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UMI
THE FEATURES OF PERCEIVED SUPPORTIVE AND NONSUPPORTIVE MESSAGES RECEIVED IN THE CONTEXT OF THE DIABETIC EXPERIENCE

DISSERTATION

Presented in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy in the Graduate School of The Ohio State University

By

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*****

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ABSTRACT

Noncompliance in the treatment areas of diet and exercise is extremely high for middle-aged, obese women with diabetes. Among the most salient factors impacting compliance and the lack of compliance by the chronically ill is the availability and/or the lack of social support. The role that the number of individuals in one's social network plays and the benefits of social support on buffering health have been well documented. However, the actual supportive and nonsupportive messages received in the context of illness have not been examined widely.

This study is the first to examine and report the features of both perceived supportive and nonsupportive messages received in the context of the diabetic woman's lived experiences. A convenience sample of thirty diabetic women was interviewed about their experiences with family members, friends, co-workers, and health professionals regarding the issues of diet and exercise. Content analysis and analytic induction techniques were utilized to examine 304 supportive and non-supportive messages/actions discussed by the study participants.
Results indicate that supportive messages compliment the successes of the diabetic and encourage the enactment of healthy behaviors. Supportive actions consist of assisting the diabetic with diet/meal planning and preparation, monitoring the signs and symptoms of the illness and diabetes education. Nonsupportive messages are characterized by temptation and nonsupportive actions are enticements, cause-effect actions and nonevents. Messages that deter harmful behavior can be supportive or nonsupportive and silence can be supportive refrain or nonsupportive indifference. The author concludes that the perception of a message as supportive or nonsupportive is based on its form, content and context. The form, content and context of supportive and nonsupportive messages are discussed within a framework of politeness theory, self-efficacy, person-centeredness, reasoned discourse and credibility.
Dedicated to my mother, Francenia M. Chandler
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CHAPTER 1

INTRODUCTION

Non-insulin-dependent diabetes mellitus (NIDDM), a disease of impaired endocrine regulation, is a lifelong chronic disease in which patients carry out over 95% of their own care (Anderson, Fitzgerald & Oh, 1993). Approximately 8 to 13 million Americans are afflicted with this chronic illness (Tillotson & Smith, 1996; Susman & Helseth, 1997). Its prevalence increases dramatically with age, from 1.3% in persons 18 to 44 years old to 10.4% in persons over the age of 65. The number of new cases averages 648,000 per year (Shortridge-Baggett & van der Bijl, 1996; Susman & Helseth, 1997), and about 160,000 people die each year from diabetes and its related complications (Shortridge-Baggett & van der Bijl, 1996). NIDDM is responsible for 12% of health care expenditures in the United States having exceeded $90 billion in 1992. The out-of-pocket medical expenses for Americans with diabetes
are 2 to 5 times higher than those for persons who do not have this disorder (Susman & Helseth, 1997).

Individuals with NIDDM are at a greater risk for developing coronary artery diseases, stroke, blindness, kidney failure, and gangrene which in turn increases their chances of morbidity and mortality (Dunning, 1994). Coronary heart disease is responsible for 55% of deaths in persons with diabetes. The risk of stroke is 2.5 times higher in diabetics and diabetic retinopathy accounts for 10% of the new cases of blindness every year. Disability rates are 2 to 3 times higher in patients with diabetes, with 50% reporting limitations related to physical impairment or other health related problems (Susman & Helseth, 1997).

Sixty to 90% of diabetics are obese and female. Those most at risk are overweight, middle-aged, female members of ethnic minorities (Wing et al., 1991; Tillotson & Smith, 1996; Fitzgerald et al., 1997; El-Kebbi et al., 1996). Women of all races, but nonwhite women in particular, have an especially high prevalence of obesity. Those individuals who are 25% overweight have more than 5 times the risk of mortality from diabetes as do lean individuals (Solomon & Manson, 1997).
NIDDM affects all groups within American society, but some groups, as suggested, are more affected than others. According to the Centers for Disease Control and Prevention (1993) the age-adjusted prevalence of known NIDDM was almost twice as great among African-Americans as whites with African-American women ages 65 to 74 years of age having the highest prevalence at 21%. It is also a major health problem among most American Indian tribes. For example, more than 40% of Navajo aged 45 years and older have it, including that portion of the population (27% overweight women) with a family history of the disease (Will et al., 1997). Likewise, Mexican Americans are 3 to 5 times more likely to suffer the effects of NIDDM than non-Hispanic whites (Schwab, Meyer, & Merrell, 1994). These ethnic groups experience 2 to 6 times greater rates of lower-extremity amputations, end-stage renal disease, hypertension, and kidney disease necessitating dialysis (American Diabetes Association, 1991; Will et al., 1997; Schwab, Meyer, & Merrell, 1994).

NIDDM, also referred to as adult-onset diabetes and Type II diabetes, is not presently curable. It can be controlled through a combination of diet, exercise, and if needed, a carefully monitored drug regimen (Dunning, 1994; Reaven, 1989; Etzwiler & Maiman, 1982; Tillotson & Smith, 1996; Wing et al., 1985; 1991; Kaplan et al., 1987; Susman &
Helseth, 1997). Diet, however, is the fundamental element of therapy in most cases of NIDDM (West, 1973). Modest weight loss of approximately 10% by Type II diabetics improves glycemic control, insulin sensitivity, cardiovascular risk factors, and long-term diabetes-related complications (Bosello, Armellini, Zamboni, & Fitchet, 1997; Wing et al., 1991). Even weight control in non-obese persons with strong family histories of diabetes delays its onset (Viswanathan et al., 1997). Daily caloric restriction independent of substantial weight loss has an important regulatory effect on the metabolism of obese patients with NIDDM (Kelley et al., 1993). Moreover, the psychological and physiological benefits may be independent of substantial weight loss (Kaplan et al., 1987; Wing et al. 1985).

**Compliance Problem**

Clinicians and researchers agree that overall patient compliance with medical regimens (e.g., taking medication, dieting, exercising) is poor, especially among the chronically ill (German, 1988; Miller et al., 1997; Burke & Dunbar-Jacob, 1995; Dunbar-Jacob, Burke & Puczynski, 1995; Burke & Dunbar-Jacob, 1995). Adherence rates vary from 10% to 85% depending on the population, the medical regimen studied, and the definition of adherence used (Burke & Dunbar-Jacob, 1995). One definition dominates the medical literature. Compliance is seen as the "extent to which the
patient's behavior coincides with the clinical prescription" (Sackett & Haynes 1976 definition as cited in German, 1988). It is a complex behavioral process strongly influenced by the environments in which patients live and health-care providers' practice (Miller, et al., 1997).

Moving beyond definition, there are areas of concern in compliance research that have been receiving a great deal of attention. Two areas explored are levels of noncompliance and contributing factors, and strategies for improving compliance. Investigations into noncompliance are important because this problem crosses diseases, regimens and age groups. Adherence, which tends to decline over time (Jacobson et al., 1987), is not static, but dynamic changing from situation to situation and from one regimen (e.g., taking medication) to another (e.g., exercising) throughout the chronically ill patient's lifespan. Therefore, potentially every chronically ill patient is susceptible to problems in addressing the various aspects of treatment regimens. These long-term health-care regimens contribute significantly to health-care costs (in the billions), morbidity and mortality (Dunbar-Jacob, Burke & Puczynski, 1995).

A multiplicity of remediable factors contributes to noncompliance. The factors cited most often are complexity, inconvenience, and duration of the regimen; changes in
lifestyle required by the regimen; occurrence of side effects; cost of treatment; and skills needed for implementation of the regimen (German, 1988; Burke & Dunbar-Jacob, 1995; Dunbar-Jacob, Burke, & Puczynski, 1995). The greater the number of regimens—for example, diet plus drug rather than drug alone—the more likely that poor adherence will result (Dunbar-Jacob, Burke & Puczynski, 1995).

In addition, instituting and maintaining lifestyle changes such as diet and exercise, are more difficult than adhering to other medical regimens (German, 1988; Burke & Dunbar-Jacob, 1995). Dietary modification requires changes in several related areas, such as grocery shopping, food preparation, and social activities. A program of regular physical exercise can be time consuming, complex, inconvenient, and costly. Both may be jeopardized by a lack of reinforcement by health-care professionals (Burke & Dunbar-Jacob, 1995) and individuals within one's social network. However, self-regulation behaviors (e.g., taking oral medications, giving insulin shots) provide an immediate effect-to-treatment benefit. These behaviors require less time; and do not require overcoming deep-rooted habits or changes in the way one enjoys self and social situations.

Like most chronically ill patients, diabetics are required to engage in a number of medical regimens. Most Type II diabetics take an oral agent and are subjected to
strict diets and exercise programs. The daily experience of diabetes is a constant attempt to control the signs and symptoms of the disease. In addition, the Type II diabetic tends to be elderly. Older patients (regardless of disease-type) are least likely to be actively involved in making decisions with health-care providers about treatment regimens (German, 1988). The compounding of these factors suggest that an individual with NIDDM is a prime candidate for adherence problems.

Diabetes research is clear. Diet adherence by the adult diabetic is less than 50 percent. This poor adherence rate is believed to be due to the chronicity of this disease and its imposing life-style changes (Anderson & Gustafson, 1989; American Diabetes Association, 1991; Dunning, 1994; Susman & Helseth, 1997; Tillotson & Smith, 1996; Will et al., 1997; Schwab, Meyer, & Merrell, 1994; Glanz, 1980; Sohar & Sneth, 1973). Dietary adherence is problematic also in the management of childhood diabetes with nonadherence rates of 47% (Delameter, Smith, Kurtz & White, 1988).

Even though the conclusions of research on compliance and the chronically ill appear to be negative, there is hope. These studies do report and agree that the most salient and positive factors influencing adherence include: the patient's knowledge, previous levels of adherence, perceived confidence in the ability to perform the behavior,
satisfaction with health care, and the availability of social support (Burke & Dunbar-Jacob, 1995; German, 1988; Miller et al., 1997).

Compliance Interventions

Improvement in diabetes self-care management requires a commitment by patients, their social networks, health-care providers and health-care organizations. Routinely, efforts at improvement have begun with intervention strategies in the form of education programs for specific disease types. Diabetes self-management education is the process of providing the diabetic with the knowledge and skills needed to perform self-care, manage crises, and make lifestyle changes to successfully manage the disease (Clement, 1995).

These strategies have proven very successful in addressing noncompliance with self-regulation behaviors like foot care, taking medication, monitoring blood glucose levels and making insulin-dose adjustments (Anderson, Fitzgerald & Oh, 1993; Brown, 1990; Rubin, Peyrot & Saudek, 1991; Clement, 1995; Padgett et al., 1988). The greatest improvement has been in patient diabetes knowledge; specifically in teaching patients about the technical portion of diabetes and its treatment (Goodall & Halford, 1991; Glasgow et al., 1992). One example of both cost savings ($378,000 over 2 years) and decreased morbidity due to diabetes education is a foot care instruction program.
that resulted in a 59% reduction in serious foot lesions for participants after one year (Litzelman et al., 1993). Moreover, in a year-long, statewide education program (that targeted foot care, taking medication, and glucose monitoring) sponsored by the Centers for Disease Control in Maine, a 33% reduction in hospitalizations indicated a decrease in morbidity that translated into a savings of $293 per patient (Schwartz & Zaremba, 1985).

However, education programs have been less effective in helping patients adjust to long-term lifestyle changes such as exercising regularly or maintaining a diet (Anderson & Gustafson, 1989; Rubin, Peyrot, & Saudek, 1991; German, 1988; Burke & Dunbar-Jacob, 1995; Dunbar-Jacob, Burke & Puczynski, 1995; Miller et al., 1997). Efforts have not led to consistent, enduring behavior changes necessary for long-term blood glucose control and decreased morbidity (Quackenbush, Brown & Duchin, 1996; Rubin, Peyrot, & Saudek, 1991; Padgett et al., 1988). According to researchers, the most promising strategy in preventing poor compliance is a combination of interventions including multi-component behavioral strategies, patient education, contracts, self-monitoring, telephone follow-ups, tailoring to individual needs and backgrounds, and social support (Clement, 1995; Miller et al., 1997; Burke & Dunbar-Jacob, 1995).
Effective diabetes education is based upon 15 years of research that has identified key psychosocial factors involved in diabetic self-care behaviors. One key factor, that will be the focus of this research, is social support (Brownell & Cohen, 1995a; 1995b; Goodall & Halford, 1991; Golin, DiMatteo & Gelberg, 1996). Review articles on the self-management of diabetes (Brownell & Cohen, 1995a; 1995b; Goodall & Halford, 1991; Golin, DiMatteo & Gelberg, 1996; Glasgow, Wilson & McCaul, 1985; Johnson, 1992) suggest that further research is needed to delineate the high-risk settings and circumstances in which poor self-management occurs; and to identify which aspects of social support are crucial for effective self-management of diabetes (Goodall & Halford, 1991).

Even though substantial literature on the relationship of social support to diabetes regimen adherence (refer to above referenced articles and Chapter 2) is available, social support has been employed rarely in diabetes education (Glasgow & Osteen, 1992). Studies of self-management education show that elderly persons and children are able to make lifestyle changes (such as dieting) with the assistance of peer and/or spousal support (Gilden et al., 1989; Wilson & Pratt, 1987; Glasgow et al., 1992; Gross et al., 1983; Kaplan, Chadwick, & Schimmel, 1985). However, the researchers who evaluated social skills training,
neglected to report the exact nature of the social skills training and the effects of the intervention on particular self-management behaviors (Brownell & Cohen, 1995).

Research Purpose

Clearly, the primary problem for NIDDM patients is maintaining long-term lifestyle changes (diet and exercise) that can improve quality of life and longevity. Since adherence is the foremost responsibility of the patient, it is necessary that health-care providers assist patients in understanding and acquiring the skills to effectively manage the illness. The most important contribution is to help the patient recognize and utilize the factors researched as aiding in compliance. Health communication scholars can lead the way in establishing intervention guidelines and strategies that incorporate the communicative aspects of social support. These guidelines and strategies can provide a framework of empowerment for the NIDDM patient. This is the ultimate goal of my research.

