

Social Support Opinions¹

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This research introduces the Social Support Opinion Survey (SSOS), the first measure of social support from the provider's perspective. Studies 1–3 developed the SSOS and confirmed that support opinions can be reliably characterized as directive (attempting to govern how others cope) and nondirective (facilitating without governing how others cope). Studies 4–6 showed that social support opinions relate to more basic cognitive, emotional, and interpersonal styles. Directive opinions were related to cognitive rigidity (need for structure, need for certainty, and just-world beliefs) and to an exchange orientation. Nondirective opinions, in contrast, were related to emotional differentiation, use of emotions as information, empathy, and a communal orientation. Thus, people may reveal who they are by how they help.

Three decades of research have established the substantial benefits of social support. However, social support is not always helpful. Some expressions of support make copers feel inept, dependent, or disrespected, and can strain rather than deepen relationships (Coyne, Wortman, & Lehman, 1988). In fact, “negative social support” can be more damaging than positive support is beneficial (Baumeister, Bratslavsky, Finkenauer, & Vohs, 2001; Pagel, Erdly, & Becker, 1987).

Why is social support sometimes ineffective or even harmful? The external conditions of helping, such as supporters' relationships to copers (Coyne, Ellard, & Smith, 1990; Coyne & Smith, 1991), the emotional and physical strain of supplying support (Coyne et al., 1988), and even time pressures (Berg, 1987) all play a part. However, there is a surprisingly underexplored

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intrapersonal explanation for why some support attempts succeed and others fail: People may hold different opinions regarding the best way to supply support.

The present research investigated whether such differences in social support opinions exist and how support opinions relate to support suppliers' personalities. The Social Support Opinion Survey (SSOS) was developed to address these questions. The SSOS is the first survey to explore social support from the provider's perspective. Therefore, it differs from the many measures that focus on support as experienced by recipients (Cohen, Underwood, & Gottlieb, 2000). The SSOS is based on the distinction between directive support and nondirective support.

Directive and Nondirective Support

People's personal problems often have a dual nature. The manifest problems—troubled relationships, work difficulties, health crises—provide the plot, characters, and decision points. Below these surface features, and perhaps animating them, are the psychological and existential stakes that problems pose. Does the coper feel capable of making good decisions; of asserting control; of regaining feelings of competence, moral rightness, and integrity? Thus, the copers' challenge is not simply solving their immediate, concrete problems, but reaffirming the value and viability of their own selves. This duplex nature of life problems can make social support a complicated task. It means that supporters must be alert to both the concrete, external problems that copers confront, as well as to the underlying psychological challenges that the problems pose. Support providers, therefore, walk a difficult path. Although often sought out by copers for their help, providers risk making things worse by doing too much.

This challenge of support provision suggests that an important dimension of support is whether it emphasizes *directive support*, which involves stepping in and asserting control, or *nondirective support*, which involves facilitating the coper's problems but without dominating the coping process (Harber, Schneider, Everard, & Fisher, 2005). The directive/nondirective distinction was first made by Carl Rogers (1961). According to Rogers, the principal goal of effective psychotherapy is to help people experience themselves as in control, competent, autonomous, and authentic. To foster these outcomes, Rogers avoided imposing his own beliefs on his clients' problems and instead attempted to create conditions through which his clients could successfully discover their own perspectives and arrive at their own solutions.

Rogers' (1961) nondirective approach is supported by current research on psychosocial resources. People function better when they have a stronger

sense of authenticity (Kasser & Sheldon, 2004) and self-worth (Reed & Aspinwall, 1998); are directed by intrinsic motives rather than by external pressures (Deci & Ryan, 1985); have a greater sense of personal efficacy (Bandura, 1977a); and feel that their lives have meaning (Silver, Boon, & Stones, 1983). Authenticity, self-worth, efficacy, inner direction, and a sense of meaning may collectively bolster secondary appraisal processes (Lazarus & Folkman, 1984), so that hardships are approached as tractable challenges, rather than as overwhelming threats.

Receipt of Directive Versus Nondirective Support

Research on receiving directive support versus nondirective support corroborates Rogers' (1961) emphasis on nondirective helping. Fisher and his colleagues (Fisher et al., 2002; Fisher, La Greca, Greco, Arfken, & Schneiderman, 1997) conducted extensive observations of asthmatics, diabetics, and other clinical populations and found that, in most cases, patients who received nondirective support fared better than did those who received directive support.³ Harber et al. (2005) drew upon this qualitative research to develop the Inventory of Nondirective and Directive Instrumental Support (INDIS), a self-report measure that distinguishes receipt of directive support from nondirective support. Using the INDIS, Harber et al. found that people who received more nondirective support reported greater hope and optimism and less depression and loneliness. People who received more directive support reported lower hope and increased depression and loneliness.

Parallels to Overprotective Helping

The morale-enhancing quality of nondirective support, and the morale-eroding quality of directive support, mirror research on overprotective helping (Coyne et al., 1988, 1990). Overprotective helping, like directive support, is characterized by efforts to impose solutions on copers. It thereby communicates to copers that they lack the skills, judgment, or character strengths to solve their own problems (Coyne et al, 1988). People who receive this kind of intrusive help experience increased dependence (Shinn, Lehman, & Wong, 1984); higher levels of anxiety, depression, loneliness, and distress (Burke & Weir, 1979; Ruehlman & Karoly, 1991); as well as reduced self-esteem and morale (Coyne et al., 1988; DiMatteo & Hays, 1981; Ruehlman

³Fisher and his colleagues took a more behaviorist approach than we do. Nonetheless, their work informs and complements the present research.

& Karoly, 1991). In contrast, support that respects copers' choices and advances their own experience of agency and autonomy, as does nondirective support, leads to elevated mood, heightened self-esteem and self-competence, and improved health (Burleson, 1985; Deci & Ryan, 1985; Williams, Gagné, Ryan, & Deci, 2002).

In sum, the outcomes of nondirective helping differ markedly from those associated with directive helping. The former generally promotes coping by boosting morale, feelings of self-worth, and a sense of control, while the latter often erodes these resources.

Support Opinions and Other Dimensions of Social Support

Social support varies along many dimensions other than the directive/nondirective one. These include emotional, informational, tangible, and instrumental forms of support; quality versus quantity of support; and perceived versus received support (Cohen et al., 2000). Although these dimensions affect how copers experience support, they do not seem central to support opinions. This is because these other dimensions focus primarily on the *form* of support. Directive and nondirective support, in contrast, focus mainly on the *manner* and *spirit* in which support is supplied and, therefore, conceptually cut across these other dimensions. For example, a person favoring directive support might dominate emotional coping (e.g., "You *must* share your feelings"), and a person favoring nondirective support might nonintrusively provide instrumental coping (e.g., "If you need a ride to the hospital, just let me know").

Support Opinions and Personality

Helping others is often a complicated and taxing activity that demands particular cognitive, emotional, and interpersonal skills and efforts from support providers. These attributes include cognitive complexity (Burleson, 1985), empathy and emotional clarity (Davis, 1996; Kang & Shaver, 2004), openness to others' disclosures (Pennebaker, 1990), and a willingness to suppress one's own needs for control and efficacy (Coyne et al., 1990; Rogers, 1961). This suggests that the kind of support that people endorse (i.e., directive or nondirective) reflects the match between their personalities and the demands of helping.

Dispositions and Directive Support

Directive support involves overt action on the part of helpers and attention to the immediate, external aspects of problems, rather than to the more

opaque domain of copers' psychological states. These characteristics of directive helping are likely to work well for people who have a low tolerance for ambiguity and a high need for structure (e.g., "There is one right way to understand this problem, and one right way to solve it"). Directive support may also relate to just-world beliefs (e.g., "If you don't follow my instructions, then it's not surprising if things don't get better"). Lastly, because directive support emphasizes the external features of problems and typically involves more overt, quantifiable helping, it may be a good match for those who approach relationships as zero-sum exchanges (e.g., "I helped you in these specific ways, now you owe me in kind").⁴ In sum, directive support "fits" with a more rigid cognitive style and an exchange perspective on relationships. Therefore, we predict that people higher in cognitive rigidity, and those who approach interpersonal relationships as exchanges, will endorse directive support more strongly.

Dispositions and Nondirective Support

Nondirective support, in contrast, focuses more on copers' intrapsychic challenges (e.g., need to restore feelings of self-worth, acceptance, and competence), rather than on external conditions of copers' problems. Addressing these psychological needs typically requires attention to copers' efforts to regain autonomy and control. To realize these goals, helpers must often provide support in such a way that their own needs to assert control or display efficacy are subordinated to those of the copers. Indeed, social support is often most effective when it is least visible (Bolger, Zuckerman, & Kessler, 2000).

Because nondirective support emphasizes the psychological aspects of coping, people who favor supplying nondirective support are predicted to display greater empathy and emotional sensitivity, as well as greater attention to and use of their own emotions. The latter would be important for two reasons. First, attention to one's own emotions heightens understanding of others' emotions and, thereby, fosters empathy (Booth-Butterfield & Booth-Butterfield, 1990; Kang & Shaver, 2004). Second, constraining one's own psychological needs (e.g., for control, efficacy) so that they do not intrude on those of the copers may require an ability to identify and monitor these needs (McWilliams, 2004). Those who endorse nondirective support are also expected to be more communally oriented and less exchange oriented regarding their personal relations, meaning that gains and losses of a valued other

⁴These parenthetical examples are meant to illustrate in broad strokes what are more likely implicitly held and less fully developed assumptions and motives.

are regarded as congruent with one's own (Mills & Clark, 1994). Consequently, nondirective support is more likely motivated by the desire to advance shared rather than personal outcomes.

Situational Influences on Support Opinions

Support opinions may also reflect situational factors. These factors include the severity of copers' problems and the identity of the coper.

