "They also checked on me and brought me bread and wine [Holy Communion]."

Another example of the support to continue religious practices was from a widowed, retired schoolteacher. This woman described herself as active in her church and community but also was responsible for the care of her young grandson. When receiving radiation therapy for breast cancer, church members assisted this woman and her dependent grandchild with the following type of support.

I work in the church. I'm the hostess of my church, and I kept up with what was going on, but I was not in the service. They would bring me tapes; the ministry saw that I got tapes. . . . And my grandson, he didn't have to miss church. They would come by and make sure to get him, be sure that he got in church.

Assistance to live at home: Women (n = 4, 27%) were the only participants with the support of having family members move in or stay with them. This kind of support provided companionship for the participants who lived alone, but it also allowed participants to remain in their own homes during debilitating cancer treatments. In two cases, sons moved in permanently with their mothers. Other examples were when family members and friends stayed with participants for a day or week during a short episode when they were sick or during times when close monitoring was needed.

One divorced woman was living alone when she was diagnosed with breast cancer. Her mother-in-law and aunt stayed with her during those times when she was having side effects from chemotherapy treatments. "My aunt left work and stayed [with me] until my mother came. . . . My mother-in-law, at the time, if I had treatment, she would come and stay with me during the day."

This type of instrumental support through changes in living arrangements may have kept these patients from needing in-home care from healthcare agencies or even from being institutionalized. Several researchers have found that African Americans are more likely to use informal sources of home care and less likely to use formal homecare services (Norgard & Rodgers, 1997) or to institutionalize their sick family members (Connell & Gibson, 1997).

Informational Support

Women (n = 12, 80%) and men (n = 11, 80%) were comparable in the frequency with which they received informational support. Beyond the usual types of advice and information on what to expect and how to manage symptoms, these participants received informational support that validated and helped them to understand what they had learned from healthcare providers. Participants also valued the support of receiving cancer information from people who had similar experiences.

Getting information about what to expect: Very few researchers have examined the types of advice and information exchanged in an informal network of family and friends (Dirksen, 2000). Investigators have assumed that patients with cancer prefer to obtain information from healthcare providers (Helgeson & Cohen, 1996). However, more than half of the

patients (n = 15, 54%) in the study reported here actively sought information about what to expect when diagnosed with cancer from their relatives or friends who either had personal experiences with cancer or were employed in health care.

Although one man diagnosed with prostate cancer received information from his physician, he turned to his brother, a prostate cancer survivor, and his daughter, who was an RN, for information. The information received from his brother helped him to know what to expect. He recalled that help.

> [My brother] had a prostate cancer operation; he'd already had it. I talked with him, and he told me all the negatives about it and, of course, the positives. So, I was pretty informed about what was gonna take place before I had the operation. He talked to me how it's gonna be, some anxieties that will affect you, such as wonder how long before it comes back, wonder how would you know that it's coming back, all these things.

An evaluation of this type of support was,

> It was good because he had experienced it. Anytime, I don't care whether you're a doctor or what you might be, if you've never experienced the thing, you don't know what it really is on any person. You know what's on the outside, you know what it is, but as far as their mental and anxiety, you don't know. You think you know, but you don't know.

Validation of information received: Women (n = 4, 27%) and men (n = 5, 38%) mentioned turning to their social network members to validate the accuracy of information received from their healthcare providers. One woman was a domestic worker who talked about the wonderful relationship she had with her doctors and nurses, how they talked to her and explained her condition to her. However, she still wanted validation from her cousin who was also a nurse. She said, "She would tell me that what they said was right. That what they said was what I was supposed to do."

Assistance to understand information received: Another type of informational support received was help from family and friends in understanding the language used by doctors and nurses. A retired factory worker with 11 years of education believed that his doctors provided him with adequate information about his prostate cancer, but he relied on his daughter, who was a nurse, to help him understand medical language and answer lingering questions. He gave the example of when he turned to his daughter to answer his questions about his prostate-specific antigen level. He described why he did not ask his doctors to explain it to him.

> I'm not gonna ask them [questions] 'cause I have a daughter who will tell me in a second. If I didn't have a daughter that was a nurse, I would ask the doctor, what do you mean? So I said, well, "I'm not going to ask you, 'cause I have a daughter." Now if I didn't have a daughter, I would ask the doctors what did they mean. . . . But I wasn't worried about it because of my daughter. I know she's gonna tell me exact.

Discussion

The findings of this study suggest a need to refine prevalent conceptualizations of social support to include the experiences of African Americans. Social support research has been based on the experiences of white and middle-class people without considerations for cultural or financial resources that tend to influence types of social support.

Most studies involving emotional support have examined the amounts of confiding support or participants' ability to verbally express illness-related concerns to others. When this type of support has not been used or has not been available in the groups studied, investigators have assumed an absence of emotional support. In the current study, the most frequent type of emotional support for these participants was the presence of others. Women and men described a type of support where others were there for them and available for whatever was needed. This is an important finding in that emotional support primarily has been conceptualized as verbal expressions of problems; however, the findings in this study suggest the need to consider the importance of nonverbal expressions of love and caring in social support research.