In reaching this goal, two objectives are the focus of the present project: (1) extend the research on social support and diabetes by examining social support from a communication perspective; and (2) articulate implications for intervention strategies designed to aid NIDDM patients in diet adherence.
In summary, non-insulin-dependent diabetes mellitus is an enormous problem in the American community. Its severity is evident particularly among obese female members of ethnic minorities. Though controllable with a program of diet, exercise and/or drugs, diabetes self-care adherence needs improvement. Social support is a key factor in good diabetes self-care management. However, diabetes education programs rarely have incorporated research findings regarding social support; and those available findings are based on a restricted view of the concept. The following chapter addresses these issues about social support in greater detail.
CHAPTER 2

CONCEPTUAL VIEWS OF SOCIAL SUPPORT

Social support, as a construct for research, has its foundation in the disciplines of sociology and psychology. Both view the concept in varying ways; and diabetes researchers have embraced these ideas. In the section below, I will present the sociological, psychological, and communicative perspectives on social support. Subsequent sections of the chapter include a summary of the employment of this construct in the medical literature; a critique of the social support literature from a communication perspective; and the development of a conceptual framework for examining the role of social support in diabetic dietary adherence.

Definitions of Social Support

The concept of social support was first used in mental health literature in seminal articles during the late 1970's by physician-epidemiologists Cassel and Cobb (cited in House, Landis & Umberson, 1988) to document the link between social ties and health. Early perspectives on social support are based on sociological notions concerning
the individual's social network size, density and interconnectedness and/or perceptions of belonging (Burleson, Albrecht, & Sarason, 1994; Albrecht, Burleson & Goldsmith, 1994). The term social network refers to the specific set of linkages among a defined set of persons (Schaefer, Coyne, & Lazarus, 1981) or the web of social ties that surround individuals (Forster & Stoller, 1992).

Research grounded in the sociological perspective suggests that the mere existence of social ties results in better or protected health (Burleson, Albrecht & Sarason, 1994). Network analysis focuses on quantitative descriptions of social networks. The fundamental properties or characteristics of social networks are size (the number of individuals in the social unit), homogeneity and/or heterogeneity (the similarities or dissimilarities of individuals in the social unit), reciprocity (the degree support is given or received), multiplexity (the extent of multiple contacts for communication to occur in the network), and density (the interconnectedness of network members) (Albrecht & Adelman, 1987). A network is dense to the degree that network members have relationships with one another. Lower density heterogeneous networks can be associated with lower normative pressure, a greater variety of roles for the individual, and less inter-network conflict. They are therefore, more helpful and satisfying than high-density homogeneous networks, especially when one
is experiencing a major life transition (Albrecht & Adelman, 1987; Hobfoll & Stokes, 1988).

Research stemming from the psychological perspective focuses on how the quality of one's social ties influences one's sense of support by buffering against stress and health problems (Sullivan & Reardon, 1986; Sarason, et al., 1987; Burleson, Albrecht, & Sarason, 1994). Psychologists examine perceptions of support but have neglected to suggest how social support is conveyed. They have not linked perceptions of support specifically to verbal and nonverbal messages (Burleson, Albrecht, & Sarason, 1994). For example, Procidano and Heller (1983) and Wethington and Kessler (1986) define social support from a psychological viewpoint as the extent to which an individual believes or perceives that his/her needs for support, information, and feedback are fulfilled. Metts, Manns and Kruzic (1996) combine sociological and psychological ideas defining social support as including one's connections to groups and significant others and perceptions that support is available when needed and satisfying when received. Other conceptualizations combine affective and behavioral dimensions and view social support as "the emotional, instrumental, and financial products delivered through the web of friends and acquaintances that surround an individual" (Query & James, 1989, p. 167).
In the 1980s, communication scholars began to examine social support as an interactional process of caring for, comforting, and aiding others within the context of various types of relationships (Albrecht & Adelman, 1987; Burleson, Albrecht & Sarason, 1994; Zimmermann & Applegate, 1992; Thoits, 1986; Hobfoll & Stokes, 1988; Reardon & Aydin, 1993; Sarason, Pierce, & Sarason, 1990; Sarason, Sarason, & Pierce, 1994; Ford, Barrow & Stohl, 1996; Leatham & Duck, 1990). These scholars are concerned primarily with two types of social support: emotional and instrumental. Emotional support components include verbal and nonverbal expressions of caring, sympathy and concern, attachment and esteem support. Providing someone with positive feedback on her abilities or indicating a belief that she is capable of handling a stressful event are examples of this type of support. Instrumental support involves both concrete assistance whereby goods and services are provided, and informational assistance through guidance or advisement concerning possible solutions to a problem that aids in another's understanding and adjustment to changes (Cohen & Wills, 1985; Thoits, 1986; Gottlieb, 1985; Jacobson, 1986; Cutrona & Suhr, 1994; Cutrona et al., 1990).

Albrecht and Adelman (1987), major authorities in the study of communicating social support, define social support as the "verbal and nonverbal communication between recipients and providers that reduces uncertainty about the
situation, the self, the other, or the relationship, and functions to enhance a perception of personal control in one's life experience" (p. 19). Successful support providers reduce uncertainty by (1) providing information for perspective shifts on cause-effect contingencies; (2) encouraging enhanced control through skill acquisition; (3) encouraging enhanced control through tangible assistance; (4) encouraging enhanced control through acceptance or assurance, and (5) encouraging enhanced control through ventilation (Albrecht & Adelman, 1987).

Social support is a complex process of individual interpretation and interpersonal negotiation of face guided by shared conventions for inferring messages about support, acceptance, and autonomy (Goldsmith, 1992, 1995). In interactional perspectives, communication is the central mechanism through which support is conveyed, contributing to the development of psychological processes, and generating a basis for advising people on how to be more supportive (Burleson, Albrecht, & Sarason, 1994).

Within this approach, scholars explore the functions of supportive messages or the extent to which one's interpersonal relationships provide particular resources. Supportive messages and/or comforting strategies function to inform, persuade, control, and instruct others (Samter & Burleson, 1984). Coping assistance acts to bolster self-esteem and a sense of environmental mastery by assisting
the individual in changing either the situation, or the meaning of the situation, or both (Thoits, 1986). In essence, social support enables us to provide, bolster, or facilitate the provision of objects, conditions, personal characteristics, and energies extending the self and what the self can achieve alone (Hobfoll & Stokes, 1988).

A communicative approach to the study of social support recognizes that the seeking, giving, receiving and perceiving of support are symbolic and rhetorical processes (Goldsmith & Fitch, 1997). Meaning, the effects of received or perceived support do not come about automatically through the mere issuance of a supportive message (e.g., providing diet information) but rather through interactants' interpretations of messages (shaped by situational, conversational, and cultural contexts) and their implications (Burleson, 1982, 1984; Burleson & Samter, 1985a, 1985b; Cutrona, 1996). Hence, successful interactants are those who deploy discursive resources in ways that ease respective, and sometimes conflicting goals (Goldsmith, 1992, 1995; Goldsmith & Fitch, 1997). Communication scholars then, by definition, are not interested solely in the number of people in one's network or even the quantity of messages given or received, but in the quality of messages both received and perceived (Zimmerman & Applegate, 1992; Albrecht, Adelman, & Associates, 1987; Goldsmith & Fitch, 1997). Their research
suggests that one's competency in performing various speech acts determine supportiveness. Therefore, communication scholars are interested in both the production and reception of messages.

**Health Outcomes and Social Support**

As previously suggested, the belief that health outcomes are influenced by the presence of social relationships, instrumental support, and emotional support has been a recurrent theme in medical literature incorporating sociological, psychological and communication perspectives (House, Landis, & Umberson, 1988; Hammer, 1983; Ell et al., 1992; Schaeter, Coyne, & Lazarus, 1981; Sherbourne & Hays, 1990; Peyrot, McMurry, & Hedges, 1988; Weinberger, Hiner, & Tierney, 1987; Shye et al., 1995; Forster & Stoller, 1992; Litwak, 1989). Social support is believed to reduce negative psychological responses, increase psychological well being, and influence treatment compliance. The social network is thought to be directly and causally involved in health outcomes through the impact of social feedback on physiological processes (Hammer, 1983).

For example, the availability of social resources predicts both perceptions of social support and positive well-being for caregivers of Alzheimer patients (Ellis, Miller, & Given, 1989); and seropositive individuals turn to support groups, other HIV positive persons, family
members, weaker ties, and intimate friends for different
types of support throughout illness trajectory (Metts,
Manns, & Kruzic, 1996). Effective support is most likely to
come through empathic understanding from socially similar
others who have faced or are facing the same stressors
(Thoits, 1986). Marital status and emotional support
predict survival for patients with breast cancer (Ell et
al., 1992; Sullivan & Reardon, 1986; Reardon & Aydin,
1993). Perceived tangible and emotional support are
directly associated with depression and negative morale
(Schaeter, Coyne, & Lazarus, 1981; Hammer, 1983). African-
American women with symptomatic osteoarthritis of the knee
and/or hip who have more contact with family and friends
report fewer financial needs and fewer emotional deficits
(Weinberger, Hiner, & Tierney, 1987). Social support in
the form of social integration seems to be very important
in predicting mortality among women (Forster & Stoller,
1992; Shye et al., 1995). Also, chronically ill married
individuals experience better physical functioning, fewer
feelings of depression, less loss of behavioral and
emotional control, and less life stress than the
chronically ill unmarried (Wolfe et al., 1989; Sherbourne &

Additionally, there is a body of research in
psychology (Rook, 1984; Dakof & Taylor, 1990; Dunkel-
Schetter, 1984; Lehman, Ellard, & Wortman, 1986; Elliott,
(1985; Lehman & Hemphill, 1990; Pearlin & McCall, 1990; Tucker & Johnson, 1989; Ratcliff & Bogdan, 1988) on the kinds of support-intended acts that are perceived by recipients as helpful or unhelpful. These researchers have developed descriptive typologies based on interviews with people in a variety of health-related situations. They conclude that persons with multiple sclerosis (MS) are unlikely to blame others when accounting for unhelpful support attempts, attributing unhelpful acts to a lack of knowledge of MS and "just trying to be helpful" (Lehman Hemphill, 1990); people are aware of what to say and do in times of bereavement, but find it difficult to act due to their own anxiety (Lehman, Ellard, & Wortman, 1986); emotional and esteem support are perceived as helpful or unhelpful depending on the source (Dakof & Taylor, 1990); and that help from health-care providers in the form of emotional and instrumental assistance is particularly important to cancer patients (Dunkel-Schetter, 1984).

A few health researchers (Sullivan & Reardon, 1986; Query & James, 1989; Ellis, Miller, & Given, 1989; Salazar, Becker, & Daughety, 1994; Metts, Manns, & Kruzic, 1996; Cutrona & Suhr, 1992; Reardon & Aydin, 1993; Zimmermann & Applegate, 1992; Winstead et al., 1992; Pryor & Mengel, 1987) examine social support from an interactional and/or communication perspective. The focus, of course, is on social network integration and/or the influence of one's
sense of support on buffering against stress or other health problems. However, many times satisfaction and communication competence are treated as dependent variables.

For example, Query and James (1989) assessed communication competence, social network size, and social support satisfaction among senior citizens residing in retirement communities. Elders with larger social networks were assessed as more communicatively competent and better able to mobilize support than elders with smaller networks. Winstead et al. (1992) assessed communication competence and found that after interacting with a friend as opposed to a stranger in anticipation of a stressful event (e.g., giving a speech) people are less depressed, and judged more confident. In addition, breast cancer patients who feel a sense of control over their illness and satisfaction with their social support networks experience less stress and are more likely to maintain a prescribed diet (Sullivan & Reardon, 1986; Reardon & Aydin, 1993).

Social Support and Diabetes. As acknowledged, many NIDDM patients are not likely to exercise regularly and maintain strict diets or restrict caloric intake in order to lose weight and acquire glycemic control benefits (Glasgow et al., 1989; Wilson et al., 1986). Adherence to these lifestyle changes is influenced both positively and negatively by a variety of psychosocial factors. One of
the most salient and positively influential factors (accounting for 10 - 30% of the variance) in adhering to a diabetes self-care regimen, is the availability of social support (Ruggiero et al., 1990; Pham, Fortin, & Thibaudeau, 1996).

Most of the research into social support and diabetic regimen adherence (Belgrave, 1994; Tillotson & Smith, 1996; Ruggiero et al., 1990; Shenkel et al., 1985; Glasgow et al., 1989; Wilson et al., 1986; Boehm et al., 1997; Pham, Fortin, & Thibaudeau, 1996; Schlundt et al., 1994; El-Kebbi et al., 1996; MacLean, 1991; Maillet et al., 1996) focuses on the positive role of family members, friends and significant others. Family members are thought to provide the necessary physical and emotional support in initiating and maintaining compliance (Tillotson & Smith, 1996).

Shenkel et al. (1985) state that patients consistently follow through with dieting requirements according to their perceptions of significant others' expectations. The greater the availability of social support the greater the adherence to dieting (Wilson et al., 1986; Belgrave & Lewis, 1994; Pham, Fortin, & Thibaudeau, 1996).

Effective familial social support includes spousal support in the form of joint participation in a weight loss program (Wing, Marcus, Epstein & Jawad, 1991), emotional support in the form of giving comfort and reassurance, cognitive support in the form of information about
treatment procedures, and instrumental support in providing transportation (Belgrave & Lewis, 1994). Peers in self-help groups and diabetes education programs offer the opportunity to exchange information, ask questions and discuss topics such as cheating that might not be broached with one's physician (MacLean, 1991; Pryor & Mengel, 1987). Health professionals are supportive also when they listen to complaints and concerns about following a diet (MacLean, 1991).