Problem Severity

When circumstances are particularly dire (e.g., impending risk to life or property), attention to immediate remedies may supersede concern for copers' psychological needs. Failure to step in forcefully at such times could jeopardize copers' well-being and also imply insufficient caring (Coyne et al., 1988). Support opinions, therefore, should be responsive to event severity—directive support should be more heavily endorsed for severe problems, compared to mild ones.

Identity of the Coper

Opinions about helping may be influenced by the supporter's relationship to the coper. On the one hand, directive helping may appear to be more appropriate for someone very close and important, with whom helpers have substantial investments. On the other hand, nondirective support may be reserved for close others because of the psychological effort it entails, and because it is often less visible and, therefore, less likely to be credited. Because both explanations are plausible, we enter this research without specific predictions.

Goals of the Present Research

The present research has three major goals. The first is to develop a psychometrically sound measure of support opinions that distinguishes between directive and nondirective support. The second goal is to determine whether support opinions arise from individual differences in cognitive, emotional, and interpersonal styles. The third goal is to determine whether support opinions are responsive to situational constraints; specifically, the

severity of the coping problem and the identity of the coper. The six studies comprising this research are designed to meet these goals.

Study 1

Study 1 initiated development of the Social Support Opinion Survey (SSOS). Specifically, we attempted to identify items that would reflect preference for supplying directive support and nondirective support. The ideal item set would reflect a two-factor structure that could be used to form two mutually independent subscales (one directive and the other nondirective). In addition to identifying this initial item set, Study 1 also provides a preliminary test of the psychometric properties of the new SSOS.

Method

Participants

Study participants were 330 students (206 female, 124 male) in several large introductory psychology courses. The students received extra course credit for their participation.

Procedure

The initial scale consisted of 22 items, 10 relating to directive support and 12 relating to nondirective support. These items reflected prior research on receipt of directive and nondirective support (Fisher et al., 1997; Harber et al., 2005), and themes in the overinvolvement literature and in Rogers' (1961) client-centered approach. Participants rated each item on a 5-point scale, ranging from 1 (*slightly important to me*) to 5 (*extremely important to me*). Participants completed the measures as part of a mass testing.

Results and Discussion

Exploratory Analysis

We first conducted a principal components analysis (PCA) on the 22 items. Because we expected to find two distinct constructs (i.e., directive and nondirective), two factors were rotated orthogonally using varimax rotation. We eliminated 8 items because they either loaded less than .40 on either factor

Table 1

Principal Components Analysis: Study 1

Item	Directive	Nondirective
8. Decide for person	.70	-.19
2. Encourage to get over problem quickly	.66	-.18
1. Take charge as much as possible	.66	.22
10. Advise others	.52	-.03
13. Push the person	.49	.13
6. Take charge of problems	.49	.13
5. Listen	-.10	.68
4. At own pace	-.07	.63
11. Accept wish to be alone	-.03	.62
7. Person's point of view	.19	.61
9. On his/her side	.25	.56
12. Give only asked-for help	-.11	.55
3. Back off	-.05	.53
14. Support solutions	.05	.48

Note. This analysis was restricted to a two-factor solution with an oblique rotation. Items are abbreviated, and the complete item text is available in the Appendix. Boldface entries signify association with a common factor.

or they loaded on both factors. The remaining 14 items resolved, as predicted, into the directive and nondirective factors. Items in the directive factor involved endorsing a more intrusive and dominant role in helping, while items in the nondirective factor involved endorsing helping, mindful of needs of autonomy and control (see Table 1).

Confirmatory Factor Analysis

We next conducted a series of confirmatory factor analyses using the LISREL program (Version 8.53; Jöreskog & Sörbom, 1999). Ours was a two-factor model that assumed two major types of support—directive and nondirective. It was also assumed that each of the 14 items loaded exclusively on one factor or the other, but not on both. In addition, these analyses evaluated how our hypothesized model fared when compared to several alternative models.

In these analyses, we report four measures of model fit. Chi square (χ^2) assesses whether a tested model significantly deviates from perfection (operationally defined as a model that fully accounts for all the covariances in the data). However, because even minor deviations from perfection can be statistically significant with a sufficiently large sample, numerous alternative measures of fit have been developed. In slightly different ways, Bentler's (1990) confirmatory fit index (CFI) and LISREL's goodness of fit index (GFI) indicate how much a predicted model improves over a model that fails to account for any of the covariances among the data. For both the CFI and GFI, values of .80 and above are conventionally interpreted as adequate fit, while values of .90 or above are evidence of good fit.

We also report the root mean square error of approximation (RMSEA), which is a measure of the discrepancy between the covariances predicted by a model and the population covariances per degrees of freedom used. For the RMSEA, therefore, lower values indicate better fit (i.e., less discrepancy). Values below .10 are generally considered to be acceptable, while those below .05 indicate close fit (Browne & Cudeck, 1993; Widaman & Thompson, 2003).

Single-Factor Model

Our major hypotheses predicted that SSOS responses would load on two factors: directive support and nondirective support. Before proceeding to test this two-factor model, however, we assessed whether a simpler, one-factor model might account for the data. This model assumed that all 14 items loaded on a single factor. This model failed to fit the data well, $\chi^2(77, N = 330) = 357.22, p < .001$ (CFI = .61, GFI = .85, RMSEA = .11).

Hypothesized Two-Factor Model

Next, we tested our hypothesized two-factor model. Specifically, SSOS Items 1, 2, 6, 8, 10, and 13 were designed to assess endorsement of directive support, while SSOS Items 3, 4, 5, 7, 9, 11, 12, and 14 were designed to assess endorsement of nondirective support (see the Appendix for the full questionnaire). Accordingly, we tested a two-factor model assuming that the hypothesized directive items all loaded on one factor and the hypothesized nondirective items loaded on another (see Table 2 for factor loadings).

This model fit fairly well, $\chi^2(76, N = 330) = 201.33, p < .001$ (CFI = .82, GFI = .92, RMSEA = .07), especially considering that it is highly con-

Table 2

Confirmatory Factor Loadings: Study 1

Item	Nondirective	Directive
1. Take charge as much as possible	.46	—
2. Encourage to get over problem quickly	.45	—
6. Take charge of problems	.60	—
8. Decide for person	.56	—
10. Advise others	.47	—
13. Push the person	.25	—
3. Back off	—	.34
4. At own pace	—	.46
5. Listen	—	.59
7. Person's point of view	—	.38
9. On his/her side	—	.24
11. Accept wish to be alone	—	.46
12. Give only asked-for help	—	.29
14. Support solutions	—	.27

Note. All loadings are standardized and were obtained in the model referred to in the text as “two-factor model with correlated errors.” See Appendix for a full description of each item.

strained, requiring 14 items to load on only two factors. Although this was a dramatic improvement over the one-factor model, $\chi^2(1, N = 330) = 155.67$, $p < .001$, the marginal acceptability of the CFI and RMSEA prompted us to consider whether some minor adjustments to the model might yield a closer fit. Specifically, we thought that it might be appropriate to allow the errors to correlate among items that used similar wording (i.e., Items 1, 6, and 13, and Items 11 and 12).

Although the model still significantly deviated from perfection, $\chi^2(72, N = 330) = 158.45$ $p < .001$, it also shows that this model significantly improved the fit, $\chi^2(4, N = 330) = 42.93$, $p < .001$. Other indexes also reflected the improved fit (CFI = .88, GFI = .94, RMSEA = .06). Standardized factor loadings are presented in Table 3. Note that the two factors were almost completely independent of one another ($r = -.09$), indicating that endorsing directive support did not prevent people from also endorsing nondirective support.

Table 3

Confirmatory Factor Analyses and Fit Assessment of Hypothesized and Alternative Models: Study 1

Model	χ^2 (df)	CFI	GFI	RMSEA
Null model	800.98 (91)	—	—	—
One-factor model	357.22 (77)	.61	.85	.11
Hypothesized two-factor model	201.33 (76)	.82	.92	.07
Hypothesized two-factor model with correlated errors	158.45 (72)	.88	.94	.06
Random two-factor model with correlated errors (I)	259.64 (72)	.74	.89	.10
Random two-factor model with correlated errors (II)	260.70 (72)	.73	.89	.10

Note. Chi square for all models was significant at $p < .001$. CFI = confirmatory fit index; GFI = goodness of fit index; RMSEA = root mean square error of approximation.

Random Two-Factor Models

The two-factor models were major improvements over the one-factor model. However, the two-factor models might fit the data better than a one-factor model entirely because they have fewer constraints. To evaluate this possibility, we estimated two additional two-factor models in which the items were randomly assigned to factors through the flip of a coin. For both models, we assumed the same pattern of correlated errors as for the final, predicted, two-factor model.

The fit analyses of the two random models (Table 3) indicate that the improvement of fit of our hypothesized two-factor model over the one-factor model was partially theoretical and partially artifactual. Both random two-factor models performed substantially better than the one-factor model (this was true even when we tested these models without allowing correlated errors), indicating that some of the improvement in fit derived simply from the greater flexibility of any two-factor model over a one-factor model. Nonetheless, both random models reduced the chi square (compared to the one-factor model) only by about 100, whereas our final two-factor model reduced it by about 200. Furthermore, the CFIs for the random models were considerably lower than that of our final two-factor model; and the RMSEA indicated that the random models' predictions were much more discrepant

from the data than was our final two-factor model (the GFIs were only slightly lower). The random models, which allowed some measurement errors to correlate, even performed substantially worse than the more constrained, but predicted, two-factor model in which measurement errors were not allowed to correlate.

In sum, statistical artifact was not the main reason that our hypothesized two-factor model improved over the one-factor model. Instead, our hypothesized two-factor model (a) fit the data reasonably well; (b) fit the data far better than does a one-factor model; and (c) fit the data primarily because the hypothesized two-factor structure captured two dimensions of how people think about providing social support.