Also not emphasized has been the use of distracting activities as a type of social support. Facing the problems, accepting the diagnosis, and openly expressing concerns about health problems have been valued coping methods in today's society (Makabe & Hull, 2000). Yet, the authors found that these patients felt supported when members of their social networks provided opportunities for distraction from their problems. Getting out to walk, shop, or relax with friends and family members offered these participants respite from their cancer-related worries. Although distraction as a strategy may be viewed negatively, Thoits (1986) argued that behaviors used to assist individuals to change the meaning of stressful situations are forms of social support.

Another type of emotional support that the authors labeled protecting and monitoring occurred when participants, family members, and friends expressed caring for each other through efforts to protect each other from physical and mental hurt and pain. An interesting finding was the way in which close family members or friends acted to protect patients from negative comments and curious observers.

The category of instrumental support has included types of material assistance, goods, and services such as the loan of money, flowers, cards, transportation, assistance with household tasks, and even child care for some populations. The authors also found these types of instrumental support in the current study in addition to other support. Offers of prayers, assistance to continue religious practices, assistance to continue living in their homes, and assistance to maintain valued social roles in the family and in the church were among the other types listed.

When the importance of church and religious practices is considered among older African Americans, the authors were not surprised to find that having the support of prayers and continued contact with the church were of value to this population. Also, having the support of others moving in either on a permanent or temporary basis allowed many of these participants to remain in their homes during cancer treatments. This finding can be related to other studies where family members and friends relocated to assume caregiving duties of older adults (Neufeld & Harrison, 1995).

Interestingly, the only gender differences were with types of instrumental support. Women were more likely to receive the support of prayers from others and to receive the support that allowed them to continue religious practices. This finding is related closely to a growing body of research showing

the importance of religious practices in older adults in general (Koenig, Pargament, & Nielsen, 1998) and particularly among older African Americans (Krause, 1992; Levin, Taylor, & Chatters, 1994). When gender differences have been examined, older African American women displayed higher levels of religiosity than men (Levin et al.; Taylor & Chatters, 1991). Additionally, older African American women were more likely to ask for the prayers of others (Taylor & Chatters, 1991).

On the other hand, men were more likely to receive types of instrumental support that allowed them to maintain their status within their churches, homes, and jobs. The most likely explanation for this gender difference is that although the majority of the women and men were retired, men found maintaining their social roles more important. Broman (1991) examined gender and work roles among African Americans with similar findings. Maintaining family and work roles was more important to psychological well-being for men than for women.

These findings also support the need to expand perspectives on types of informational support, particularly for members of ethnic minority groups who may have fewer opportunities to interact with professional healthcare workers. Information about what to expect, validation of information received, and help to interpret that information were unique types of informational support that these participants valued. Whereas the social support literature has focused solely on the provision of informational support from professional healthcare providers, this finding suggests that informal networks can be invaluable sources in the transfer of information into usable forms for patients with cancer. Given the history of institutional racism in the United States (Byrd & Clayton, 1992; Dula, 1994; Gamble, 1993; King, 1996), the authors were not surprised to find a dependence on family and friends for health-related information among African Americans in this study.

Study Limitations

In this study, a major factor that might have influenced the findings was that participants were sampled from a preexisting subject list of patients with cancer who had completed a psychoeducational intervention in which the intervention itself might have constituted a kind of social support. However, participants in this study openly discussed a wide range of social support experiences primarily within the context of their naturally occurring networks.

Implications for Nursing

Research

Investigators who study psychosocial issues among patients with cancer must be more sensitive to cultural differences among ethnic or racial groups. Social support instruments generally have been developed from the perspective of white, middle-class people. For example, many frequently used social support questionnaires consist of components derived from theoretical models and definitions proposed by white, male researchers (Brandt & Weinert, 1981; Norbeck, Lindsey, & Carrieri, 1981; Sarason, Levine, Basham, & Sarason, 1983), with reliability and validity evaluations conducted with white college students (Norbeck et al.; Sarason et al., 1983) or other white, middle-class, healthy populations (Brandt & Weinert). In contrast, the types of social support illustrated in this study were derived from the experiences of members of an ethnic minority population in the context of a cancer diagnosis.

The authors found that existing categories of social support are defined broadly enough to be valid for these African Americans; however, measures used in research need to be refined to more accurately measure social support in African Americans.

The results of this study also can be used to guide researchers in the design of intervention studies. For example, understanding that the emotional support of having others listen to patients' problems may not be a primary strategy used. Rather, the inclusion of strategies to promote the support of presence of family members and of distracting activities might be more culturally relevant for African American patients.

Practice

This study also has implications for clinicians. Knowledge about the types of social support valued among African American patients with cancer can be used to guide clinicians in the development of more appropriate strategies to promote improved health outcomes for this population. For example, the authors' findings suggest that a patient's informal network is an important source for cancer information. Although African American patients should be provided with cancer-related information, clinicians also must understand that these patients may rely on people with similar backgrounds for reassurance of the accuracy of information received.

In summary, the study's findings showcase the subtleties of social support in a population of African Americans residing in the southeastern United States. However, whether the types of social support found in this study are specific to this population or also are used by other groups needs to be tested. Given the impact of social support on the health and well-being of patients with cancer, and the poorer health outcomes for African Americans with cancer, having a culturally sensitive understanding of social support becomes even more important.

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   www.netwellness.org/centers/aahealth

➤ Cancer Facts and Figures for African Americans 2003–2004
   www.cancer.org/downloads/STT/861403.pdf

➤ Medline Plus: African American Health
   www.nlm.nih.gov/medlineplus/africanamericanhealth.html

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