While the influence of significant others like that of family members can be positive; sometimes, it is negative. The diabetic diet often restricts and discourages the eating of ethnic, traditional, popular, and inexpensive foods. Many diabetics miss foods containing sugar and cooked in fat, and can not afford to buy the prescribed sugar-free sweets, low-sugar and low-fat foods. These restrictions may be incompatible with the preferences of other family members. As a result of these habitual, economic, and social barriers, the diabetic may be pressured into noncompliance (El-Kebbi et al., 1996). Other dietary barriers include: attempts to cope with stress, time constraints, lack of planning, competing priorities, and participating in social events where food is served (El-Kebbi et al., 1996; Maillet et al., MacLean, 1991; 1996; Schlundt et al., 1994).
Critique of Methods

Since the late 1970s researchers across disciplines define and measure social support in varying ways in an attempt to link social network patterns, relationships, and perceptions to health-related outcomes (Albrecht, Burleson & Goldsmith, 1994). Diabetes researchers employ self-report instruments whereby the respondent is asked to choose between predetermined, limited, response options that may not reflect their attitudes or lived experiences. Measures include the Self-Evaluation of Adherence to Diabetic Treatment (Pham, Fortin, & Thibaudeau), the Diabetes Care Profile (Boehm et al., 1997), the Diabetes Education Profile (Glasgow et al., 1989), and the Multidimensional Diabetes Questionnaire (Talbot et al., 1997). Containing 28 to 110 items, these instruments measure everything from health beliefs, self-efficacy, diabetes-specific social support, and global social support (emotional, cognitive, instrument). Even though the instruments are titled differently, items are similar across instruments. Typical Likert scaled items are: "My friends help me a lot to follow my meal plan;" "My family accepts me and my diabetes;" and "My friends listen to me when I want to talk about my diabetes."

Likewise, questionnaires outside of diabetes research operationalize social support in similar ways. The popular Social Support Questionnaire (Sarason et al., 1987) asks:
"Who accepts you totally, including both your worst and your best points?" and "Whom can you really count on to tell you, in a thoughtful manner, when you need to improve in some way?" Other scales (see Ellis, Miller, & Given, 1989; Reardon & Aydin, 1993) have Likert scale items like: "There are people I can depend on to help me if I really need it;" and, "There is someone I could talk to about important decisions in my life."

Whether or not the scale is diabetes specific, the primary purpose of the instrument is the assessment of the availability of social support. Few of the items represent specific messages a diabetic could or has received from significant others. Therefore, we are not informed about how social support is verbally enacted. Thus, in portraying social support as a psychological and/or sociological phenomenon, it is reported in terms of perceptions of and numbers of people around the patient. This focus on the structural elements of social networks such as size, frequency of contact, and access to close attachments and functional elements of social support (instrumental, emotional, etc.) does little to inform our understanding about the core essence of social support (Gottlieb, 1981).

Additionally, the operationalization of social support in qualitative studies (Elliott, 1985; Ratcliff & Bogdan, 1988; Dakof & Taylor, 1990; Dunkel-Schetter, 1984; Lehman,
Ellard, & Wortman, 1986; Ford & Ellis, 1998) is both informative and problematic. In these studies typologizing helpful and nonhelpful acts, an "it is or it isn't" or an either or approach is used. Respondents are asked questions like: "How did that counselor's response help or hinder you at the time?" (Elliott, 1985, p. 308); "What is the most helpful thing that someone has said or done to help you with your cancer?" and "What has someone said or done that you experienced as most annoying, or that upset you, made you angry, or just somehow rubbed you the wrong way?" (Dakof & Taylor, 1990, p. 81). Then the researcher finds acts (primarily things that were done) which are either helpful or unhelpful. As a result, we learn that some helpful counseling behaviors consist of "problem-solving," "problem clarification," and "understanding," and that some unhelpful counseling behaviors consist of "negative-counselor reactions" and "misperceptions." However, we do not know what was said that resulted in "problem-solving," "misperception" or "understanding" as the perceived outcome of an encounter.

Once the researcher has teased out helpful and unhelpful behaviors, he/she finds that some actions are categorized as both helpful and unhelpful. For instance, bereaved individuals (Lehman, Ellard, & Wortman, 1986) see advice as helpful and unhelpful. The researcher is then left to explain, unsuccessfully, how this contradiction has
occurred. The point is, it is both the features of situations and messages that lead to better or worse support attempts. Therefore, inquiry should be made into the context and content peculiarities of supportive and non-supportive messages.

In summary, social support is clearly instrumental in health outcomes. All investigations into its structural and functional components add to our comprehension of this multidimensional construct. We know that social integration and the availability of instrumental, cognitive, and emotional support impact diabetes regimen adherence. However, current operationalizations of social support limit our understanding of social support from a communication perspective. Therefore, it is necessary to investigate both the context and content of supportive messages. Such an approach would emphasize the communicative nature of social support and lead to more comprehensive intervention programs aimed at compliance with treatment regimens.

A Message-Centered Approach to Social Support

Increasingly, researchers in support reveal the complex content factors that interact to influence perceived supportiveness and nonsupportiveness (see Burleson & Samter, 1985a, 1985b; Goldsmith, 1992; Tardy, 1992; Miller & Ray, 1994; Ray, 1993; Metts, Geist, & Gary, 1994; Zimmermann & Applegate, 1994; Ford, Babrow, & Stohl, 1994).
1995; Ford & Ellis, 1998; Sullivan, 1996; Westmyer & Myers, 1996; Hale, Tighe, & Mongeau, 1997). For example, some message-centered social support research focuses on comforting strategies (e.g., Burleson & Samter, 1985a, 1985b; Goldsmith, 1992; Hale, Tighe, & Mongeau, 1997; Zimmerman & Applegate, 1992) that distinguish helpful from unhelpful supportive messages. Comforting strategies encompass messages that seek to alleviate the emotional distress that individual's experience on a daily basis. Burleson and Samter (1985a) developed a hierarchical system for coding comforting messages as more or less sophisticated based on degree of person-centeredness (message behavior reflecting an awareness and adaptation to the subjective, affective, and relational aspects of communicative contexts).

In experiments utilizing college students (Burleson & Samter, 1985a, 1985b; Goldsmith, 1992; Westmyer & Myers, 1996; Hale, Tighe, & Mongeau, 1997; Sullivan, 1996), possible-comforting messages directed to friends (e.g., for failing a test, ending a dating relationship) were compared. The most sophisticated messages possessed the following characteristics: neutral evaluation, a concentration on feelings, and more acceptance of the other with greater cognitively oriented explanations of the feelings experienced by the other (Burleson & Samter, 1985a, 1985b). The messages typify regard for positive and
negative face (Goldsmith, 1992); and include communication skills in conflict management and ego support (Westmyer & Myers, 1996).

Hale, Tighe and Mongeau (1997) studied the effects of event type and gender on comforting messages. They found comforting messages were more sensitive in response to major events (i.e., parental death, parental divorce) than to daily events (i.e., ending a dating relationship). Major events occur infrequently producing extreme distress, while daily events occur frequently producing transient discomfort. They concluded women generally give and receive more sensitive comforting messages than men do.

Sullivan (1996) examined attributions made concerning beliefs about why people provide helpful and unhelpful messages across various stressful life events. They did not report what those events were, but discovered the most frequent types of helpful and unhelpful messages fall into the category of emotional and esteem support, not network support nor tangible aid. Helpful messages were attributed to concern for the individual and unhelpful messages to attempts to be helpful.

Only three studies (Zimmermann & Applegate, 1992; Ford, Babrow & Stohl, 1995; Ford & Ellis, 1998) address supportive messages within the context of health-care. Both Zimmermann and Applegate (1992) and Ford and Ellis (1998) focused on the professionals working within the

First, Zimmermann and Applegate (1992) examined comforting communication among members of hospice interdisciplinary teams. Hospice is a program of supportive services provided by medical professionals and volunteers to dying persons and their families. The scholars, who used data generated through observation, focus group interviews (in which patients responded to hypothetical situations) and a written questionnaire, determined that hospice team members use sophisticated levels of comforting message strategies that explicitly recognize and elaborate on the target person's perspective. However, they also discovered that formal hospice training negatively impacted the person-centered comforting abilities of hospice workers. They did not evaluate the content and methods of the training program and were unable to interpret this finding.

Second, Ford and Ellis (1998) investigated helpful and unhelpful messages. They presented a preliminary analysis of recalled messages of support and nonsupport received by nurses in a Midwestern hospital. In interviews, nurses were asked to recall specific incidents of support and nonsupport they had experienced in the workplace. The results indicated the nurses view the act of support as one of altruism on the part of their co-workers. The recalled
nonsupportive messages reflected receiver difficulties in managing and interpreting senders' intent and motivation. The nurses defended the behaviors of senders and described them as "support attempts that failed" (p. 51).

Finally, Ford, Babrow and Stohl (1995) studied social support messages and the management of uncertainty among breast cancer patients. Breast cancer patients were asked to formulate messages that they would find supportive in response to four hypothetical scenarios. The same patients were asked to judge whether their messages would serve to reduce, maintain, or increase their certainty in the hypothetical situations. Two-thirds of the messages were judged to be uncertainty reducing, certainty increasing, or certainty maintaining. One-third was seen as increasing or sustaining uncertainty. In this preliminary work, the researchers did not present examples of these message types.

In summary, few studies examine supportive and/or nonsupportive messages. Even fewer investigate these messages in a health context. However, the conclusions of these studies extend communication research in the areas of comforting strategies, person-centered message development, contextual factors influencing support and nonsupport, and uncertainty reduction theory. Overall, these researchers have led the way in detailing message peculiarities, providing us with a framework for developing techniques for
social skills training directed toward improved social support.

Research Questions

Many problems associated with diabetes are interpersonal in nature. These interpersonal problems have an effect on the ability of NIDDM patients to adhere to major lifestyle changes. The review of literature shows that virtually all the studies that examined predictors of diabetes self-care management have found that people who maintain close interpersonal relationships with family and friends during their illness are more likely to cope effectively with the disease.

However, diabetes research is lacking in key areas. First, little is known about the situations and circumstances of dietary noncompliance. Second, different types of support (e.g., network integration, emotional, instrumental) seem to impact health outcomes; but it is not clear which type is the most significant in the lived experience of diabetics. For example, we know that diabetics perceive some actions as helpful like diabetes education but we do not know what actions of others are perceived as unhelpful. Third, the structure of supportive and nonsupportive messages has not been examined in the context of the diabetic experience. Therefore, one must conclude that further exploration is needed into the lived experience of diabetes.
As mentioned previously, a message-centered approach to the study of social support has focused on the transient daily stressors of college students and the experiences of health professionals. My study extends communication research by utilizing a message-centered approach to investigate how patients cope with the daily stressors resulting from living as a diabetic. The following research questions are addressed:

RQ1: What are the features of supportive and nonsupportive messages relevant to NIDDM self-care behaviors (i.e., diet and exercise)? What actions are perceived as supportive or nonsupportive?

RQ2: What are the social settings and circumstances in which supportive and nonsupportive messages and actions are produced?
Participants

Participants were 30 female Type II diabetics from the metropolitan area of Charlotte, North Carolina. They responded to a flyer (see Appendix A) obtained through communication students at the University of North Carolina, or Community Health Services. This convenience sample consisted of 17 (56%) African Americans and 13 (44%) White Americans. All were high school graduates and 10 (33%) had earned a bachelor’s or master’s degree. Their ages ranged from 33 to 72 (M = 52) with 12 (39%) between the ages of 40 and 49. The majority 23 (78%) were employed at the time of the study. Eighteen (61%) were single, widowed or divorced. In addition, twenty-one (72%) lived in households earning more than $20,000 a year.

All (100%) believed that diet, exercise, and any other prescribed diabetes treatment procedures were helpful in controlling diabetes and preventing long-term diabetes.
complications. However, 17 (56%) stated that they did not follow the medical regimen suggested by their physician while 13 (44%) categorized themselves as compliant. For their participation, each was paid $20.00.

**Procedures**

Prescreening was conducted by telephone using a prepared script (see Appendix B). During the prescreening, a time was scheduled for the interview. Upon arrival at the allotted place and time, the participant was informed once again about the specifics of the study and asked to sign a consent form. Then the participant was asked a set of items adapted from Talbot et al., (1997) to assess patients' perceptions of the effects of diabetes self-care behaviors on metabolic control and on the prevention of complications (see Part I of Appendix C).

In addition, the participant was presented with scenarios from Schlundt et al. (1994) to assist her in recalling particular events. She was asked (in three broad questions) to describe her supportive and nonsupportive experiences (see Part II of Appendix C). Follow-up probes elicited detail regarding the situation, the context and timing of the encounter, as well as the relationship of the participants in the encounter. The interview was concluded with nine demographic questions (see Part III of Appendix C). The entire process took 30 to 60 minutes. Responses were tape-recorded and transcribed.
Coding. Content analysis is the "systematic and publicly accountable means of interpreting the symbolic aspects of some specific phenomena in order to submit the resulting interpretations to qualitative and/or quantitative study" (Dervin, 1991, p. 1). In preparing the data for analysis, the researcher first determined the unit of analysis. The unit of analysis is what is studied (Babbie, 1998). As previously mentioned, the data consisted of discourse that contained information on several specific situations experienced by the interviewees, with considerable elaboration about the relationship between the actors in the encounters, what was said, and the interviewees' interpretations of the encounters. All of this contextual information was important in the coding of messages received and actions accomplished. Therefore, it was determined that the most suitable unit of analysis for this project would be the paragraph.

The researcher used the works of several authors (e.g., National Council of Teachers of English, 1966; Crothers, 1971; Pincas, 1970; Bond & Hayes, 1984; Unger, 1996) to discern what a paragraph is in discourse. A paragraph was then defined as a collection of related utterances dealing with a single topic. Further explanation can be found on the first page of the codebook (Appendix D). After extensive training, two undergraduate
research assistants unitized the transcripts. One student, a nontraditional student with nearly 5 years experience as a court reporter, unitized the bulk of the interviews as she transcribed them. Her training in court reporting helped her to divide effectively and consistently the tape-recorded words into useful paragraphs.