Descriptive Summary of SSOS Subscales

Reliability (Cronbach's alpha) was computed for each subscale of the SSOS. Results show that the directive subscale demonstrated acceptable reliability ($\alpha = .76$), as did the nondirective subscale ($\alpha = .75$). Two overall scores were obtained by averaging responses to the directive and nondirective subscales, respectively. These summary scores correspond to the SSOS response scales, which were rated on a 5-point scale ranging from 1 (*minimal overall endorsement*) to 5 (*maximum overall endorsement*). The mean directive score was 2.22 ($SD = 0.70$), and the mean nondirective score was 3.79 ($SD = 0.59$). Overall, Study 1 provided initial, strong evidence that the SSOS reliably captures two distinct constructs related to directive and nondirective support.

Study 2

Study 2 was designed to replicate the two-factor structure identified in Study 1, and thereby to show that the initial outcome did not capitalize on chance. Study 2 attempted to demonstrate that the SSOS retains its structure across problems of varying severity. Doing so would reinforce the reliability of the measure. However, whereas the directive and nondirective subscales were expected to retain their respective structures across problems of moderate to great severity, they were also expected to be sensitive to such changes. Specifically, both kinds of helping should be more heavily endorsed for more severe problems, for the obvious reason that more helping is indicated by more serious problems. Demonstrating this responsiveness to problem severity would help to confirm the validity of the SSOS.

A less obvious, but theoretically important prediction is that endorsement of directive help will be selectively increased for more severe problems, and

less so for more moderate problems (see Fisher et al., 2002). This is because for more acute situations, where outcomes are potentially dire and irreversible, it may be both appropriate and necessary for helpers to assert themselves more forcefully. Confirming such selective variability in response would address one of the principal predictions of our model of social support opinions, which is that support opinions are responsive to situational constraints.

Method

Participants

Study participants were 404 undergraduates (242 female, 162 male) who were recruited from an introductory psychology course. They received research participation credit for participating. Participants' mean age was 21.4 years ($SD = 5.3$). The sample was comprised of African Americans (8.8%), Asians (22.7%), Hispanics (11.4%), Middle Easterners (2.0%), Whites (49.5%), and "others" (5.6%).

Measures

Social Support Opinion Survey (SSOS). To assess the sensitivity of the SSOS to problem severity, two versions of the 14-item measure were created. The versions differed only in the instructions, which directed participants to focus on either a major problem or a moderate problem when completing the measure. The *moderate problem* version asked participants to "think of a *moderate problem* a person could have, such as conflict with a romantic partner, friend or co-worker; stress related to school or to work; or other day-to-day problems of this sort." The *major problem* version asked participants to "think of a *major problem* a person could have, such as coming down with a serious illness, loss of a job, being the victim of a major crime, or other such serious life problem."

All participants completed both the major-problem and moderate-problem versions of the SSOS. The order of the two versions was counter-balanced between participants.

Background survey. Participants completed a brief background survey that inquired about gender, age, ethnicity, and the identity of the help recipient (e.g., parent, friend) they considered as they were completing each of the two SSOS versions. The background survey followed the two versions of the SSOS.

Results and Discussion

Confirmatory Analyses

The hypothesized model for Study 2 was conceptually identical to the final model of Study 1 (two factors with correlated errors). However, the SSOS was administered twice in this study: once for the major problem, and once for the moderate problem. If the two-factor model applies whenever people think about helping, then it should retain its structure for both moderate and severe problems. Two factors by two situations yielded a four-factor model for the full set of data (i.e., nondirective factor for major problem, directive factor for major problem, nondirective factor for moderate problem, and directive factor for moderate problem).

This is the model we tested in Study 2, with one additional difference from the Study 1 model. Because the SSOS was administered twice (once for each level of problem severity), the exact same questions were administered twice. Therefore, we allowed the error terms for identical questions to correlate with one another.

This model fit the data quite well, $\chi^2(314, N = 404) = 658.73, p < .001$ (CFI = .93, GFI = .89, RMSEA = .05); null model, $\chi^2(378, N = 404) = 5021.20, p < .001$. Factor loadings (see Table 4) were comparable to and typically higher than those obtained in Study 1. The two directive subscales demonstrated acceptable reliability (directive, major problem: $\alpha = .71$; directive, moderate problem: $\alpha = .72$), but the nondirective subscales were a bit weaker (nondirective, major problem: $\alpha = .64$; nondirective, moderate problem: $\alpha = .66$). In addition to reconfirming the directive and nondirective subscales of the SSOS, these results also show that the subscales were unaffected by problem severity, but instead retained their structures for both moderate and major problems.

Counterbalancing check. The effect of the order in which the major-problem and moderate-problem versions of the SSOS were administered was examined in a two-way, repeated-measures ANOVA. Version order did not affect responses to either the directive subscale, $F(1, 403) = 1.42, p = .23$; or the nondirective subscale, $F(1, 403) = 2.12, p = .15$.

Data reduction. We produced a general directive scale and a general nondirective scale for analyses where problem severity was not of interest. This could be done because the factor structures of directive and nondirective subscales were the same and the item loadings were similar across severity levels. The directive/major-problem subscale and the directive/moderate-problem subscale together formed an overall directive subscale of acceptable reliability ($\alpha = .78$). The nondirective/major-problem subscale and the nondirective/moderate-problem subscale similarly formed an overall

Table 4

Confirmatory Factor Loadings of Four-Factor Model: Study 2

Item	Major problem		Moderate problem	
	Directive	Nondirective	Directive	Nondirective
1. Take charge	.57	—	.53	—
2. Get over problem quickly	.43	—	.45	—
6. Solving problems	.65	—	.65	—
8. Decide for the person	.65	—	.69	—
10. Advise others	.56	—	.60	—
13. Push the person	.33	—	.33	—
3. Back off	—	.40	—	.55
4. Own pace	—	.56	—	.54
5. Listen to problems	—	.43	—	.51
7. See the person's view	—	.39	—	.45
9. On his/her side	—	.19	—	.28
11. Accept wish to be alone	—	.50	—	.40
12. Give only asked-for help	—	.45	—	.33
14. Support even if disagree	—	.36	—	.22

Note. All loadings are standardized and were obtained in the model referred to in the text as "four-factor model with correlated errors." See Appendix for a full description of each item.

nondirective subscale of acceptable reliability ($\alpha = .70$). This procedure was repeated in the remaining four studies.

Initial Tests of SSOS Properties

Having replicated reliable and distinct directive and nondirective subscales, it was possible to explore the interrelations between these two modes

Table 5

Intercorrelations Between Directive and Nondirective Subscales: Study 2

	1	2	3	4	5
1. Directive/Combined	—				
2. Directive/Major problem	.91**	—			
3. Directive/Moderate problem	.90**	.64*	—		
4. Nondirective/Combined	.08	.07	.08	—	
5. Nondirective/Major problem	.05	.01	.08	.88**	—
6. Nondirective/Moderate problem	.09	.12*	.05	.88**	.54**

Note. $N = 404$.

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

of helping. It was also possible to examine how each of these helping modes was affected by problem severity, by respondents' demographic characteristics, and by the identity of their help recipients.

Relationship between directive and nondirective factors. Table 5 presents the correlation matrix of the directive and nondirective factors. It shows that the directive and nondirective subscales are, as expected, mutually independent. It shows close relationships between directive support for major problems and moderate problems, and between nondirective support for major problems and moderate problems. Further analyses discriminating between major and moderate problems were not done, except those specifically related to problem severity.

Endorsement of directive and nondirective helping. Nondirective helping was more strongly endorsed ($M = 3.72$, $SD = 0.47$) than was directive helping ($M = 2.85$, $SD = 0.66$), $t(403) = 22.37$, $p < .001$. Nondirective helping was typically rated as *very important*, which may reflect appreciation that nondirective help enhances morale. However, directive helping was not disparaged, as the mean rating approached *moderately important*.

Respondent age and gender. Age was unrelated to the directive subscale ($r = -.03$, $p = .59$), but it was correlated with the nondirective subscale ($r = .19$, $p < .01$). Gender interacted with support opinions, $F(1, 401) = 20.37$, $p < .001$ (see Figure 1). Men were more likely than were women to endorse directive support, $t(401) = 2.15$, $p < .05$; and women were more likely than men to endorse nondirective support, $t(401) = 4.37$, $p < .001$.

Respondent ethnicity. Ethnic groups varied in their endorsement of directive helping, $F(5, 389) = 7.32$, $p < .001$. Post hoc tests⁵ show that Asians and

⁵All post hoc tests were analyzed using Tukey's test of multiple comparisons.

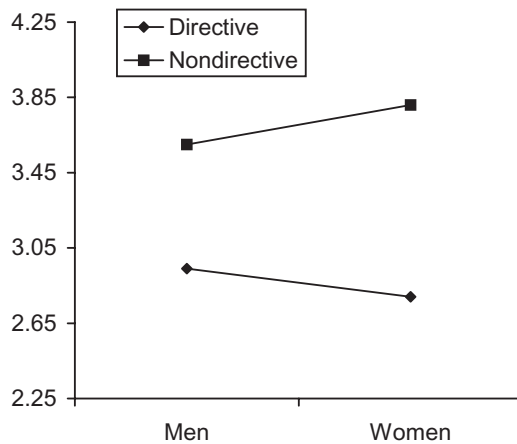


Figure 1. Endorsement of directive and nondirective helping as a function of gender: Study 2.

Hispanics more strongly endorsed directive support than did African Americans and Whites. Ethnic groups also varied in their endorsements of nondirective helping. African Americans endorsed it the most, while Middle Easterners endorsed it the least, $F(5, 398) = 1.97, p < .10$. However, because these ethnicity effects did not recur in any of our remaining studies, we do not discuss this outcome further.

Tests of Situational Predictions of Social Support Opinions

Problem severity. We expected that endorsement of both directive support and nondirective support would be greater for more severe problems than for more moderate problems, and that this increased endorsement would be especially pronounced for directive support. This prediction was tested in a 2 (Directive vs. Nondirective) $\times$ 2 (Problem: severe vs. moderate) repeated-measures ANOVA. The results confirmed both predictions (see Figure 2).