Within the paragraphs only utterances that typically addressed food or exercise were coded. A content category scheme was developed using the analytic induction procedure discussed in Baxter (1991). First, a cursory examination of the data suggested several issues consistently arise in a discussion of diabetes. Most (e.g., diagnosis, treatment, symptoms), if not all, of these issues can be expected in any discussion of chronic illness. These issues were used to determine the overall theme of each paragraph. Second, the dichotomous constructs of support and nonsupport as discussed in the social support literature served as the conceptual framework for examining the messages and actions of others recalled by the study participants. The interviewees' evaluation of a message or action as helpful or unhelpful resulted in an assignment of a direction code. Support was defined as one's perception of caring and assistance in achieving one's goals through the reception of messages and actions. Nonsupport was defined as one's perception of a lack of caring or a lack of assistance in achieving one's goals through the
reception of messages and actions. Messages and/or actions not directed specifically toward the interviewee were indicated as such and not assessed any further codes.

Third, researchers of social network integration suggest that the type, density, and number of social ties result in better health (Albrecht & Adelman, 1987b; Burleson, Albrecht, & Sarason, 1994; Albrecht, Burleson, & Goldsmith, 1994; Hobfoll & Stokes, 1988; Schaefer, Coyne, & Lazarus, 1981; Forster & Stoller, 1992; Sullivan & Reardon, 1986; Query & James, 1989). However, researchers (see El-Kebbi et al., 1996; MaClean, 1991; Boehm et al., 1997) of social support and diabetic regimen adherence present conflicting conclusions on where and from whom messages result in positive or negative health behaviors. As a result, codes were devised to determine whether messages were received primarily from family, friends, or significant others and whether actions were taken primarily by family members, friends, health professionals or significant others. Additionally, context codes were designed to address where--the setting, location, situation or place in which a message was received or action taken. The work of Schlundt, Rea, Kline, and Pichert (1994) was the starting point for the resultant context codes.

Fourth, support researchers indicate that support occurs along two dimensions: an emotional level and an instrumental level (Cohen & Willis, 1985; Thoits, 1986;
Gottlieb, 1985; Jacobson, 1986; Cutrona & Suhr, 1994; Cutrona et al., 1990). However, in order to make a clear distinction between what was said to the diabetic and what was done for the diabetic, I assessed both support and nonsupport as occurring on one of two levels: as message-based or action-based. These levels were used as subcategories within the general categories of support and nonsupport. The message level consisted of both verbal and nonverbal expressions of emotions such as caring, a lack of caring, concern or a lack of concern. The action level consisted of the provision or lack of provision of concrete goods and services.

Finally, in my critique of the social support literature, I point out that some messages have been categorized as both helpful and unhelpful. My goal then was to discern the features or types of messages that lead to successful or unsuccessful support attempts. Therefore, feature codes were devised. These codes refer to the structure, form or characteristics of a message. A feature was defined as a distinguishing trait, quality, or property of a message. The research of Goldsmith (1992), Cutrona and Suhr (1992), and Ford and Ellis (1998) were instrumental in developing initial categories. As the data were examined, other features not discussed in the literature became apparent (i.e., rudeness, discouragement, indifference).
The data set and the code book (Appendix D) containing the category labels and definitions, the numeric codes assigned to subcategories, examples that illustrate each category, and coding rules were given to two undergraduate student coders. Extensive training occurred. Throughout the coding process results were examined to identify problems in interpretation of category labels and definitions. Adjustments were made as needed.

Unitizing of the 30 interviews resulted in the coding of 420 paragraphs. Agreement was 100% on the unitizing of paragraphs. However, many paragraphs (116) contained considerable discussion of the respondents' thoughts and actions outside of interactions or encounters with others or involved themes outside of the author's primary interests (diet and exercise). Since the nature of the study is interpersonal and restrictive, only the discussion of encounters with others that directly addressed the issues of food, diet and exercise are addressed. Therefore, the author reports on only 304 of the 420 total paragraphs. The other themes, personal thoughts and actions of the study participants will be used in future research on the relationship between motivation and actions.

Once unitizing and coding of content categories was completed, a reliability check was conducted. "Reliability is expressed as a function of the agreement achieved among
coders regarding the assignment of units to categories" (Krippendorff, 1980, p. 133). Dervin (1991), Watt and van der Berg (1995) suggest that a reliability check on 10% of the coded units with 80% agreement or better is good. To determine the level of reliability, the coding results of the two undergraduates were compared to that of the author's utilizing an enumeration system described in Holsti (1969). Frequencies were gathered by counting every occurrence of a given subcategory or attribute.

<table>
<thead>
<tr>
<th>Category</th>
<th>Judge 1</th>
<th>Judge 2</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme*</td>
<td>.77</td>
<td>.76</td>
<td>.76</td>
</tr>
<tr>
<td>Direction*</td>
<td>.88</td>
<td>.90</td>
<td>.89</td>
</tr>
<tr>
<td>Network</td>
<td>.85</td>
<td>.88</td>
<td>.87</td>
</tr>
<tr>
<td>Level</td>
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<td>.83</td>
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</tr>
<tr>
<td>Feature</td>
<td>.76</td>
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<td>.77</td>
</tr>
<tr>
<td>Context</td>
<td>.88</td>
<td>.81</td>
<td>.85</td>
</tr>
</tbody>
</table>

Table 3.1: Reliability data for content categories. *N = 78. For all other categories, N = 59. A total of 392 coding decisions were made. Overall mean = .83.

Correcting for chance agreement using Scott's Pi, M = .80.
Table 3.1 shows the amount of agreement between coders in evaluating the content of the paragraphs. Agreement was high on the coding of direction (whether the message was perceived as supportive or nonsupportive), network (from whom the message was received), and context (the setting in which the message was received). Agreement was less on the evaluation of the overall theme and feature of a message. However, as noted by Dervin (1991) and Watt and van der Berg (1995) reliabilities of .65 to .85 are useful for tentative considerations.
CHAPTER 4

RESULTS

Research Question 1: What are the features of supportive and nonsupportive messages relevant to NIDDM self-care behaviors (i.e., diet and exercise)? What types of actions are perceived as supportive and nonsupportive?

This chapter reports the findings of the author’s examination of three hundred and four messages and actions relating to the themes of diet and exercise. Support and nonsupport are primarily enacted through the interpretation of messages as indicated by the 198 (65%) messages and 106 (35%) actions discussed in this chapter. The high percentage of messages indicates just how important what one says is in the context of diabetes. Diabetics perceived most messages and actions as supportive (58%). However, 42% of the messages received and actions taken were perceived as nonsupportive. Even though the majority of messages and actions were perceived as helpful, there is obviously a problem with the structure of these supportive messages when noncompliance continues to remain high.
Supportive messages and actions are discussed first. Secondly, nonsupportive messages and actions are discussed. Each category is defined, explained and illustrated. An alpha level of .05 was used for all statistical tests.

Support

As stated previously, most messages (58%) received by the study participants and actions taken on behalf of the study participants were perceived as supportive. One hundred and seventy six messages and actions were perceived as supportive. Of the 176, one hundred and five (60%) are messages and seventy-one (40%) are actions.

Supportive Messages

Overwhelmingly, members of the diabetic's social network provided support through verbal messages suggesting support is significantly linked to what people say to one another in interaction. In the context of the diabetic experience where the issues of diet and exercise determine one's quality of life, attempts to deter harmful eating, encourage future achievement, compliment successful action, and refrain from interfering, form the basis of support (see Table 4.1). These supportive messages are defined, explained and illustrated in the following pages.
Table 4.1: Frequencies and percentages of supportive messages. N = 105. Other includes humor, advice and temptation.

<table>
<thead>
<tr>
<th>Feature</th>
<th>Frequency</th>
<th>Percent</th>
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</thead>
<tbody>
<tr>
<td>Deterrence</td>
<td>51</td>
<td>48.6</td>
</tr>
<tr>
<td>Encouragement</td>
<td>18</td>
<td>17.1</td>
</tr>
<tr>
<td>Compliment</td>
<td>17</td>
<td>16.2</td>
</tr>
<tr>
<td>Refrain</td>
<td>8</td>
<td>8.0</td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
<td>10.1</td>
</tr>
</tbody>
</table>

**Deterrence.** Approximately 50% percent of the supportive messages discussed by study participants were expressions of deterrence (see Table 4.1). In nearly half of the instances (25 of 51 or 49% of the messages in this category), supporters used rule-like terminology such as shouldn’t, don’t, can’t and not to command the diabetic to not eat at all, to avoid eating a harmful item, or to cease eating a diabetes-inappropriate food. Family members were more likely to use this approach. Examples are:
At my father's retirement party I got some potato salad. My sister said, "No, uh-uh, you know you ain't supposed to have that. Just take it off your plate. Just put it back." You better take it off. I'm going to go in there and tell Daddy. You know I'll tell on you."

"You shouldn't eat anything; it's too late. You shouldn't eat anything."

"No, you don't need that."

"Don't eat those cookies." "You can't have any cake."

"Now, you know you can't eat that candy because it'll run your sugar up."

"Stay away from the soft drinks."

In 51% of the instances discussed by the study participants in this category, the supporter suggested a more diabetes-appropriate item or items for consumption, alternative ways for preparing food or restaurants with a variety of foods. Or, the supporter asked a question or a series of questions about what food items were appropriate for the diabetic. The diabetic interpreted the suggestion and/or question(s) as an attempt to prevent or keep her from eating potentially harmful foods. Family members, friends, co-workers and even health professionals made suggestions.
I went to a wedding where they had all this food laid out and I kept going up to look at the hors d'oeuvres. She watched me and said, "They've got a whole plate of fruit over here that you can have. Just go over there and get some vegetables. You can get cucumbers, carrots, whatever you want."

"Well, we'll go to a Chinese restaurant because Chinese [food] is not as fattening as Chilies."

"They have plenty stuff that you can drink. Just shop around. You'll find them and it'll be better than that Sprite I'm telling you. It'll be better on your kidneys."

Additional illustrations of these mitigated commands include:

She said, "Do you want me to fix your plate for you or do you want to fix it?" I would choose to fix it with the vegetables and fruits and would get full on them.

"Wouldn't you rather have something else Mom instead of that piece of candy? How about if I get you some celery or carrots or something? How about I get you an apple? Would you rather have some popcorn?"

If I order something that I know I shouldn't because I'm in a bad mood, my mother will say, "Do you really think you should have that? You really should eat some fruit, you know, get you some peaches or something." If I say they got sugar in them, she says, "Well, get you some Jell-O or something. You don't need that piece of pie. It's not going to do you any good." She always brings me back to reality. "You know what can happen. You know what will happen, so stick with something good."

Encouragement. The most frequent statements deterred harmful eating behaviors (see Table 4.1). However, when the diabetic had not yet accomplished her goal(s) to lose weight, modify her eating habits, or successfully monitor
her glucose level, supporters also encouraged her. Health professionals did fifty percent of the encouragement discussed by study participants. The remaining encouragement (50%) came from either family members or friends.

Understanding was expressed. Confidence in her ability to accomplish short-term goals (e.g., choosing to eat healthy at a specific meal) or eventually accomplish her long-term goal(s) successfully was expressed. In some instances (17% of the category) the diabetic observed specific behavior enacted by the supporter that the supporter then attempted to get the diabetic to model. For example:

She’ll get something like fruit or Jell-O and she’ll do away with her dessert to try and help me, encourage me. “I’ll eat it if you eat it.”

In even more situations (25%), the supporter made statements that projected/predicted the future success of the diabetic with treatment prescriptions by focusing on a reward. Illustrations are:

Dr. Wright would always tell me that I could lose the weight. He would say, “Well, next summer you can put on your bikini.”

He said, “You have active adult type 2 and you can control this with your weight and exercise. You don’t have to be on insulin or pills or anything. This can be done.”
In the majority of instances (50%), supporters simply expressed an understanding for the difficulty that the diabetic undoubtedly experienced in making long-term lifestyle changes.

"You know it must be hard for you Marsha, because you are diabetic -- to be thinner or to regulate your weight."

She (physician) would say to me every time I went in practically, "You can't be prefect. So if something happened this week that you know you shouldn't have done, it is okay. Think of it as you rewarded yourself for your other good days." And that is probably the one thing that keeps me going.

Compliment. Nearly equal to perceptions of encouragement, study participants mentioned expressions of praise as helpful. When the diabetic had successfully controlled her weight, successfully changed her diet, or successfully controlled her glucose level, supporters noticed and made statements acknowledging these accomplishments. Fifty-nine percent of the compliments addressed weight loss and healthy food choices/preparation (see examples 1, 3, and 4 below).

Health professionals expressed 41% and family members expressed 24% of the seventeen compliments mentioned by the study participants. Others including friends, co-workers and people in general equally (12%) provided compliments.
The following statements are representative of the compliments received by study participants:

I put on some pants that I had gotten for Christmas and my son told me I needed a belt. I told him that the doctor said I had lost three pounds. He said, "That’s good. I can tell mama. I can tell because your pants won’t stay up like they use to and they are baggy. I wish I could lose like that, but it’s hard; it’s hard."

I don’t test myself everyday because I had it so monitored (blood sugar) that the doctor said, "You’re fine, you don’t need to buy one of those monitors."

When I lost the 40 pounds everyone would say, “Gosh you look great!” They would tell me that my skin was even glowing because I was eating so healthy.

They would say things like, “Oh, I really like this chicken. I really like fried chicken but this grilled chicken is very good.”

Refrain. Finally, in addition to perceptions of deterrence, encouragement and compliment, study participants mentioned the refrain of others as helpful. This was a rare sign of support (see Table 4.1) that was accomplished by family members (88%) and friends (12%). In refraining, family members and friends held back and did not comment on the actions of the diabetic. Specifically (100% of the instances in this category), the harmful food choices made by the diabetic were not discussed.

Linguistically, the diabetic interpreted the refrain as an
endorsement of the judgment she made or as a validation of her self-concept. For example:

I will eat any desserts I want-- candy, anything and they just laugh at me and kinda roll their eyes sometimes. Most of the time they don’t even do that cause they know me. I eat what I want.

The kids don’t say “oh, Mom, what are you doing? You know you’re not supposed to have that piece of cake.” I think they trust that I’ve got good judgment.

Supportive Actions

Study participants discussed both the messages and actions that they found supportive. Overwhelming, the verbal messages (60%) received from various others including, family members, health professionals, friends, and co-workers were deemed most helpful. However, 40% of the support discussed by the study participants were the actions taken by others. All (71) supportive actions were in the form of tangible assistance (see Table 4.2). These pro-health actions were related to the diabetic regimen.

Supporters, including family members, friends, co-workers, and health professionals assisted the diabetic primarily with diet/meal planning and preparation, monitoring insulin and blood pressure levels and with learning more about diabetes. Help with exercising appeared to be rare. Other help was in the form of loans, transportation, and housework.
<table>
<thead>
<tr>
<th>Types</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diet</td>
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<td>62.0</td>
</tr>
<tr>
<td>Monitoring</td>
<td>13</td>
<td>18.3</td>
</tr>
<tr>
<td>Education</td>
<td>5</td>
<td>7.0</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>12.7</td>
</tr>
</tbody>
</table>

Table 4.2: Frequencies and percentages of supportive actions in the form of tangible assistance. $N = 71$.

Tangible Assistance: Diet. Most often, assistance with dieting was perceived as helpful. Much like supportive messages, the role of food is central to the supportive act. Fifty-five percent of the actions related to diet were done by family members. They helped with the selection of healthy foods, were careful about eating inappropriate foods in the presence of the diabetic and prepared their own meals containing diabetes-inappropriate items. Health professionals did 27% of the actions mentioned. They provided diet medication and plans for the diabetic. Then friends and co-workers of diabetics accomplished the remaining 18% of supportive acts concerning diet. They demonstrated thoughtfulness by
carefully selecting restaurants and providing healthy food choices for office functions. The following observations of study participants represent diet specific tangible assistance:

My kids and husband were big ice cream lovers. They completely stopped buying that and bringing it into the house for a five or six month period because ice cream was one of my favorite things. They also looked for alternatives to that like freezing sugar free yogurt or going to the yogurt place and getting the sugar free ice cream or yogurt.

(The people that I go out with) try to choose a place that I can get fruits or vegetables or a salad or something of that nature.

He'll (husband) leave out of the kitchen and go upstairs and eat it (something I'm not supposed to have) so I won't see it. I tell him thank you because that's helping me stay on my diet.

Knowing that I don't use salt or pork in seasoning food, my daughter will fix her own the way she likes it. [Respondent is responsible for food preparation for the entire family].

My doctor put me on a 1600 calorie-a-day diet. But I told my dietician that I wasn't losing any weight so she gave me a diet with two 1200-calorie days.

Tangible Assistance: Monitoring. In addition to assistance with dieting, study participants discussed the support they received in monitoring the signs and symptoms of diabetes. This support was provided nearly equally by family members and health professionals. Health professionals provided 46% of the support by taking care of
the diabetic’s feet, checking blood pressure and glucose levels, and changing medication as needed. The actions of family members (54%) were similar to those of health professionals. Family members acted as nurses in helping the diabetic to take medication at designated times, checking blood pressure and glucose levels and providing her with the latest monitoring equipment. The following comments illustrate these supportive acts observed by study participants:

My daughter comes down and takes out her little pouch with the days of the week and she looks at it and says, “You didn’t take your Saturday medicine yet!” I told her that I was trying to get ready for the baby shower. “Well here.” She opens it up (the pouch) gives it (pill) to me and says, “Go ahead, take them.” She makes sure that I take care of myself.

He’ll put my glucose in his pocket or stick it in his sock to make sure I have it when I need it.

They did the basal metabolism rate on me and found that mine is normal but it’s a low normal.

My aunt works for a university in Virginia and they do some kinds of studies on diabetes. She got me a new meter to check my blood sugar with.

Nonsupport

Nonsupportive Messages

As previously mentioned, members of the diabetic’s social network provided support through verbal messages suggesting support is significantly linked to what people
say to one another in interaction. It is evident that nonsupport is linked also to what people say or do not say to one another. (Compare the 73% of nonsupportive messages to the 27% of nonsupportive actions). Nonsupportive messages are linked to compliance as well. The subjects of this study who admitted that they did not follow the medical prescriptions of their doctor(s) ($M = 5.52, SD = 4.00$) recalled significantly more nonsupportive messages than subjects complying with medical prescriptions ($M = 2.61, SD = 2.06$), $t (28) = 2.38, p = .02$. The non-compliant recalled on average 2.9 more nonsupportive messages than the compliant. In the context of the diabetic experience where the issues of diet and exercise determine one’s quality of life, messages characterized by deterrence, indifference, and temptation form the basis of nonsupport (see Table 4.3). Nonsupportive messages are defined, explained and illustrated in the following pages. A comprehensive list of both nonsupportive messages and actions is located in appendix E.
<table>
<thead>
<tr>
<th>Feature</th>
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</thead>
<tbody>
<tr>
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<td>45.2</td>
</tr>
<tr>
<td>Indifference</td>
<td>26</td>
<td>28.0</td>
</tr>
<tr>
<td>Temptation</td>
<td>16</td>
<td>17.2</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>9.6</td>
</tr>
</tbody>
</table>

Table 4.3: Frequencies and percentages of nonsupportive messages. N = 93. Other includes excessive questioning, questionable offerings, encouragement and mixed messages.

**Deterrence.** Overwhelmingly, the diabetic women in this study received messages that attempted to deter harmful eating. These messages were perceived as helpful or unhelpful equally. Forty-five percent of the nonsupportive messages discussed by study participants were expressions of deterrence (compared to nearly 50% supportive; see Tables 4.1 and 4.3). However, unlike supportive messages in this category, nonsupportive messages comprise two types: pro-health deterrence (86%) and con-health deterrence (14%).

Pro-health deterrence is equivalent to the type of deterrence found in the supportive domain. In most
instances (25 of 36 or 69% of the pro-health messages), rule-like terminology (such as shouldn’t and don’t) was used to command the diabetic to not eat at all, to avoid eating a harmful item, or to cease eating a diabetes-inappropriate food. Family members made commands like: “Don’t eat that.” “No, you not eating this.” Health professionals made commands too. For example a nurse commented: “If it tastes good, don’t eat it.” Others (including family members, co-workers, and friends) asked questions about what food items were appropriate and what the diabetic had eaten already. Examples are: “Should you be eating that?” and “What you done ate that you had no business eating?”

Along the supportive domain, in deterring harmful eating, supporters suggested diabetes-appropriate items for consumption, alternative ways for preparing food and restaurants with healthy foods. Nonsupporters rarely made such suggestions in order to deter harmful eating. Instead, many of the remarks directed toward diabetics were impolite, rude, offensive, or insensitive. For example:

While on vacation at my sister’s beach house I got a slice of pizza and a tossed salad and she said, “You just love to eat, don’t you?” [Comment made in a teasing manner by a very thin sister].
I drove past Krispy Kreme and had to get a box of donuts. I brought it home and ate one. He (husband) goes, "Now, what are you going to do with the other eleven?" I told him that he was free to have some. He said, "I don't need them." [Emphasis placed on the word "I"].

She (dietician) told me what I could eat and what I should not eat. She told me to drink water and eat rice. I told her that I don't like this and she said, "Well, you need to change your eating habits. You need to eat to live instead of live to eat."

Usually, deterrence focuses on the prevention of negative behavior as in the case of pro-health deterrence. However, in a few instances (14%), the diabetic was discouraged from engaging in positive health behaviors such as eating diabetes-appropriate foods and taking medication to control glucose levels. When counseled upon diagnosis, diabetics are advised to eat as many as six meals or a combination of meals and snacks a day. Sometimes, this healthy behavior was discouraged. Family members, friends and co-workers equally engaged in con-health deterrence.

For example:

My diabetic girlfriend says, "I don't even know — I don’t know why you buy that stuff. I mean that’s not good. I don’t like that." I asked her to just try some diet drinks. "That stuff is nasty. I don’t want that stuff. I don’t even know why you eat that stuff. Why you buying that?"

"You really do eat a lot," or "You really have to eat a lot real often, don’t you?" Then she [sister that is thin] brags about how little she eats.
My daughter would say, "Mom, do you have to do -- you know, can you do that somewhere else?" [Patient was injecting insulin with a needle].

**Indifference.** In addition to deterrence, study participants evaluated indifference as unhelpful. Twenty-eight percent of the nonsupportive messages fell within this category (see Table 4.3). Study participants who considered themselves non-compliant (M = 1.29, SD = 1.64) recalled one more instance of indifference than the study participants who considered themselves compliant (M = .30, SD = .63), t (22) = 2.25, p. = .03. A Wilcoxon-Mann-Whitney U analysis confirmed that the sum of the average ranks of messages of indifference by the non-compliant (M rank = 18.09, n = 17) was higher than the sum of the average ranks of messages of indifference by the compliant (M rank = 12.12, n = 13) Z (30) = -2.05, p = .04.

Indifference is a demonstration of a lack of interest or concern for the diabetic by holding back and not commenting on her actions or being inattentive to her needs as if what she does and wants does not matter one way or the other. Unlike the instances of refraining, the diabetic expressed anger and frustration in her tone of voice and pitch (paralanguage) as she discussed these instances. Linguistically, she did not comment that this
inattention was perceived by her as validation or non-validation of her self-concept nor an endorsement or non-endorsement of her judgment. Family members (58%), friends (23%), health professionals (15%) and co-workers (4%) showed a lack of interest in the diabetic's actions (e.g., eating inappropriate foods/eating appropriate foods) or were inattentive to her needs as demonstrated by the following observations:

My friends don't say anything.

He (doctor) says "Come in, sit down, how you doing, let me see your blood sugar, nice to see you, we'll see you in three months." It's hard to talk to him. I always feel lost when I go out of there. [Subject discussed how routine her doctor visits had become with standard phrases made by the physician with little indication that he wanted to actually take time to talk with her].

Sometimes, when I wanted to go to lunch at a reasonable time, they (co-workers) would have a meeting and it would go on and on and on. Then I would be off my eating schedule.

"Well you can always get a fruit or something. Get an order of fruit." [The restaurant did not serve fruit].

Temptation. In addition to messages characteristic of deterrence and indifference, study participants discussed other statements (making up 17% of nonsupportive messages) that were made to them that were not helpful in their attempts to diet and eat correctly. Remarks (made by family members, friends and co-workers equally) that
enticed or invited the diabetic to experience pleasure by eating foods outside of the prescribed diet were among these unhelpful messages. Most of the statements (80%) were simple, much like the first three examples below. However, a few (20%) were in the form of a request containing an accusation that the requester was being harmed if the diabetic did not comply with the request. The harm appeared to be deprivation. Examples four and five represent these expressions.

"I just made a pound cake and I’m coming out there and bring you half of it."

"Let’s go get something like a hamburger or hotdog."

"Just a little piece won’t hurt you."

"But I can’t have a drink if you don’t have one. After all it is your birthday. Go ahead and have one. This is a special occasion."

"Why we always gotta go to Wendy’s? I don’t want salad all the time. Come on y’all. Can’t you just give in one day? I want to eat some real food. Y’all eat like rabbits."

Nonsupportive Actions

Other than the ninety-three nonsupportive messages, study participants discussed thirty-five nonsupportive actions. Nonsupportive actions are enticements, cause and effect happenings, and nonevents (see Table 4.4). The role of diet and food in the life of the diabetic was the focus
of the majority of nonsupportive actions (60%). This finding underscores just how important it is for the diabetic to receive support in the area of diet. The remaining actions (40%) involved treatment prescriptions like foot-care and exercising. Definitions and illustrations of the types of nonsupportive actions follow.

<table>
<thead>
<tr>
<th>Actions</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enticements</td>
<td>18</td>
<td>51.0</td>
</tr>
<tr>
<td>Cause-effect</td>
<td>10</td>
<td>29.0</td>
</tr>
<tr>
<td>Nonevents</td>
<td>7</td>
<td>20.0</td>
</tr>
</tbody>
</table>

Table 4.4: Frequencies and percentages of nonsupportive actions. N = 35.

Enticements. The majority of actions deemed unhelpful to the diabetic are enticements. The study participants discussed these actions which were accomplished primarily by family members (55%), friends (28%), and co-workers (17%). They talked about how these actions ignited thoughts within them to eat harmful foods. Family members, friends and co-workers either presented the diabetic with food items or introduced items into the
Diabetic's environment that are known to adversely effect blood glucose levels. Usually, these sugary food items are avoided totally or eaten in moderation by the diabetic. Examples of enticements are:

She bakes and brings me pound cakes.

They will eat candy bars, potato chips and all this right there in my face.

They fixed like Sundays and had cake and stuff and I was like, "Oh, why y'all torturing me?"

At work there is candy everywhere. They keep a big stash right here on the receptionist's desk.

Cause-effect. Other unhelpful actions reported by the study participants were perceived as the agents that brought about negative consequences for the diabetic. These acts were committed by others or by the diabetic herself as instructed by another. Nine (90%) of the ten cause-effect actions mentioned by the study participants involved health professionals. For example, in one case, a diabetic’s toenails were cut by her podiatrist then later a toenail became infected. She saw the infection as a result of the nail being cut too close. In another instance, a diabetic acted on the medical instructions (e.g., double medication) given by a physician and then attributed a later event (e.g., blurred vision) as a consequence of
following the medical prescription. These actions are presented here in the diabetic's own words along with other examples of cause-effect actions.

I go to him (podiatrist) for him to take care of me because he told me don't cut your toenails, but when he did it, he cut it too close that I can hardly walk. The toe got infected and I have to go back so he can numb and take the piece or something.

I thought about the Glucotrol I'm on. He (doctor) had me double it. But since I've doubled it, I'm taking three pills in the morning, two Glucotrols and one Rezilin. Maybe that is too much. Maybe that blurred my vision.

I was on this diet and I lost a lot of weight and my sugar was like nonexistent. It was down as low as 50. But then they took me off this diet and I started climbing back up slowly and slowly.

My dad bought this new orange juice and gave me a cup. I felt tired so I took my blood sugar and it was 234. I looked at the sugar content on the carton and it was way too much.