A main effect occurred because endorsement of both directive support and nondirective support increased for major problems, compared to moderate problems, $F(1, 403) = 132.09, p < .001$. However, an interaction occurred because this increase was larger for directive support, $F(1, 403) = 34.30, p < .001$. Supporters' increased willingness to endorse directive support for more serious problems is consistent with reports from support recipients (e.g., Fisher et al., 2002). Thus, supporters may want to assert themselves more fully when problems are dire.

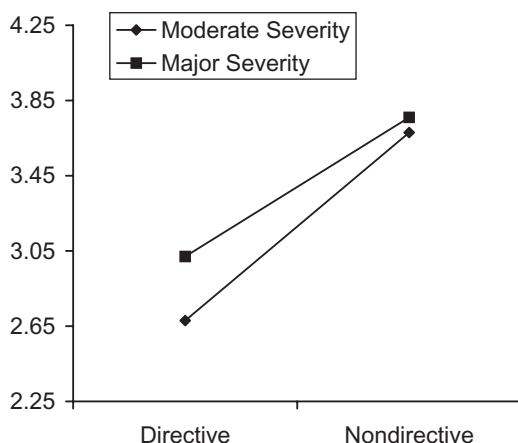


Figure 2. Endorsement of directive and nondirective helping as a function of problem severity: Study 2.

Recipient identity. Participants indicated on the background survey the identity of the person on whom they focused while completing the SSOS. Support recipients, from most to least commonly selected, were best friends (98), romantic partners (83), siblings (55), parents (53), no one in particular (49), other friend (34), other relative (12), and other person (4). The identity of the helping recipient did not affect the endorsement of either directive support, $F(5, 329) = 0.67$, $p = .65$, or of nondirective support, $F(7, 329) = 0.87$, $p = .50$.⁶ This suggests that helping modes are determined more by attitudes of the help giver, rather than by the identity of the help recipient.

Conclusions

Study 2 replicated the theoretically predicted two-factor structure of the SSOS found in Study 1. It showed that this structure holds for both moderate and severe problems. Study 2 also demonstrated an influence of one situational factor on support endorsement: problem severity. Support of any kind was endorsed more heavily for more severe problems, but this was especially true for directive support. However, support opinions were not determined by the identity of the support recipient.

⁶Participants who listed "Other person" or "No one in particular" were excluded from these analyses across all studies.

Study 3

The purpose of Study 3 was to determine the test–retest reliability of the SSOS. It did so measuring responses from the same set of respondents, at the beginning of an academic term and again 8 weeks later. Demonstrating test–retest reliability is intended to confirm not only the psychometric soundness of the SSOS, but also the stability of social support opinions.

Method

Participants

Study participants were 182 students (108 female, 74 male) in introductory psychology classes who received course credit for their participation. Participants' mean age was 19.2 years ($SD = 1.9$). The sample was comprised of African Americans (12.0%), Asians (28.8%), Hispanics (18.6%), Middle Easterners (8.4%), Whites (23.0%), and "others" (8.9%).

Procedure

Participants completed the SSOS at the start of the term as part of a prescreening packet of measures. They completed it a second time roughly 8 weeks later, as an in-class exercise. The retention rate between the two administrations was 78%.

Results and Discussion

The directive and nondirective subscales were formed from both the initial (test) and follow-up (retest) administrations of the SSOS. The test–retest reliability for the directive subscale was .74, and for the nondirective subscale was .77.⁷ According to Wills and Shinar (2000), test–retest values greater than .70 indicate adequate reliability. The SSOS, therefore, appears to have not only strong internal consistency—as indicated by Studies 1 and 2—but solid test–retest reliability as well.

⁷Extreme outliers (i.e., 2.5 SD above or below the mean of the pre/post difference) were excluded. When they were included, the alphas were .74 and .71 for directive and nondirective, respectively.

Study 4

Providing effective support may require a high tolerance for ambiguity and a low need for structure (Burlleson, 1985). This is because people's troubles are not typically remedied through pre-established scripts or practiced routines, and they often do not resolve quickly or fully. Another cognitive challenge of support is that copers' problems often contradict implicit beliefs in a just world (e.g., Lerner, 1980). In fact, people with high just-world beliefs are more likely to blame victims for their problems (Schuller, Smith, & Olson, 1994).

People's opinions about the respective value of directive and nondirective support may reflect these cognitive styles. People with high needs for structure and certainty and high just-world beliefs may favor directive support, because this mode provides more opportunity for concrete action. Also, directive support may fit more closely with an unambiguous "A $\rightarrow$ B" approach to problems and problem solving, wherein problems have specific, narrowly definable causes and correspondingly clear and specific solutions. Nondirective support, which is oriented more toward copers' own idiosyncratic paths toward recovery, rather than to predetermined outcomes, may be less contingent on certainty, structure, and just-world beliefs. Study 4 tested whether SSOS responses are related to these different cognitive styles.

Another purpose of Study 4 is to distinguish SSOS responses from established personality dimensions. Therefore, SSOS scores were compared to the Big Five (McCrae & Costa, 1999) personality dimensions of extraversion, agreeableness, conscientiousness, stability, and openness.

Method

Participants

Study participants were 224 undergraduates (136 female, 88 male) who participated in the study as part of an omnibus prescreening, for which they received experiment-participation credit. Participants' mean age was 19.8 years ($SD = 3.8$). The sample was comprised of African Americans (18.9%), Asians (22.1%), Hispanics (18.5%), Middle Easterners (8.1%), Whites (21.9%), and "others" (9.6%).

Measures

Social Support Opinion Survey (SSOS). The 14-item version of the SSOS, as confirmed by Studies 1, 2, and 3, was administered first. All participants

completed the major-problem and moderate-problem versions of the SSOS in order to assess the influence of problem severity. The order of these two versions was counterbalanced between participants.

Multidimensional Beliefs in a Just World Scale (MDBJWS; Furnham & Procter, 1992). The MDBJWS is a 30-item measure that captures individual differences in the belief that good and bad outcomes are justly distributed. People who score higher on the MDBJWS tend to blame victims for their misfortunes. Because of the interpersonal nature of the present research, only the 20 items comprising the “others’ outcomes” subscale of the MDBJWS were retained.

Personal Need for Structure (PNS; Neuberg & Newsom, 1993). The PNS is a 12-item measure that captures the desire for cognitive simplicity and clarity, and aversion to cognitive complexity and ambiguity. It is positively related to authoritarianism, intolerance for ambiguity, dogmatism, and rigidity.

Need for Closure: Intolerance for Ambiguity (NFC:IA; Kruglanski, Webster, & Klem, 1993). The NFC is a 42-item measure that addresses need for cognitive closure. The nine-item intolerance for ambiguity subscale was used in the present study.

Ten-Item Personality Inventory (TIPI; Gosling, Rentfrow, & Swann, 2003). The TIPI is a brief, 10-item measure. The scale economically yet reliably captures the Big Five personality dimensions of extraversion, agreeableness, conscientiousness, emotional stability, and openness.

General Background Questions. The final item in the survey packet was the General Background Questions. The questionnaire inquires as to participants’ gender, age, and ethnicity.

Procedure

Participants completed the survey packet in a mass testing. The testing session was conducted toward the end of a class session early in the school term.

Results and Discussion

Preliminary Analyses

Order of SSOS version. Effects of presentation order of the moderate- and severe-problem versions of the SSOS were tested in a two-way repeated-measures ANOVA. Results show that when the major-event version was presented first, SSOS directive scores were lower ($M = 2.87$, $SD = 0.65$) than

when the minor-event version was presented first ($M = 3.07$, $SD = 0.70$), $F(1, 221) = 5.01$, $p < .05$. However, presentation order did not affect nondirective scores, $F(1, 219) = 0.01$, $p = .94$. Because of these mixed and generally mild order effects, and because order had no effect in Study 2, presentation order was not included in further analyses. The combined directive factor (comprised of responses to major and moderate problems) was again reliable ($\alpha = .84$), as was the combined nondirective factor ($\alpha = .81$).

Age and ethnicity. The SSOS subscales were unrelated to participant age (directive factor: $r = -.06$, $p = .42$; nondirective factor: $r = .01$, $p = .83$). They were also unrelated to ethnicity: directive factor, $F(5, 213) = 1.35$, $p = .25$; and nondirective factor, $F(5, 211) = 0.80$, $p = .55$. These results suggest that age and ethnicity differences, which emerged in Study 2, are not robust.

Gender. Gender interacted with directive and nondirective helping in much the same way as shown in Study 2, $F(2, 214) = 12.08$, $p < .001$. Men were marginally more likely to endorse directive helping ($M = 3.06$, $SD = 0.64$) than were women ($M = 2.90$, $SD = 0.71$), $t(219) = 1.77$, $p < .10$; and women were more likely to endorse nondirective helping ($M = 3.78$, $SD = 0.47$) than were men ($M = 3.59$, $SD = 0.59$), $t(217) = 2.62$, $p < .01$. This nearly exact replication of Study 2 results suggests that the interaction between gender and helping attitudes is robust.

Effects of problem severity. According to our model of social support opinions, endorsement of all forms of helping should be greater for more severe problems, and this increase should be especially strong for directive support. As in Study 2, both predictions were confirmed. Endorsement of directive support ($M = 3.07$, $SD = 0.73$ vs. $M = 2.86$, $SD = 0.74$) and endorsement of nondirective support ($M = 3.75$, $SD = 0.59$ vs. $M = 3.67$, $SD = 0.57$) were greater for major problems than for moderate problems, $F(1, 217) = 35.17$, $p < .001$. And, as in Study 2, this effect was selectively stronger for directive helping, $F(1, 217) = 8.60$, $p < .005$. Overall, nondirective support was more highly endorsed ($M = 3.71$, $SD = 0.53$) than was directive support ($M = 2.96$, $SD = 0.69$), $F(1, 217) = 203.67$, $p < .001$.

Main Analyses

Social/cognitive styles. Directive support opinions may reflect tendencies to see the world as predictable and structured, and as a place where good and bad outcomes are justly distributed. Consistent with these predictions, just-world beliefs, need for structure, and intolerance for ambiguity were all positively related to the directive subscale of the SSOS (see Table 6). None of these variables were related to nondirective support, indicating that nondirective support is not moderated by cognitive style.

Table 6

Correlations Between SSOS Factors and Social/Cognitive Style: Study 4

	Just-world beliefs	Need for structure	Need for certainty
Directive	.20**	.20**	.27**
Nondirective	.03	-.08	.07

Note. $N = 224$. SSOS = Social Support Opinion Survey.

** $p < .01$.

Table 7

Correlations Between SSOS Factors and the Big Five Personality Indexes (As Assessed By TIPI): Study 4

	Extraversion	Agreeableness	Conscientiousness	Stability	Openness
Directive	.17*	.04	.01	.01	.03
Nondirective	.05	.08	.10	-.02	.17*

Note. SSOS = Social Support Opinion Survey; TIPI = Ten-Item Personality Inventory (Gosling, Rentfrow, & Swann, 2003).

* $p < .05$.

Basic personality indexes. We expected that support opinions would be distinct from established personality dimensions. Indeed, correlations between the SSOS factors and the Big Five personality indexes assessed by the TIPI (Gosling et al., 2003) were generally nonsignificant (see Table 7). This indicates that directive and nondirective helping styles are not redundant with other, well-established individual-difference constructs.

There were two mild correlations (each less than $r = .20$). One was a positive association between directive helping and extraversion, which may reflect a common element of assertiveness. The second was a positive association between nondirective helping and openness. This is consistent with research showing that formally trained support providers (e.g., therapists, crisis counselors) display a more open style with help seekers than do untrained support providers (McCarthy & Knapp, 1984).

Study 5

Nondirective support does not mean taking a passive or laissez-faire role in the coping process. Instead, it requires sensitivity to copers' problem-

solving needs and abilities, and a sensibility about when to help and when to step back from helping. In addition, nondirective helping may require an appreciation of the psychological and emotional challenges that copers face. Providing nondirective support, therefore, may involve a distinct set of emotional skills and sensibilities. Among these are *empathy*, which is the ability to understand another person's thoughts and feelings sympathetically (Davis, 1996). Interestingly, empathy itself requires attention to one's own emotions, and the ability to distinguish among one's own emotional states (Kang & Shaver, 2004). Therefore, we expected that people who endorsed nondirective support would have greater empathy, and that they would also have the emotional skills that mediate empathy.

Directive support, which is more about guiding copers toward objective ends, may be less contingent on emotional skills and sensibilities. Study 5 tested these predictions by measuring associations between SSOS responses and several measures of emotional skills. In addition, data coincidentally collected by other researchers in an omnibus prescreening provided an opportunity to reexamine the associations between directive support and tolerance for ambiguity and just-world beliefs, as demonstrated in Study 4.

Method

Participants

Study participants were 133 undergraduates (98 female, 35 male) who participated in this study for extra course credit. Participants' mean age was 22.2 years ($SD = 4.8$). The sample was comprised of African Americans (20.3%), Asians (18.8%), Hispanics (15.6%), Middle Easterners (6.3%), Whites (28.1%) and others (10.9%).

Measures

Interpersonal Reactivity Index (IRI; Davis, 1996). The IRI is a 28-item multidimensional measure of empathy. We used two of the measure's subscales (perspective taking and empathic concern; 7 items each) in the present study. *Perspective taking* focuses on the ability to understand others' subjective states. *Empathic concern* focuses on "other-oriented emotions," such as compassion and sympathy. These subscales of the IRI have good convergent and divergent validity.

Range and Differentiation of Emotional Experience Scale (RDEES; Kang & Shaver, 2004). The RDEES is a 14-item instrument that captures two distinct aspects of emotional complexity: the range of different emotions a person experiences, and a person's ability to distinguish among their own different emotions. The scale was included in the present study because it is related to empathy, cognitive complexity, and interpersonal skills.

Affective Orientation Scale (AOS; Booth-Butterfield & Booth-Butterfield, 1990). The AOS is a 20-item, single-factor instrument that captures the degree to which people use their emotions as information. The measure is positively related to conversational sensitivity and to recall for emotional events.

Need for Closure Scale: Intolerance for Ambiguity. The NFC:IA scale is the same intolerance for ambiguity subscale of Kruglanski et al.'s (1993) measure that was used in Study 4.

Belief in a Just World (BJW; Lipkus, Dalbert, & Siegler, 1996). The BJW is a 16-item measure of just-world beliefs consisting of two 8-item subscales. One subscale focuses on outcomes to the self, and the other focuses on outcomes to others. Only the other-oriented subscale was used.

Procedure

Participants completed the SSOS (major- and moderate-event versions), the NFC:IA, and the BJW in a mass testing 3 weeks before completing the remaining measures, which were administered together in a second mass testing. Separating the SSOS from the emotional skills measures was done in order to reduce demand and reactivity confounds.

Results and Discussion

Preliminary Analyses

Order and gender effects. The order in which the two versions of the SSOS were administered did not affect response to the directive version of the SSOS, $F(1, 127) = 0.90, p = .35$; or the nondirective version of the SSOS, $F(1, 126) = 0.49, p < .49$. The composite directive scale ($\alpha = .77$) and the composite nondirective scale ($\alpha = .66$) were again formed by combining across the major-problem and moderate-problem versions of the SSOS.

As in Study 3, SSOS factors were unrelated to participant age (directive, $r = -.12, p = .19$; nondirective, $r = .02, p = .83$). They were also unrelated to ethnicity: directive, $F(5, 117) = 0.87, p = .50$; and nondirective,

$F(5, 116) = 1.77, p = .13$. Gender and support opinions again interacted, although marginally so, $F(1, 125) = 2.80, p < .10$. Men tended to endorse directive support more than did women, and women tended to endorse nondirective support more than did men.

Effects of problem severity. The predicted effect of problem severity on the relative endorsement of directive and nondirective support was again confirmed. Endorsement of directive support ($M = 3.27, SD = 0.75$ vs. $M = 2.99, SD = 0.78$) and endorsement of nondirective support ($M = 3.78, SD = 0.52$ vs. $M = 3.66, SD = 0.55$) were greater for major problems than for moderate problems, $F(1, 127) = 32.89, p < .001$. This effect was again selectively (but marginally) stronger for directive helping, $F(1, 127) = 3.87, p < .06$. The identity of the support recipient was again unrelated to both directive support and nondirective support for both major and moderate problems (all F s < 2.00 , all p s $> .10$).

Main Analyses

Support opinions and emotional skills. Table 8 presents correlations between the SSOS directive and nondirective subscales and the five emotional styles/skills measures and the two cognitive orientation measures. The results correspond closely to the individual-differences prediction concerning the endorsement of support opinions. Both the perspective-taking and concern subscales of the IRI (Davis, 1996) empathy measure were positively related to nondirective support, indicating that people who favor nondirective helping attempt to see things from copers' perspectives and feel sympathetically as they do so.

Also as predicted, people who favored nondirective support were more attuned to their own emotions and to those of others. Nondirective support positively correlated with emotional differentiation (RDEES; Kang & Shaver, 2004) and with use of emotions as information (AOS; Booth-Butterfield & Booth-Butterfield, 1990). Nondirective support may involve a high level of psychological mindedness (e.g., Beitel, Ferrer, & Cecero, 2004), including appreciation of one's own emotional states, as well as those of the copier. This may be better accomplished when one has a full range of emotions on which to draw (RDEES/range), has clarity about these emotions (RDEES/specificity), and accepts these emotions as informative (AOS). Directive helping was unrelated to all of these emotion-based measures.

Support opinions and social-cognitive styles. Directive support was once again positively related to need for certainty and to just-world beliefs (Table 8). These findings replicate the results of Study 4 and, as predicted by our social support opinion model, indicate that endorsing directive support

Table 8
Correlations Between SSOS Factors and Cognitive and Emotional Styles: Study 5

	Empathy: Concern	Empathy: Perspective	Emotional range	Emotional specificity	Affective orientation	Need for certainty	Just-world beliefs
Directive	.07	-.07	.07	.13	.15	.24**	.23**
Nondirective	.27**	.35**	.19*	.28**	.21*	.14	.10

Note. $N = 129$. SSOS = Social Support Opinion Survey.
* $p < .05$. ** $p < .01$.

may reflect cognitive styles that are more rule-bound and less tolerant of ambiguity or of violations of basic beliefs.

Study 6

The kinds of support people endorse may reflect how they approach social relations more broadly. Specifically, endorsement of nondirective support and directive support are predicted to relate differentially to communal and exchange orientations (Mills & Clark, 1994). A communal orientation is characterized by regarding the other's needs with the same concern as if those needs were one's own. Communally oriented people do not seek repayment for helping, they sympathetically attend to others' emotional disclosures, and they experience helping as intrinsically satisfying. Exchange orientations exist when there is an expectation of reciprocity for efforts or materials supplied to another, a close tracking of expenditures to others, and feelings of exploitation when reciprocation in kind is not soon supplied.

We predicted that those who endorse nondirective helping would have a stronger communal orientation. This is because nondirective support involves a willingness to see things from the coper's perspective, to suppress one's own desires for control and efficacy in order to advance those of the coper, and to supply help in a way that may even be invisible to the coper. Conversely, we predicted that those who more strongly endorse directive helping, in which help is more overt and therefore more quantifiable, would have a stronger exchange orientation. Study 6 tests these predictions.

Support Opinions and Interpersonal Skills

Study 5 showed that endorsement of nondirective help is related to intrapersonal emotional skills, including sensitivity to and appreciation of one's own emotions. Study 6 tested whether nondirective support is also associated with interpersonal emotional skills, including emotional sensitivity and willingness to disclose (Burhmester, Furman, Wittenberg, & Reis, 1988). Burhmester et al.'s emotional sensitivity measure is conceptually similar to Davis' (1996) IRI, but is grounded in more specific and concrete behaviors. Burhmester et al.'s willingness to disclose measure is important because copers are often more comfortable confiding to those who reveal sensitive things about themselves (Jourard, 1964). Therefore, we predicted that nondirective opinions would be positively related to both of these interpersonal measures of emotional skills.