Nonevents. Mentioned but not as frequently as enticements or cause-effect actions were nonevents. A few of the study participants had expectations that others, especially immediate family members, would assist them with exercising. However, these expectations were not met. Of the nonevents discussed, 86% involved family members while 14% involved co-workers. For example:

We say we are going to walk and we don't do it. It's always too hot or too cool. There is always an excuse.
My mom keeps saying she will (walk) but she’s 68 years old and she doesn’t walk that well on one of her legs. So she’s not able to do it as much.

My son doesn’t get home until 6:00 p.m. when it’s getting dark and he runs off and leaves me [in reference to exercising].

Research Question 2: What are the social settings and circumstances in which supportive and nonsupportive messages and actions are produced?

A comparison of group means based on ethnicity, educational level, marital status, age, income levels, years with the illness, employment status and adherence status uncovered only one significant difference between groups on the type of messages received or actions performed. A Mann-Whitney U analysis revealed a significant difference between African American diabetics and White diabetics on the number of refrain messages recalled. The sum of the average ranks of the refrain messages of African Americans (M rank = 13.06, n = 17) was smaller than the sum of the average ranks of refrain messages for Whites (M rank = 18.69, n = 13) $Z (30) = -2.35, p = .02$. However, although not significant, African-American diabetics (M = 6.70, SD = 4.53) recalled nearly 2
more supportive messages than White diabetics (M = 4.76, SD = 2.61), t (28) = 1.37, p. = .18. Analysis also uncovered that the compliant (M = 8.38, SD = 5.50) averaged nearly 3 more years of lived experience with diabetes than the non-compliant (M = 5.76, SD = 4.86), t (28) = -1.38, p = .17.

Additionally, the majority of supportive messages were received from or actions accomplished by family members (41%) and health professionals (26%). The remaining supportive messages were received from and actions accomplished by friends (14%), co-workers (12%), and other people in general (7%). Like supportive messages, the majority of nonsupportive messages were received from and actions accomplished by family members (48%) and health professionals (17%). The remaining nonsupportive messages were received and actions accomplished by friends (13%), co-workers (8%), and other people in general (14%).

Since the majority of supportive and nonsupportive messages were received from family members and health professionals, it is not surprising that the setting for most of these messages was the home or a health facility (see Table 4.5). Whether supportive or not, most messages/actions occurred when the diabetic was at home in
the company of family members during the course of everyday events. It makes sense that many of the messages received would be in the environment where people are most likely to eat and delivered by those with whom the diabetic interacts with on a regular basis. In fact, 64 (50%) of the nonsupportive messages were received from family members either in the home, while eating out in a restaurant or during the celebration of a special occasion.

<table>
<thead>
<tr>
<th>Setting</th>
<th>#S</th>
<th>%</th>
<th>#N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>53</td>
<td>30.0</td>
<td>38</td>
<td>30.0</td>
</tr>
<tr>
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<td>44</td>
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<td>18.5</td>
</tr>
<tr>
<td>Work</td>
<td>21</td>
<td>12.2</td>
<td>8</td>
<td>6.0</td>
</tr>
<tr>
<td>Restaurant</td>
<td>18</td>
<td>10.0</td>
<td>23</td>
<td>18.5</td>
</tr>
<tr>
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<td>14</td>
<td>7.8</td>
<td>12</td>
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<tr>
<td>Other</td>
<td>26</td>
<td>15.0</td>
<td>24</td>
<td>19.0</td>
</tr>
</tbody>
</table>

Table 4.5: The settings for supportive and nonsupportive messages and actions. #S = the number of supportive messages and actions. N = 176. #N = the number of nonsupportive messages and actions. N = 128. The other category includes instances when no specific place or setting was indicated.
In this chapter, the author discusses theoretical implications, practical implications for counseling diabetics and their families, and concludes with a discussion of the limitations of the current research and future research directions. The perceptions of diabetics that specific messages are supportive or nonsupportive are examined within a framework of content versus form. The discussion includes the application of politeness theory while incorporating the key concepts of self-efficacy, person-centeredness, reasoned discourse and credibility.

**Theoretical Implications**

**Supportive Messages**

Recent investigations (Dakof & Taylor, 1990; Lehman et al., 1986; Lehman & Hemphill, 1990) and data from the present study provide an understanding of support attempts seen as helpful. Studies of the bereaved, cancer and multiple sclerosis patients conclude that expressions of
concern, love and understanding are most helpful. However, when members of the diabetic’s social network attempt to deter harmful eating, compliment, encourage, and refrain, they are perceived as supportive.

Deterrence may be unique to the diabetic experience and other chronic illnesses with a focus on diet. The need for supporters to prevent the diabetic from ever engaging in harmful eating after diagnosis is based upon the impression and medical “fact” that diabetes is a disease within the partial control of the individual. Clearly, the supporter and diabetic have the same primary, ultimate long-term goal — to see the diabetic maintain or establish good health. However, this shared long-term goal may be in conflict with the diabetic’s immediate, short-term goal — to eat what she wishes. Nevertheless, it is the supporter’s responsibility to effectively communicate her intent to see harm prevented. As suggested by a variety of communication scholars (Burleson, 1982, 1984; Cutrona, 1996; Goldsmith & Fitch, 1997), performance is everything.

In evaluating the performance of support attempts, the focus must be on the structure of the message to discern why a message was perceived as helpful. The most sophisticated deterrence messages posed the question of
whether or not the diabetic should eat a particular item, then gave a reason why the choice may/not be a good one and/or suggested alternatives. The least sophisticated deterrence messages were distinguished by rule-like words such as shouldn’t, don’t, and can’t to instruct the recipient to not eat at all, or to avoid eating some specific item. Expressions with rule-like terminology and even statements that question an action of another have the potential to threaten face.

Hence, deterrence involves face work (a term coined by Goffman, 1967, 1974). Face work refers to the ways in which individuals cooperate with one another to promote both social affiliation and the autonomy of the individual (Brown & Levinson, 1987; Spiers, 1998; Wood & Kroger, 1994). Brown and Levinson (1987) argue that people are concerned about positive face (when others like and respect one) and negative face (when one does not feel constrained by others). Therefore, people use politeness strategies to fulfill the face needs of others. The level of politeness a speaker will use is based on the power distance between speaker and hearer, the social distance between speaker and hearer and the ranking of the imposition involved.
In most instances, family and friends deter diabetic women from eating harmful foods. These intimates have minimal power and social distances between them, but a request or demand concerning the food choices of another is very serious. When choosing to utilize the more sophisticated deterrence strategy by posing a question of whether or not the diabetic should eat a particular item, then giving a reason why the choice may not be a good one and/or suggesting alternatives, the supporter is engaged in negative politeness. "Negative politeness is redressive action addressed to the addressee's negative face" (Brown & Levinson, 1987, p. 129). The supporter goes on record with the face-threatening act but simultaneously gives the diabetic an "out." The supporter's message then appears less presumptuous and non-coercive. In other words, any potential threat is mitigated. By giving reasons why one should not eat a specific food, the supporter is including the diabetic in the reasoning process and making apparent their shared desire of good health for the diabetic. The diabetic is "led to see the reasonableness" of the supporter's face-threatening act and effective communication has taken place.
Additionally, "the use of contractions may serve positive-politeness ends as a marker of in-group membership and casual informality" (Brown & Levinson, 1987, p. 270-271). For example, a teenage daughter attempted to deter harmful eating by saying to her mother, "Wouldn't you rather have something else Mom instead of that piece of candy? How about if I get you some celery or carrots? How about I get..." These negative questions "presuppose" a "yes" answer and are "used as a way to indicate that the speaker knows the hearer's wants and thus partially redresses the imposition of the face-threatening act" (Brown & Levinson, 1987, p. 122).

Less sophisticated imperatives like, "Don't eat those cookies," and "Stay away from the soft drinks," are bald-on-record strategies that conform to Grice's (1975) maxims of quality, quantity, relevance and manner. A bald-on-record strategy is used primarily when the speaker cares more about accomplishing the face-threatening act with maximum efficiency than satisfying the face needs of the hearer (Brown & Levinson, 1987). Immediate family members, specifically female members (sisters, mothers and aunts) expressed these less sophisticated imperatives that were evaluated as helpful by the diabetic. These commands
minimize the face threats of diabetics by implication because they are done in her interest. In doing the face-threatening act the supporter conveys caring for the diabetic (and her positive face) and no redress is required. Gender (the fact that both the speaker and receiver are female) may play a role in how these imperatives are perceived.

One finding of my study is that health professionals compliment and encourage as a sign of support bolstering the conclusions of previous studies (Dunkel-Schetter, 1984; Dakof & Taylor, 1990) that physicians’ actions perceived as helpful are along the esteem/emotional dimension. Family members and friends also encourage and compliment. Even though all speech acts have the potential to threaten face, compliments and encouragement may have been less threatening due to the credibility and authority inherent in the positions held by the health professionals. Family members and friends may have had some status within the relationship that helped to make these messages effective (e.g., a mother-daughter relationship).

Compliments and encouragement enacted by credible individuals represent pure unambiguous speech acts. They along with tangible assistance in diet/meal planning,
exercising, monitoring insulin and blood pressure levels, function to reinforce good self-care behaviors thereby enhancing self-efficacy. Since diabetics are susceptible to relapses in dietary behaviors, they need feedback about how they are doing. These positive messages may assist the diabetic in managing negative emotional states such as stress, depression, loneliness, boredom, restlessness and social pressures to eat unhealthy foods.

Self-efficacy refers to a diabetic’s belief in her ability to “organize and execute the courses of action required to manage prospective situations” (Bandura, 1995, p. 2). According to Bandura (1995) one of the most effective ways to develop a sense of efficacy is through mastery experiences. Successes build a belief in one’s personal efficacy. When others recognize and comment on our successes, personal efficacy is reinforced. In adapting new health behaviors, the diabetic does not simply adopt ready-made habits, but acquires the cognitive and behavioral tools necessary to motivate long-term life-style changes through sustained effort. Therefore, messages which compliment and encourage assist the diabetic in recognizing the potential for success experiences around
diet when her ultimate goal is to engage in healthy self-care behaviors.

One aspect of politeness that is not discussed in the literature is silence. Technically, most communication scholars would argue that silence is not a speech act. However, an interpretation of silence in the presence of another that is understood to mean something by the other constitutes a nonverbal speech act. In many respects, the effect of silence may be greater than that of the spoken word as in the case of refraining (holding back and not commenting on something). The message may be communicated through the eyes and other facial expressions. Under these circumstances, silence can be viewed as a redressive, bald-on-record strategy. Grice's maxims are not violated because nothing needs to be said. It is as if "the message" is lingering invisibly between the two interactants but both are aware of its existence. And, in not formally verbalizing "the message" the faces of both the speaker and hearer are protected. Most important is the interpretation of the diabetic that the refrain is a validation of her actions and self-concept.
Nonsupportive Messages

The notion of minimization as discussed in the work of Lehman and Hemphill (1990) was not evident in the messages received by diabetics. The severity of the illness is not questioned, nor its existence denied. This may be due to the increase of information available about diabetes through national and local health campaigns. However, messages characterized by pro-health deterrence, con-health deterrence, indifference and temptation form the basis of nonsupport in the context of the diabetic experience.

All nonsupportive messages directed toward diabetics lack person-centeredness. Person-centered messages "reflect an awareness of and adaptation to the subjective, affective, and relational aspects of communicative contexts" (Zimmermann & Applegate, 1992, p. 243). Clearly, pro-health deterrence marked by rudeness, con-health deterrence, indifference, and temptation deny individual perspectivity by condemning or ignoring the specific feelings that exist for the diabetic. The majority of these messages are attacks directed toward the self-concept of the diabetic. All are face-threatening acts without redress that have harmed or damaged both the positive and negative faces of the diabetic. Each statement fails to
provide a rationale for compliance, an opening for further
discussion or a way "out" for the diabetic.

Factors impacting pro-health deterrence (particularly
the less sophisticated imperatives) and temptation may be
the social and power distances involved. Generally, the
speaker is a family member or friend with neither
(particularly the speaker) having superior power status.
Even in situations involving co-workers, most are of equal
status and not necessarily on good terms with one another.
The speaker appears to have her/his self interests in mind
in wanting to eat a particular food in a specific
restaurant, or in not wanting to be inconvenienced by
spending time talking with the diabetic. This self-
interest may be momentarily more important than the face
needs of the hearer.

Overall, nonsupportive messages and actions (i.e.,
enticements, cause-effect, and nonevents) function to
undermine self-efficacy. These messages negatively impact
the diabetic's belief in her own ability to follow through
with the medical prescriptions of her doctor. Since
diabetics are constantly dealing with high-risk situations,
lapses in healthy eating and exercising are very high.
Therefore, negative emotional states brought on by
nonsupportive statements and actions, interpersonal conflicts, as well as social pressures to eat forbidden foods, can trigger ineffective coping strategies.

Context

Many researchers (Schlundt, Rea, Kline & Pichert, 1994; Schlundt & McFall, 1987; Schlundt & Bell, 1987; Schlundt, Sbrocco, & Bell, 1989; Schlundt & Zimering, 1988; Schlundt et al., 1991) seriously underestimate the context of the health facility (whether a hospital, clinic or private practice office) as an obstacle to dietary adherence (see Table 4.4). These scholars failed to uncover the importance of this setting because they focused only on the places where food is actually consumed. However, as in the case of cancer patients (Dunkel-Schetter, 1984), the comments and actions of health-care providers are very important to diabetics. Health professionals are clearly significant others in the diabetic's successful and unsuccessful attempt to adopt and practice healthy self-care behaviors (Lo, 1999; MacLean & Lo, 1998).

Numerous studies document the importance of the work environment, restaurants, and social events/special occasions on dietary adherence (Schlundt, Rea, Kline &
Pichert, 1994; Schlundt & McFall, 1987; Schlundt & Bell, 1987; Schlundt, Sbrocco, & Bell, 1989; Schlundt & Zimering, 1988; Schlundt et al., 1991). And, while this study did not specifically investigate adherence differences, it appears to support previous findings in assessing these settings as potential obstacles to dietary adherence (see Tables 4.4). Eating in restaurants and during various social events (i.e., birthday celebrations, holidays, and vacationing) are settings in which both supportive and nonsupportive messages are received. Across the board when friends provided foods within the prescribed diabetic diet, showed deference to the diabetic, and/or questioned the diabetic's food choices sensitively, the situation was assessed as supportive.