Exploratory Questions

Providing and Receiving Social Support

Another purpose of Study 6 was to relate people's endorsement of directive and nondirective helping. The kinds of support that they themselves receive. Correspondences between endorsing and receiving directive or non-directive support may help to explain how different support opinions develop. In addition, Study 6 included an omnibus measure of benign social support to examine the relation between support opinions and receipt of social support more broadly defined. Study 6 also examined whether the SSOS was affected, and thereby compromised, by social desirability concerns. Therefore, the SSOS was related to the Balanced Inventory of Desirable Responding (BIDR; Paulhus, 1988).

Study 6 Overview

Study 6 was designed to meet three objectives. Those objectives were: (a) to test whether support opinions relate to interpersonal styles, including communal and exchange orientations, and the interpersonal emotional skills of emotional support and mutual disclosure; (b) to relate the SSOS to measures of perceived and received social support; and (c) to assess whether the SSOS is compromised by social desirability motives.

Method

Participants

Study participants were 204 undergraduates (120 female, 84 male) who were recruited from an introductory psychology course and who received research participation credit for their contributions. Participants' mean age was 20.1 years ($SD = 3.1$). The sample was comprised of African Americans (3.9%), Asians (21.4%), Hispanics (9.2%), Middle Easterners (1.9%), Whites (56.3%), and "others" (6.8 %). The study was administered to participants in groups of 10 to 40, and lasted roughly 45 min.

Measures

Social Support Opinion Survey (SSOS). The 14-item version of the SSOS was administered first. All participants completed the major-problem and

moderate-problem versions of the SSOS. The order of these two versions was counterbalanced between participants.

Balanced Inventory of Desirable Responding (BIDR). The impression management subscale of the BIDR (Paulhus, 1988) was used in the present study to determine whether SSOS responses are compromised by social desirability concerns.

Communal Orientation Scale (COS). The COS (Clark, Oullette, Powell, & Milberg, 1987) is a 14-item measure. It is intended to capture the degree to which people value helping, and see themselves as willing to give and receive noncontingent help from others.

Exchange Orientation Scale (EOS). The EOS (Mills & Clark, 1994) is a nine-item scale. In the present study, it was used to measure the degree to which people regard interpersonal relationships as zero-sum exchanges, in which efforts are made for others with the expectation of reciprocation.

Interpersonal Competency Questionnaire: Disclosure and Emotional Support (ICQ:DSC and ICQ:ES). The ICQ (Buhrmester et al., 1988) is a 40-item scale that measures different types of social skills. The emotional support (ES) subscale addresses willingness to extend help in general and supportive listening in particular. The disclosure subscale (DSC) indexes interpersonal trust and willingness to confide in others.

Social Provisions Scale (SPS). The SPS (Cutrona & Russell, 1987) is a 24-item measure of social support. It is widely used to measure perceived social support and has been validated across a variety of adult populations.

Inventory of Nondirective and Directive Instrumental Support (INDIS). The INDIS (Harber et al., 2005) is a nine-item measure of received social support. The INDIS consists of two mutually independent subscales, measuring receipt of directive support and of nondirective support. Respondents consider a recent and important episode in which they received social support, and then complete the INDIS twice: once for help supplied by a specific family member, and once for help supplied by a specific friend.

General Background Questions. The General Background Questions form was the final item in the survey packet. The questionnaire asks about participants' gender, age, and ethnicity.

Results and Discussion

Preliminary Analyses

Characteristics of directive and nondirective subscales. The order in which the two versions of the SSOS (major vs. moderate event) were administered marginally affected response to the directive version of the SSOS,

$F(1, 202) = 3.77, p < .10$, but had no effect on the nondirective version of the SSOS, $F(1, 202) = 0.05, p < .83$. As in the previous studies, responses to the major/directive and moderate/directive subscales were combined into an overall directive scale ($\alpha = .82$), and an overall nondirective scale ($\alpha = .78$).

Respondent age and ethnicity. The SSOS directive and nondirective subscales were unrelated to age and ethnicity (all $ps > .20$). These findings, in combination with the previous studies, strongly suggest that the SSOS factors are unrelated to respondent age or ethnicity.

Respondent gender. Gender again interacted with the directive and nondirective factors, $F(1, 202) = 6.95, p < .01$. Men were marginally more likely to endorse directive helping ($M = 2.91, SD = 0.69$) than were women ($M = 2.73, SD = 0.67$), $t(202) = 1.87, p < .10$; and women were marginally more likely to endorse nondirective helping ($M = 3.75, SD = 0.48$) than were men ($M = 3.63, SD = 0.52$), $t(202) = -1.66, p = .10$. This is the fourth consecutive demonstration that women more strongly support nondirective support than do men, whereas men slightly endorse directive support more strongly than do women, suggesting that it is a highly reliable finding.

Identity of the support recipient. The identity of the support recipient again did not affect endorsement of directive support or nondirective support, across severity levels (all $ps > .10$). As in the previous studies, these results indicate that support values are stable individual-difference properties.

Effects of problem severity. As in Studies 2, 4, and 5, endorsement of directive support ($M = 2.94, SD = 0.78$ vs. $M = 2.67, SD = 0.69$) and endorsement of nondirective support ($M = 3.72, SD = 0.56$ vs. $M = 3.62, SD = 0.55$) were greater for major problems than for moderate problems, $F(1, 203) = 94.09, p < .001$. And, this effect was again selectively stronger for directive helping, $F(1, 203) = 4.81, p < .05$.

Main Analyses

SSOS and communal and exchange orientations. We predicted that nondirective support would be related to a communal orientation, because nondirective support involves greater psychological effort on behalf of the recipient. Also, because it is based on self-restraint and empathy, nondirective support is less visible and, therefore, less quantifiable. Directive support is predicted to correlate with an exchange orientation because directive support is more overt and more quantifiable. Both predictions were confirmed (see Table 9).

We also found a significant negative correlation between nondirective support and exchange orientation. This unexpected result is consistent with

Table 9

Correlations Between SSOS Factors and Measures of Interpersonal Values and Interpersonal Competencies: Study 6

	Communal orientation	Exchange orientation	Emotional sensitivity	Disclosure skills
Directive	.06	.17*	.09	.19**
Nondirective	.19**	-.17*	.20**	.21**

Note. $N = 204$. SSOS = Social Support Opinion Survey.

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

our model of support opinions. It indicates that endorsing nondirective support involves not only a communal identification with the copers' goals, but also reduced interest in repayment from copers for help rendered.

Support opinions, emotional sensitivity, and self-disclosure. Table 9 also shows that support opinions were related to interpersonal skills, and mainly in the predicted manner. Nondirective support was positively related to emotional sensitivity and self-disclosure. This is consistent with our hypothesis that nondirective support reflects an interpersonal orientation that emphasizes emotions and psychological coping.

The positive relation of directive support to disclosure skills was unexpected, and appears at first glance contrary to the problem-focused nature of the directive mode. However, we speculate that disclosure might satisfy the ends of directive support by serving as a vehicle for advice-giving (e.g., "When I was in your shoes, this is what I did, and you should do likewise"). Additional research will be necessary to determine whether disclosure means different things for those who endorse directive versus nondirective support.

SSOS and perceived and received support. Table 10 displays the relationships between directive and nondirective support opinions with perceived support (i.e., SPS; Cutrona & Russell, 1987) and with received support (i.e., INDIS; Harber et al., 2005). The SSOS nondirective subscale, but not the directive subscale, was positively related to perceived support. This is an intriguing outcome, suggesting that receipt of beneficial support enables the provision of nondirective support to others. Of course, the causal direction may be reversed, such that those who favor nondirective support might attract more support from others, or a third factor may explain this relation (e.g., some social networks may engender nondirective opinions and be rich in benign support).

Directive and nondirective opinions were closely related to receiving directive and nondirective support from others. Because both measures

Table 10

Correlations Between Support Opinions and Perceived Social Support and Received Directive and Nondirective Support: Study 6

	SPS	INDIS			
		Directive/ Family	Directive/ Friend	Nondirective/ Family	Nondirective/ Friend
Directive	.01	.28**	.41**	.02	.09
Nondirective	.35**	.04	.04	.16*	.31**

Note. $N = 204$. SPS = Social Provisions Scale (perceived support); INDIS = Inventory of Nondirective and Directive Instrumental Support (Harber, Schneider, Everard, & Fisher, 2005); Directive/Nondirective Family/Friend = source of received directive or nondirective support, as measured by the INDIS.

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

address directive and nondirective social support, the correspondence between them may reflect a response-set bias. However, the diverse range of correlations between the measures' respective subscales ($r = .16-.41$) suggests that response bias did not overly determine this outcome. The General Discussion will address more theoretically based implications of the correlation between support opinions and receipt of directive and nondirective support.

Social desirability. The SSOS was not greatly affected by social desirability concerns. There was no relation between directive helping and the BIDR ($r = -.07$, $p = .35$), and only a modest relation between nondirective helping and the BIDR ($r = .16$, $p < .05$). Apparently, people say they endorse non-directive helping very slightly more than they actually do.

General Discussion

Helping is one of the most value-laden of human activities. It is an activity central to many people's self-definitions, and it is one of the most demanding on material and psychological resources. Therefore, people would seem to have clear opinions about how best to supply social support. Furthermore, because helping draws so deeply on values, perspectives, and skills, social support opinions should reflect basic aspects of people's personalities. The present research tested and confirmed these interlocking propositions. In so doing, it is the first research to explore systematically social support from the perspective of support provider.