It is not uncommon for the diabetic to do a lot of self-evaluation about the reasons she does or does not comply with medical prescriptions. Reasons for compliance range from a lack of family pressure due to living alone, to the lack of peer pressure in not having friends. She discusses the role of God in her life and witnessing severe consequences of the illness for others. She is motivated to educate herself about the illness, loves healthy foods and/or lacks stress and anxiety in her life. Reasons for
noncompliance range from stress in the work place, depression, defiance of another’s wants and a lack of personal willpower. Noncompliance is attributed also to misinformation about the cause and meaning of the illness, a lack of acceptance of the diagnosis, a lack of knowledge about food exchanges, and a redefinition of what it feels like to be "normal."

In summary, the author developed a typology of supportive and nonsupportive messages in the context of the diabetic experience. These messages have theoretical implications for the use of politeness strategies in facilitating and reinforcing the self-efficacy of diabetics and in developing intervention programs aimed at communication competence for her social network. Family members, health professionals, friends, and co-workers were all found to have a stake in diabetic compliance with healthy self-care behaviors (i.e., diet and exercise).

Counseling Implications

In a nationwide sample, 76% of people with NIDDM reported having never attended a diabetes education class or any other education program about diabetes (Clement, 1995). Nonetheless, it can be very useful for diabetic patients and members of their social network(s) to receive
extensive counseling in illness management. Counseling would assist the NIDDM patient in developing allies who can help ease behavioral change, reduce obstacles to maintenance, and be supportive during failures and successes (Burke & Dunbar-Jacob, 1995). The focus of counseling could be the identification of relevant social environments and messages that might be altered to increase support for dietary changes.

Within an intervention program having a framework of empowerment, bolstering the self-efficacy of the diabetic is very important. An intervention program or diabetes education program can teach the diabetic skills to handle the sign and symptoms of her illness, but skill attainment means little when a person doubts her capabilities. However, the combination of skill acquisition with social validation may reduce or eliminate doubts about one’s abilities.

An individual’s self-efficacy beliefs are constructed from various sources of information. Primary sources of self-efficacy beliefs include learning from one’s own experiences and learning from the experiences of others. Verbal persuasion and other types of social influence that convince one that she possesses certain capabilities, and
the physiological and affective states from which she judges her own capabilities are also sources of self-efficacy beliefs (Bandura, 1995; 1997).

As stated previously, messages that encourage and compliment the diabetic's efforts to follow medical prescriptions constitute verbal persuasion that informs and reinforces the diabetic's beliefs in her ability to make difficult lifestyle changes. An intervention program would teach the diabetic to recognize these validating supportive messages and to use them in self-persuasion exercises. Predictably, the constant and consistent exercise of generating thoughts about the compliments and encouragements received (and repeating them out loud over and over again) will keep the successes of the diabetic uppermost in her mind facilitating attitude change and behavioral modification. The diabetic could be directed to take the successes of experiences external to diabetes (i.e., other compliments) and incorporate them into an overall thought and verbal pattern of "I have good reasons to believe I can make these lifestyle changes." The incorporation of positive perceptions of experiences outside of the domain of the diabetic experience is essential in attitude change because small successes in
other areas can lead to higher accomplishments even in new settings and at new activities (see Jerusalem and Mittag in Bandura, 1995). The diabetic would be taught how to actively share her accomplishments with others to further bolster the impact of these supportive messages on her own sense of self-efficacy.

Additionally, the diabetic can be taught how to "see" instances of indifference as supportive refrain. Again, exercises can be designed to assist her to think differently about and re-interpret what did or did not happen. In re-interpreting indifference as supportive refrain, the diabetic is bolstering her sense of self-efficacy because she can take those experiences and verbally express them in a form that validates her healthy behaviors.

The diabetic can be taught to model healthy lifestyle changes. In cooperation with health professionals, a health communication expert could design a series of exercises that would give the diabetic experience with the utility of skills learned and knowledge obtained in a diabetes education program. For example, after teaching the diabetic how to use compliments and encouragements she receives to bolster her self-esteem, she could be
videotaped in simulations with confederates talking about her successes and the failures and what was learned. Other exercises may include responding to messages of temptation and indifference, successfully preparing diabetes-appropriate meals, foot care, blood-glucose monitoring, etc. Then she would be required to periodically review the tapes to further reinforce the belief that she is capable of accomplishing healthy behaviors.

According to researchers, the most promising strategy in preventing poor compliance is a combination of interventions including multi-component behavioral strategies, patient education, contracts, self-monitoring, telephone follow-ups and tailoring to individual needs and backgrounds (Clement, 1995; Miller et al., 1997; Burke & Dunbar-Jacob, 1995). Obviously, consultations with an expert in both diabetes and communicating social support could be beneficial. The expert could map an individual’s personal needs through a personal interview, develop a plan for targeting specific individuals within the social network or problematic social situations, assist in lifestyle changes, work on self-esteem issues and conduct follow-up evaluations.
However, the responsibility of achieving and maintaining good health is not the sole responsibility of the chronically ill. As indicated by the numerous supportive and nonsupportive messages received by diabetics from those in the health arena, physicians, nurses, nutritionists and dieticians play a key role in the success of diabetics. The results of this study specifically highlight the impact of health professionals in using compliments and encouragement. Due to the authority and credibility inherent in the health profession, intervention then should include the education of these parties in how to use compliments, encouragement, and supportive deterrence constructively and frequently. The elimination and prevention of cause-effect actions would be addressed to ensure and/or facilitate an aura of credibility. Health professionals would be encouraged to continue their efforts at tangible assistance in the form of diabetes education, help with foot care, and monitoring the signs and symptoms of diabetes.

Additionally, the communication expert could act as a liaison between the diabetic and health professionals. A formal discussion of the patient’s daily interactions with a health communication expert could serve a number of
functions. First, such a discussion would provide the nutritionist or dietician with a wealth of information to assist the patient in meal planning. Such a discussion would require that both the patient and medical personnel (including the primary physician) consider the illness situation in a realistic light. Second, the communication expert would be in a position to adequately mediate misunderstandings with health professionals. In the process of sharing information, the medical personnel would have a better understanding of the daily experiences that impact compliance attempts and thereby be better able to plan an attack to get the patient back on track while monitoring their own communication.

Intervention directed toward family members, friends and co-workers would concentrate on the good and bad ways to enact support. The focus would be on both the form a message takes and its content. Fact-sheets, brochures or booklets could be devised to outline and demonstrate problematic situations and to advise supporters of more effective steps to take. Common examples of messages that have been evaluated as helpful and unhelpful would be included.
For example, based on the results of this study, the researcher would advise that in the act of deterring inappropriate behavior (e.g., eating three slices of buttery pound cake), rule-like terminology is avoided and alternative suggestions made. The researcher would advise supporters with relevant experience with dieting, illness, or exercise (which lends credibility) to use lots of encouragement and compliments. Weight loss, proper preparation of foods and the overall control of the illness should be especially encouraged and complimented. Family members, friends and co-workers of long-term compliant African-American diabetics should exercise refrain more often when witnessing inappropriate behavior relevant to the experience of diabetes. Similarly, when family members, friends and co-workers have knowledge that the diabetic is consistently compliant, acts of indifference should be minimized.

Furthermore, it is advisable to avoid making comments and to engage in actions that tempt and entice the diabetic to eat inappropriate foods. One should never discourage the diabetic from healthy behaviors, and always follow-through on promises made to assist with exercising. Supporters would be encouraged to increase their efforts in
modeling healthy eating and exercising and with tangible assistance in dieting, monitoring the signs and symptoms of the illness and diabetes education.

A more intense intervention might call for concerned family members, friends, or co-workers to attend a workshop on social support with NIDDM patients. A communication expert would serve as moderator for the sessions giving participants an opportunity to role-play the lived experiences of NIDDM patients. It would provide an open forum for several NIDDM patients to share their positive and negative experiences in a non-threatening environment. This interaction could lead to intense discussions about the comments made in support attempts.

Conclusion

In conclusion, it is clear that the daily experience of diabetes is a constant attempt to control the signs and symptoms of the disease, and that among the most salient and positive factors influencing adherence is social support. The results of this study substantiate this position.

The author has presented a typology of supportive and nonsupportive messages based on a sample of 30 individuals. She is confident that the results add significantly to our
knowledge and understanding of the lived experiences of women with diabetes. She agrees with the assertion of many scholars (and particularly that of Riessman, 1993, p. 70) that "the ultimate goal of social science is to learn about substance, make theoretical claims through method and learn about the general from the particular." As a result, the author views the attention to the experiences of 30 individuals as a starting point of analysis, not the end point.

The author acknowledges that her inquiry into the context and content peculiarities of supportive and nonsupportive messages did not work as well as she expected. A change in methodology might lead to more information in this area. One method might consist of semi-controlled simulations with both the diabetic and members of her social network. However, knowledge has been gained into the type of messages and actions that are unmistakably supportive (i.e., compliments, encouragement and tangible assistance) and non-supportive (i.e., con-health deterrence, temptation, enticements, cause-effect actions and nonevents) in the context of the diabetic experience.
Clearly, messages of deterrence are frequent in the lived experience of diabetes and future research might clarify the various forms these messages take in an evaluation of support or nonsupport by diabetics. The author would like to further assess the differences and similarities between supportive refrain and nonsupportive indifference. Probing in the interviewing process may have lead to a distinction that may or may not exist. At any rate, it is evident that silence or the failure of others to say something in reference to the behaviors of diabetic companion is important. Additional research could determine the link between the number of years a diabetic has lived with diabetes and the number of refrain or indifference instances recalled/experienced. Failure to establish this link is probably a result of the number of instances in these categories.
APPENDIX A

STUDY: SOCIAL SUPPORT AND WOMEN WITH NON-INSULIN-DEPENDENT DIABETES

PARTICIPANT REQUIREMENTS:

Must have been diagnosed with Type II, adult-onset, or non-insulin dependent diabetes

Female between the ages of 35 and 75

Currently dieting and/or have been instructed to diet by a physician

Not pregnant

Willing to participate in a one-time only session for 30 to 60 minutes in which you will be interviewed about your diet experiences

***YOU WILL BE PAID $20.00***

TO PARTICIPATE CONTACT:

DARLENE K. DRUMMOND
Assistant Professor
Department of Communication Studies
The University of North Carolina @ Charlotte
235F Fretwell Building
9201 University City Boulevard
Charlotte, NC 28223-0001

(704) 547-2855 or (704) 503-4434

(Please leave a message! Your call will be returned as soon as possible.)
APPENDIX B

INTRODUCTION AND ORAL TELEPHONE SOLICITATION

Hello, _____________. My name is Darlene K. Drummond. I am an Assistant Professor in the Department of Communication Studies at the University of North Carolina @ Charlotte. Thank you for inquiring about participation in the study, Social Support and Women with Non-Insulin-Dependent Diabetes Mellitus. This research is intended to provide insight into the communication surrounding the diabetic woman’s everyday experiences.

For this study, we are interested particularly in what your family members, friends, peers, co-workers, and/or significant others say that either helps or hinders your attempts to adhere to your diabetic self-care regimen, specifically dieting. If you agree to participate, you will be asked a series of demographic questions and questions about your experiences with dieting or eating healthy. This would be a one-time interview with me for only 60 to 90 minutes. You will be free to withdraw your consent to participate at any time without prejudice.

Throughout the length of the project, your identity shall remain confidential. Your responses will be audio-taped, transcribed, and later reviewed by the principal investigator and research team. The audio-tapes and written transcripts will be secured in a locked file cabinet and at no time be handled by anyone other than the
investigators of this study. All material will be retained for four years as required by university policy and then subsequently destroyed. In short, at no time will any of your responses be linked to you personally; instead all comments will be attributed generally to "a woman with diabetes."

The interview will take place at a time and place convenient to you. For your participation, you will be paid $20.00. To obtain further information about me, the study, or to verify its legitimacy, please contact Dr. Bill Hill, Professor & Chair, The Department of Communication Studies, University of North Carolina @ Charlotte, (704)547-4005.

Before we schedule a time and place for the interview, I would like to ask a few questions to make sure you meet our criteria.

Questions:
(1) How did you hear about or learn about this study?
(2) At what age were you diagnosed with diabetes? (NOTE: If doing childhood, not Type II, can't participate)
(3) Are you currently dieting or have you ever been instructed to diet by a physician to control your diabetes? (NOTE: If "no," can't participate)
(4) During the months of February and March, when would you be available for the interview?
Where would you like to have the interview? Time?

IF DETERMINED NOT ABLE TO PARTICIPATE BASED ON CRITERIA:

Thank you for calling and taking the time to inquire about our study. At this time, we are unable to interview you based on our prescreening guidelines. However, please encourage your diabetic friends to contact us.

IF DETERMINED ABLE TO PARTICIPATE:

I would like to schedule your interview for ______ at ____. The interview will take place at ______________. To confirm, I will call at least two days before. Thank you. I look forward to meeting you.
APPENDIX C

Subject # ______

Part I: Outcome Expectancies

1. To what extent do you think that following your diet is important for controlling your diabetes? Very unhelpful, somewhat unhelpful, somewhat helpful, or extremely helpful?

<1> VERY UNHELPFUL
<2> SOMEWHAT UNHELPFUL
<3> SOMEWHAT HELPFUL
<4> EXTREMELY HELPFUL
<8> uncertain/don't know/refused

2. To what extent do you think exercise is important for controlling your diabetes? Very unhelpful, somewhat unhelpful, somewhat helpful, or extremely helpful?