Measuring Support Opinions

Do people have stable opinions about providing support to others? The Social Support Opinion Survey (SSOS) was developed to answer this question. As the first measure of social support from the supplier's perspective, the SSOS represents a contribution to social support research in its own right. A key feature of the SSOS is its two-factor structure, which distinguishes between nondirective and directive helping. By endorsing nondirective support, respondents indicated a belief that helpers should not intrude upon or dominate coping. By endorsing directive helping, respondents indicated a belief that helpers should take charge and attempt to manage copers' problems. Studies 1 and 2 developed and confirmed this two-factor structure, and showed that the directive and nondirective subscales comprising the SSOS are reliable and mutually independent.

The SSOS subscales are also remarkably stable. The SSOS directive and nondirective subscales have solid test-retest reliability (Study 3), and they retained their factor structures for moderate problems (e.g., relationship stress), as well as for severe problems (e.g., job loss). The SSOS subscales were also unrelated to respondent age or ethnicity, indicating that the measure was stable across these groups.

The SSOS was minimally related to the Big Five personality indexes and social desirability, indicating that the measure is not redundant with or compromised by these other constructs. Importantly, the SSOS was also unrelated to the identity of the copier, indicating that endorsement of directive and nondirective support depended more on the supporter than on the support recipient. Thus, the directive and nondirective dimensions measured by the SSOS appear to be relatively stable attributes of support providers.

Social Support Opinions and Personality

Although helping is a common activity, it is often neither a simple nor an easy one. Helping requires an ability to tolerate the complexity, ambiguity, and vicissitudes of major problems. It also involves understanding the psychological challenges that copers face and a willingness to share the practical and psychological burdens that copers bear. Studies 4, 5, and 6 showed that people's opinions about supplying support correspond to these demands.

Directive Support and Personality

Endorsement of directive support was associated with a higher need for structure, a lower tolerance for ambiguity, and stronger just-world beliefs.

Collectively, these social-cognitive measures indicate a more rigid and schema-bound cognitive style that favors clarity, simplicity, and conformity to expectancies, and that disfavors ambiguity. The correspondence between directive helping and a more rigid cognitive style is consistent with related research by Burleson (1990), who reported that people who demonstrate greater cognitive complexity tend to communicate more sensitively. Directive support was also mildly related to an exchange orientation, wherein attention to others' needs is given with the expectation of comparable reciprocation (Mills & Clark, 1994).

Directive support opinions, which emphasize overt action and pressure toward solutions, fit with this cognitive orientation and with these interpersonal attributes. Directive support is more likely to focus on the concrete and immediate aspects of problems, which typically have clearly defined features and which, therefore, suggest more straightforward courses of action. Directive support may also satisfy a need to impose (and subjectively restore) order in situations that are often ambiguous in their causes and uncertain in their outcomes. The finality that directive support affords would suit those whose cognitive style favors certainty and structure. Further, directive helping may correspond to just-world beliefs and the victim blaming that these beliefs promote (Schuller et al., 1994). If copers' difficulties are attributed to their own poor judgment or other flaws, there is less reason to endorse the remedies that copers develop, and more reason to impose solutions upon them.

Because directive support is more overt in nature (e.g., taking charge of problems, directing the efforts of other supporters) and therefore more quantifiable, it may be more amenable to a balance-sheet approach to helping. Study 5, which found directive support to be positively related to an exchange orientation toward relationships, indicated that this is so.

Nondirective Helping and Psychosocial Attributes

Endorsement of nondirective helping was more closely associated with emotional attributes than with cognitive ones. People who favored nondirective support scored more highly on both the compassion and perspective-taking dimensions of empathy, and also on social sensitivity as an interpersonal skill. Sensitivity to others' emotional needs fits with the more person-centered nature of nondirective support, in which the copers' inner states are of paramount importance (Burleson, 1985; Rogers, 1961). Empathy enables helpers to understand copers' psychological needs and also provides the compassion needed to address those needs (Davis, 1996).

Nondirective support was also associated with greater attention to and knowledge of one's own emotions, and with a greater regard for the infor-

mational value of emotions. Awareness of and respect for one's own emotions could promote nondirective support in two, complementary ways. First, these emotional aptitudes are likely to promote empathy, which is a core component of nondirective helping. This is because empathy is mediated by attention to and knowledge of one's own emotions (Kang & Shaver, 2004) and by the belief that one's own emotions convey valuable information (Booth-Butterfield & Booth-Butterfield, 1990). Second, increased attention to one's own emotions may help supporters to distinguish their own psychological needs from those of the copier. As a result, supporters may be better able to address their own needs directly, rather than doing so vicariously through their helping attempts.

Endorsement of nondirective support was positively related to a communal interpersonal orientation, in which the needs of the other are adopted as one's own. This orientation may be necessary to sustain nondirective support, which is often burdensome. For example, nonjudgmental listening can lead to short-term autonomic arousal (Pennebaker, 1990) and, in the long term, vicarious traumatization (McCann & Pearlman, 1990). Assuming these costs may require a "you *and* me," rather than a "you *or* me" social orientation. A communal orientation may also add to the therapeutic nature of nondirective support. This is because people are more willing to disclose emotions in general—and fear and anxiety in particular—to communally oriented partners (Clark & Finkel, 2005).

Support Opinions and Situational Constraints

Support opinions reflect relatively stable attributes. However, one situational factor that was expected to influence endorsement of directive and nondirective support was problem severity. More serious problems were expected to lead selectively to more directive support. This prediction was confirmed in four separate studies.

Although both directive and nondirective support were more strongly endorsed for severe problems, this increase was more pronounced for directive support. There is a clear logic to this: Problems with dire consequences, such as a potential suicide or an incapacitating ailment, may motivate and demand more assertive interventions. Failure to be directive in such situations may in itself be demoralizing to copers, communicating a lack of concern (Coyne et al., 1988).

Support Opinions and the Receipt of Social Support

Directive or nondirective support opinions were positively correlated with receiving directive or nondirective support, respectively. This correspondence

between support received and support supplied provides intriguing clues about the generation of helping styles. One possibility is that social support opinions may reflect social modeling (e.g., Bandura, 1977b), wherein people adopt the support styles—directive or nondirective—that they commonly encounter within their own social networks. Indeed, Burleson (1990) reported that comforting skills are shaped by parental behavior.

Another explanation relates to psychosocial resources. Directive support may be the more appealing helping mode for those whose own resources are diminished by chronically receiving directive help from others, while nondirective support may be more appealing to (or sustainable by) people whose resources have been augmented by receiving nondirective support. This resource explanation is supported by the positive correlation between the SSOS nondirective subscale and the SPS (Cutrona & Russell, 1987), an omnibus measure of benign (and hence resource-enhancing) support. Of course, it may be that some third factor (e.g., compassion, competence) shapes the kinds of support that people provide and receive.

Support Opinions and Gender

A consistent finding across studies was an interaction between gender and support opinions. Men tended to endorse directive support more than did women, and women endorsed nondirective support more than did men. These gender differences in support opinions correspond to gender differences in helping and communication. For example, women tend to be more empathic and interpersonally sensitive than men (Davis, 1996; Eagly, 1987). These characteristics are consistent with nondirective helping. Men are more often assertive and may be more likely to assume a “heroic” stance in regard to helping (Eagly, 1987). These are qualities that correspond to directive helping.

Caveats

There are three important cautions and qualifications to this research. First, the reliance on undergraduates may be problematic with regard to social support, where maturity and experience may have an important influence. For example, adolescents are generally more self-absorbed and egocentric than are older people (Elkind, 1967). However, the students at Rutgers/Newark (where much of these data were collected) are highly diverse culturally and economically (“Campus Diversity,” 2003). Thus, this was a sociologically representative student sample comprised of people who are familiar with substantial life problems.

Second, opinions gathered in the calm setting of a prescreening session may differ from those generated in the course of an actual crisis, where emotions run high and priorities are more intently focused. Third, the correlational nature of this research constrains inferences that can be drawn from it. Thus, while we believe that directive and nondirective support opinions arise from people's cognitive, emotional, and motivational styles, it may be that social support opinions and psychosocial styles are themselves jointly influenced by some other factors.

Implications and Future Directions

Social support researchers agree that intrusive, controlling modes of helping can undermine coping; and empathic, non-intrusive support can advance it. Less understood is why these different kinds of helping occur. The social support opinions construct addresses this question. Specifically, those who favor directive support may assume the take-charge approach to helping that often makes copers feel inept and disrespected. Those who favor non-directive helping may be more alert to copers' psychological needs for autonomy and control and, therefore, supply the kinds of help that fosters these states. Thus, the correspondence between support opinions and supportive behavior is an important next step in this line of research.

Support opinions may have substantial clinical and practical utility. For example, they may help to predict the success of long-term relationships, such as those between romantic partners, roommates, and coworkers. Support opinions may also help to determine the efficacy of healthcare workers, crisis counselors, mediators, teachers, and others whose jobs involve advising, counseling, and support.

Finally, the concept and the measure of social support opinions may have important implications for personality and social psychology. The present research shows that attitudes about helping are related to more basic cognitive, emotional, and interpersonal styles. Social support opinions, therefore, appear to be a prism through which fundamental aspects of personality are coordinated. If so, then people may reveal who they are by how they help.

References

- Bandura, A. (1977a). Self-efficacy: Toward a unifying theory of behavior change. *Psychological Review*, 84, 191–215.
- Bandura, A. (1977b). *Social learning theory*. Oxford, UK: Prentice-Hall.

- Baumeister, R. F., Bratslavsky, E., Finkenauer, C., & Vohs, K. D. (2001). Bad is stronger than good. *Review of General Psychology*, 5, 323–370.
- Beitel, M., Ferrer, E., & Cecero, J. J. (2004). Psychological mindedness and cognitive style. *Journal of Clinical Psychology*, 60, 567–582.
- Bentler, P. M. (1990). Comparative fit indexes in structural models. *Psychological Bulletin*, 107, 238–246.
- Berg, J. H. (1987). Responsiveness and self-disclosure. In V. J. Derlega & J. H. Berg (Eds.), *Self-disclosure: Theory, research, and therapy* (pp. 101–130). New York: Plenum.
- Bolger, N., Zuckerman, A., & Kessler, R. C. (2000). Invisible support and adjustment to stress. *Journal of Personality and Social Psychology*, 79, 953–961.
- Booth-Butterfield, M., & Booth-Butterfield, S. (1990). Conceptualizing affect as information in communication production. *Human Communication Research*, 16, 451–476.
- Browne, R. A., & Cudeck, M. W. (1993). Alternative ways of assessing model fit. In K. Bollen & J. S. Long (Eds.), *Testing structural equation models* (pp. 136–162). Thousand Oaks, CA: Sage.
- Buhrmester, D., Furman, W., Wittenberg, M. T., & Reis, H. T. (1988). Five domains of interpersonal competence in peer relationships. *Journal of Personality and Social Psychology*, 55, 991–1008.
- Burke, R. J., & Weir, T. (1979). Helping responses of parents and peers and adolescent well-being. *Journal of Personality*, 102, 49–62.
- Burleson, B. (1985). The production of comforting messages: Social-cognitive foundations. *Journal of Language and Social Psychology*, 4, 253–273.
- Burleson, B. (1990). Comforting as social support: Relational consequences of supportive behaviors. In S. Duck & R. C. Silver (Eds.), *Personal relationships and social support* (pp. 66–82). London: Sage.
- Campus diversity: National universities—doctoral. America's best colleges, 2003. (2003). *U.S. News & World Report*. Retrieved February 24, 2007, from www.usnews.com/usnews/edu/college/rankings/brief/natudoc_campdiv_brief.php
- Clark, M. S., & Finkel, E. J. (2005). Willingness to express emotion: The impact of relationship type, communal orientation, and their interaction. *Personal Relationships*, 12, 169–180.
- Clark, M. S., Oullette, R., Powell, M. C., & Milberg, S. (1987). Recipient's mood, relationship type, and helping. *Journal of Personality and Social Psychology*, 53, 94–103.
- Cohen, S., Underwood, L. G., & Gottlieb, B. H. (2000). *Social support measurement and intervention*. New York: Oxford University Press.

- Coyne, J. C., Ellard, J. H., & Smith, D. A. F. (1990). Social support, interdependence, and the dilemmas of helping. In B. A. Sarason, I. G. Sarason, & G. R. Pierce (Eds.), *Social support: An interactional view* (pp. 129–149). New York: John Wiley & Sons.
- Coyne, J. C., & Smith, D. A. (1991). Couples coping with myocardial infarction: A contextual perspective on wives' distress. *Journal of Personality and Social Psychology*, 61, 404–412.
- Coyne, J. C., Wortman, C. B., & Lehman, D. R. (1988). The other side of social support: Emotional overinvolvement and miscarried helping. In B. H. Gottlieb (Ed.), *Marshaling social support: Formats, processes, and effects* (pp. 305–330). Thousand Oaks, CA: Sage.
- Cutrona, C. E., & Russell, D. (1987). The provisions of social relationships and adaptations to stress. In W. H. Jones & D. Perlman (Eds.), *Advances in personal relationships* (Vol. 1, pp. 37–67). Greenwich, CT: JAI Press.
- Davis, M. H. (1996). *Empathy: A social psychological approach*. Boulder, CO: Westview.
- Deci, E. L., & Ryan, R. M. (1985). *Intrinsic motivation and self-determination in human behavior*. New York: Plenum.
- DiMatteo, M. R., & Hays, R. (1981). Social support and serious illness. In B. H. Gottlieb (Ed.), *Social networks and social support* (pp. 117–148). Beverly Hills, CA: Sage.
- Eagly, A. H. (1987). *Sex differences in social behavior: A social role interpretation*. Mahwah, NJ: Lawrence Erlbaum.
- Elkind, D. (1967). Egocentrism in adolescence. *Child Development*, 38, 1025–1034.
- Fisher, E. B., Heins, J. M., Todora, H. M. S., White, N. M., Marrero, D. G., McNabb, W. L., et al. (2002, June). *Social support from staff in a 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.
- Furnham, A., & Procter, E. (1992). Sphere-specific just-world beliefs and attitudes towards AIDS. *Human Relations*, 45, 265–279.
- Gosling, S. D., Rentfrow, P. J., & Swann, W. B., Jr. (2003). A very brief measure of the Big Five personality domains. *Journal of Research in Personality*, 37, 504–538.
- Harber, K. D., Schneider, J. K., Everard, K. M., & Fisher, E. B. (2005). Directive support, nondirective support, and morale. *Journal of Social and Clinical Psychology*, 24, 691–722.
- Jöreskog, K. A., & Sörbom, D. (1999). *LISREL 8: User's reference guide*. Lincolnwood, IL: Scientific Software International.

- Jourard, S. M. (1964). *The transparent self*. New York: D. Van Nostrand.
- Kang, S., & Shaver, P. R. (2004). Individual differences in emotional complexity: Their psychological implications. *Journal of Personality*, 72, 687–726.
- Kasser, T., & Sheldon, K. M. (2004). Nonbecoming, alienated becoming, and authentic becoming: A goal-based oriented approach. In J. Greenberg, S. L. Koole, & T. Pyszczynski (Eds.), *Handbook of experimental existential psychology* (pp. 480–496). New York: Guilford.
- Kruglanski, A. W., Webster, D. M., & Klem, A. (1993). Motivated resistance and openness to persuasion in the presence or absence of prior information. *Journal of Personality and Social Psychology*, 65, 861–876.
- Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York: Springer.
- Lerner, M. J. (1980). *The belief in a just world: A fundamental delusion*. New York: Plenum.
- Lipkus, I. M., Dalbert, C., & Siegler, I. C. (1996). The importance of distinguishing the belief in a just world for self versus for others: Implications for psychological well-being. *Personality and Social Psychology Bulletin*, 22, 666–677.
- McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, 3, 131–149.
- McCarthy, P. R., & Knapp, S. L. (1984). Helping styles of crisis interveners, psychotherapists, and untrained individuals. *American Journal of Community Psychology*, 12, 623–627.
- McCrae, R. R., & Costa, P. T., Jr. (1999). A five-factor theory of personality. In L. A. Pervin & O. P. John (Eds.), *Handbook of personality: Theory and Research* (pp. 139–153). New York: Guilford.
- McWilliams, N. (2004). *Psychoanalytic psychotherapy: A practitioner's guide*. New York: Guilford.
- Mills, J., & Clark, M. S. (1994). Communal and exchange relationships: Controversies and research. In R. Erber & R. Gilmour (Eds.), *Theoretical frameworks for personal relationships* (pp. 29–42). Hillsdale, NJ: Lawrence Erlbaum.
- Neuberg, S. L., & Newsom, J. T. (1993). Personal need for structure: Individual differences in the desire for simpler structure. *Journal of Personality and Social Psychology*, 65, 113–131.
- Pagel, M. D., Erdly, W., & Becker, J. (1987). Social networks: We get by with (and in spite of) a little help from our friends. *Journal of Personality and Social Psychology*, 53, 793–804.

- Paulhus, D. L. (1988). *Assessing self-deception and impression management in self-reports: The Balanced Inventory of Desirable Responding*. Unpublished manual, University of British Columbia, Vancouver, Canada.
- Pennebaker, J. W. (1990). *Opening up: The healing power of confiding in others*. New York: Morrow & Co.
- Reed, M. B., & Aspinwall, L. G. (1998). Self-affirmation reduces biased processing of health-risk information. *Motivation and Emotion*, 22, 99–132.
- Rogers, C. R. (1961). *On becoming a person*. Boston: Houghton-Mifflin.
- Ruchlman, L. S., & Karoly, P. (1991). With a little flak from my friends: Development and preliminary validation of the Test of Negative Social Exchange (TENSE). *Psychological Assessment*, 3, 97–104.
- Schuller, R. A., Smith, V. L., & Olson, J. M. (1994). Jurors' decisions in trials of battered women who kill: The role of prior beliefs and expert testimony. *Journal of Applied Social Psychology*, 24, 316–337.
- Shinn, M., Lehman, S., & Wong, N. W. (1984). Social interaction and social support. *Journal of Social Issues*, 40, 55–76.
- Silver, R. L., Boon, C., & Stones, M. (1983). Searching for meaning in misfortune: Making sense of incest. *Journal of Social Issues*, 39, 81–101.
- Widaman, K. F., & Thompson, J. S. (2003). On specifying the null model for incremental fit indices in structural equation modeling. *Psychological Methods*, 8, 16–37.
- Williams, G. C., Gagné, 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* (pp. 86–135). New York: Oxford.

Appendix

Social Support Opinion Survey

Instructions: Think of a person in your life who is very important to you and whom you like very much. For each question, select the response that best matches your opinion about how to help this person cope with a problem he or she is having. *Please note:* There are no “right” answers to these questions.

Items are to be rated on the following scale:

Not at all important	Slightly important	Moderately important	Very important	Extremely important
1	2	3	4	5

When supplying help for a major [moderate] problem, how important is it to you to:

1. Take charge of as much as possible. (D)
2. Encourage the person to get over his/her problem quickly. (D)
3. Know when to back off from being helpful. (N)
4. Let the person get over problems at his/her own pace. (N)
5. Listen to problems without making any judgments. (N)
6. Take charge of solving problems. (D)
7. Try to see things from the person's point of view. (N)
8. Decide for the person what kind of help they might need. (D)
9. Let the person know that you are on his/her side. (N)
10. Advise others on how to help the person. (D)
11. Accept the person's wish to be alone, even if you think company is what is needed. (N)
12. Only give help that is asked for, even if you think that other things should be done. (N)
13. Push the person to take charge of his/her problem. (D)
14. Support solutions that the person comes up with, even if you disagree with them.

Note. D = Directive; N = Nondirective. Directive and nondirective subscales should be computed 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.