<1> VERY UNHELPFUL
<2> SOMEWHAT UNHELPFUL
<3> SOMEWHAT HELPFUL
<4> EXTREMELY HELPFUL
<8> uncertain/don't know/refused

3. To what extent do you think that following your diabetes treatment (dieting) is important for delaying and/or preventing long-term diabetes complications (problems related to eyes, kidneys, heart, or feet)? Very unhelpful, somewhat unhelpful, somewhat helpful, or extremely helpful?

<1> VERY UNHELPFUL
<2> SOMEWHAT UNHELPFUL
<3> SOMEWHAT HELPFUL
<4> EXTREMELY HELPFUL
<8> uncertain/don't know/refused
PART I: Interview Questions:

(1) You get together with friends late one evening to play cards. One friend suggests calling out for pizza. You feel that you really should not snack because you have already had supper. However, you are tempted because pizza has always been one of your favorite foods. But since it is late, another friend suggests fruits, and vegetables with some dip. The others agree. You eat the fruit and vegetables and are content.

Have you ever felt like that? Tell me what happened. What did __________ say to you that you feel helped in the situation? (Probes: Where did this happen? When? Were there other people around? Is this person a relative, friend, coworker or what? Anything else like this ever happen? If so, what? Why do you think the message affected you like it did? What else does this person do to support you? )

(2) You try to follow your meal plan but you are sometimes discouraged because no one supports you in your efforts. For example, no one in your family seems to notice that you have lost weight. You feel that no one understands how you feel and how hard you try. Sometimes you feel like it's not even worth all the trouble. It is a week after that huge Christmas dinner when you proudly ate only one small serving of everything. Today the family is having its New Year feast and you eat as much as you want. Your sister can not resist commenting on how much you are eating. You feel bad.

Have you ever felt like that? Tell me what happened. What did __________ say to you that you feel was not helpful in the situation? (Probes: Where did this happen? When? Is this person a relative, friend, coworker or what? Were there other people around? Anything else like this ever happen? If so, what? Why do you think the message affected you like it did? What else does this person do that is not helpful to you? )
You have had an awful day. You were in line for a promotion and someone else got it instead of you. When you went to pick up your laundry at the dry cleaners, they had lost it. Then you got a flat tire only three blocks from home. You feel like "pigging out." You don't care what you're supposed to eat, you are really depressed and you think that you deserve something special. You meet your friend at the "all you can eat" buffet and tell her what happened. Your friend, who knows about your diabetes, means well but she encourages you to eat a big piece of chocolate cake and you do.

Have you ever felt like that? Tell me what happened. What did __________ say to you that you know was intended to be helpful, but wasn't? (Probes: Where did this happen? When? Is this person a relative, friend, coworker or what? Were there other people around? Anything else like this ever happen? If so, what? Why do you think the message affected you like it did? What else does this person do with the intent to be supportive but isn't?)

Part III: Demographic Information

(1) What is your current marital status?
   <1> married/cohabiting/living as married
   <2> separated/single/never married/widow
   <9> refused

(2) Last week were you working, going to school, keeping house, retired, or what?
   <1> working
   <2> going to school
   <3> keeping house
   <4> retired
   <5> other _____________
   <9> refused

(3) What do you consider your main ethnic or racial group?
   <1> African American/Black/Negro
   <2> White/Caucasian/Mixed European
   <3> Native American/American Indian
   <4> Hispanic/Puerto Rican/Mexican American
   <5> Asian/Chinese/Korean/Middle Eastern
(4) What is the highest grade or year of school you have completed?

<1> Elementary (1 to 8 years)
<2> High School (9 to 12 years)
<3> Some College/2 Year Program/Associates Degree
<4> Bachelor's Degree
<5> Master's Degree
<6> Doctorate/Advanced Degree
<9> Refused

(5) Excluding yourself, how many adults, 18 years or older, live in your household? __________

(6) How many children, 17 years of age or younger, live in your household? __________

(7) Would you say your total household income from all sources is...

<1> 0 - 10,000     <2> 10,001 - 20,000
<3> 20,001 - 30,000 <4> 30,001 - 40,000
<5> 40,001 - 50,000 <6> more than 50,001 <9> refused

(8) Age? __________

(9) Overall, would you say that you follow or do not follow the medical regimen suggested by your physician?

<1> no     <2> yes
APPENDIX D

CODEBOOK

Unit of analysis

The paragraph is the unit of analysis with which we will be working.
Since our data is discourse, think of the paragraph as connected discourse. Meaning it
is a collection of related utterances dealing with a single topic. A paragraph begins with
a focus or major point of discussion and does not end with another focus or wander into
another idea. The utterances are held together by logical and verbal bridges. A logical
bridge is formed when the same idea of a topic is carried over from utterance to
utterance. A verbal bridge is formed when key words are repeated in several utterances;
when pronouns are used to refer to nouns in previous utterances; and when transitional
words are used to link ideas from different utterances.

Most paragraphs contain a topic sentence that indicates in a general way what
idea or thesis the paragraph is going to address. The topic sentence can occur anywhere
in the connected discourse. It is possible that the topic sentence is not clear-cut at all.

The paragraphs contain information about a specific situation the interviewee
shared. It contains details about the participants in the encounter, what was said, or done
and the interviewee’s interpretation of the encounter. Paragraphs vary in length from one
utterance to nearly fifteen. We need to identify messages and actions within the
paragraphs. Messages are communications sent between individuals. In this study, we
are primarily interested in focusing on the verbal or nonverbal messages that the
interviewees recall receiving from others. In some cases these messages will be obvious
because they are in quotations. However, actions (what another person did) will be more
difficult to locate. You are to look for these recalled messages or actions and underline
them.

Coding

The term code refers to a 3-character symbol or a 6-character symbol that defines
what our unit of analysis—the paragraph is about. Each paragraph is a unit that receives
a code. Your focus is on learning what the code options are and then assigning them to
units. Each paragraph unit will be assigned a 3-character code, which refers to theme,
level and direction, OR a 6-character code referring to theme, direction, level, social
network integration, feature and context. These categories are defined and illustrated
below.

Content Categories

Theme

The theme of a paragraph refers to its’ global topic (i.e., what the overall
paragraph is about). Since this is a system for assessing discourse about health behaviors,
the themes are intended to identify general topics likely to arise in a discussion about
diabetes. All units receive one (and only one) theme code. The theme codes are listed
below under “Symbol.”
<table>
<thead>
<tr>
<th>Theme</th>
<th>Symbol</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td>D</td>
<td>When a paragraph consists primarily of utterances about how the person was informed about her condition. This includes talk about when the person first learned she had diabetes.</td>
</tr>
<tr>
<td>Causes</td>
<td>C</td>
<td>When a paragraph consists primarily of talk about how someone becomes diabetic. Includes statements that the illness “runs in the family,” or is a result of poor diet.</td>
</tr>
<tr>
<td>Reasons</td>
<td>R</td>
<td>When a paragraph consists primarily of talk that analyzes, draws conclusions or attempts to explain why the individual has successfully or unsuccessfully managed the illness. This includes statements that infer compliance or lack of compliance to a diabetic regimen is due to stress, negative emotions such as anxiety, loneliness, depression, anger, fear, feelings of deprivation, relationship problems (including relationship management), faith in God, death of a loved one, willpower, education, competing priorities.</td>
</tr>
<tr>
<td>Food</td>
<td>F</td>
<td>When a paragraph consists primarily of utterances that discuss various foods eaten, the enjoyment of foods, or the lack of enjoyment surrounding eating certain foods.</td>
</tr>
<tr>
<td>Exercise</td>
<td>X</td>
<td>When a paragraph consists primarily of talk about the need to, enjoyment of or the problem(s) associated with working out.</td>
</tr>
<tr>
<td>Level</td>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>Life</td>
<td>L</td>
<td>When a paragraph consists primarily of utterances about <em>personal or social aspects of the person’s life or lifestyle</em>, that do not directly relate to the topic of diabetes. Includes small talk and chitchat on non-medical subjects (e.g., vacations, sports, and current events). Included here are opening and closing rituals common in conversational interactions.</td>
</tr>
<tr>
<td>Treatment</td>
<td>T</td>
<td>When a paragraph consists primarily of utterances about medications or behavioral remedies (e.g., diet, exercise) that have been prescribed, or used to treat the condition (e.g., insulin), or tests used as a preventive measure to monitor the condition. Includes references to “testing one’s blood sugar or glucose levels.”</td>
</tr>
<tr>
<td>Symptoms</td>
<td>Y</td>
<td>When a paragraph consists primarily of utterances that describe the <em>symptoms</em> of diabetes or how the person experiences the medical condition. For example, statements about feeling tired, frequent urination, increases or decreases in blood sugar, pain, moods, sexual problems, changes in sleep patterns, etc.</td>
</tr>
<tr>
<td>Prognosis</td>
<td>P</td>
<td>When a paragraph consists primarily of utterances that discuss the long-term aspects of the medical condition, such as how the person expects to feel if she follows or fails to follow the instructions of a doctor and/or dietician; whether or not complete recovery is expected, etc.</td>
</tr>
<tr>
<td>Other</td>
<td>O</td>
<td>When a paragraph consists primarily of utterances about something other than the themes defined above.</td>
</tr>
</tbody>
</table>

**Level**

Level codes refer to two levels (message-based and action-based). A paragraph should be examined to determine where the situation discussed is either message-based or action-based. Please **assign one** (and only one) of the **following level codes to each paragraph:**

102
Assign M for message-based if

The paragraph addresses verbal or nonverbal expressions of caring, sympathy, concern, and attachment, a lack of concern or a lack of caring. Includes references to such behaviors as hugging, touching, kissing and advice giving.

Assign A for action-based if

The paragraph addresses concrete assistance whereby goods or services were or were not provided/offered. Includes statements about the provision of transportation to the doctor’s office, loans, etc.

**Direction/Evaluation**

In this section, we are primarily interested in focusing on how the respondent evaluated messages she recalls receiving from others and the actions preformed by others. Paragraph direction then generally refers to whether the respondent evaluated an action or verbal/nonverbal message of another as helpful or not helpful. In other words, direction codes identify a set of utterances or an action as indicative of support or nonsupport. It will be necessary to use the entire paragraph to make this determination.

Each paragraph is assigned either an N code, an S code or a U code as follows:

Assign an N if the paragraph

Does not refer to comments or actions of others directed toward the interviewee. Especially assign if the individual is referring to her own actions, thoughts, or comments. Assign when the interviewee refers to stories about the experiences of others with diabetes. Also assign when the interviewee refers to what someone “should or could have said,” or “should/could have done.”

Assign an S if the paragraph

Is about verbal or nonverbal expressions or actions of caring made (done) by another that are perceived as helpful to the respondent in achieving her goals.

Assign a U if the paragraph

Is about verbal or nonverbal expressions or actions of noncaring made (done) by another that are perceived by the respondent as unhelpful in achieving her goals.
Social Network Integration

Once you have determined the respondent’s evaluation of a situation as either supportive or non-supportive, please indicate **from whom the message was received or who took the action**.

One of the following numbers should follow a direction code of S or U only.

1. Reference to immediate family generally (made/done by more than one family member as indicated by “they,” “my husband and son,” “my children”)

2. Daughter(s), sister(s) or mother (regardless of residence; includes any other female relative living with respondent)

3. Son(s), brother(s) or father (regardless of residence; includes any other male relative living with respondent except the husband)

4. Husband

5. Extended family (Includes family members not living in household like aunts, uncles, niece, in-laws, etc.)

6. Co-worker(s)

7. Health professional (i.e., nurse, doctor, nutritionist, etc.)

8. Friend(s) (non-relatives including church members)

9. Reference to a combination of the above (i.e., “my family and friends,” “my support system,” “somebody”)

Features

Feature codes refer to the structure, form or characteristics of a message or the type of action taken. A feature is a distinguishing trait, quality or property of a message/action. Below are the specific feature codes that can be identified along a message-based level or action-based level of support or non-support.

Only those features listed for the message-based level should be utilized with an assignment of M for level. Only those types listed for the action-based level should be utilized with an assignment of A for level.
<table>
<thead>
<tr>
<th>Level</th>
<th>Feature Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Message-Based</td>
<td>1</td>
<td><strong>Encouragement</strong> - statement that provides the recipient with hope and confidence (i.e., “Everything will be okay”).</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td><strong>Empathy</strong> – statement expressing understanding of the situation or discloses a personal experience that communicates understanding.</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td><strong>Sympathy</strong> – statement expressing sorrow or regret for the recipient’s situation or distress.</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td><strong>Affection</strong> – shows caring through physical contact including the mere presence of another, hugs, kisses, patting, etc.</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td><strong>Relief of Blame</strong> – statement made to alleviate the recipient’s feelings of guilt (i.e., “You are not diabetic because of what you eat!”).</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td><strong>Compliment</strong> – Positive things said about the recipient that emphasizes her abilities (i.e., “You have lost weight!” “That sugar-free cake is really good!”).</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td><strong>Rudeness</strong> – abrupt, discourteous, patronizing, or insensitive remark(s). Includes comments that minimize or question the severity of diabetes or its complications. Includes attempts to discuss illness when the patient doesn’t care to.</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td><strong>Avoidance</strong> - Statement indicating that one avoids contact or fails to further associate with the respondent after illness diagnosis.</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td><strong>Listening</strong> – Statement indicating that another is attentive to the comments of the patient.</td>
</tr>
<tr>
<td>Dimension</td>
<td>Feature Code</td>
<td>Definition</td>
</tr>
<tr>
<td>-------------------</td>
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</tr>
<tr>
<td>Message-based cont.</td>
<td>10</td>
<td><strong>Recognition</strong> – when another sees something is physically or emotionally wrong (different) about the patient and then suggests she get help.</td>
</tr>
<tr>
<td></td>
<td>11</td>
<td><strong>Validation</strong> – an expression of agreement with another’s point of view.</td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>Offered/provided informational assistance by referring one to some other source of help (i.e., “Maybe you should see Dr. Smith…”).</td>
</tr>
<tr>
<td></td>
<td>13</td>
<td><strong>Teaching</strong> – Provided informational assistance by giving detailed information, facts, or news about diabetes or about the skills needed to deal with the illness.</td>
</tr>
<tr>
<td></td>
<td>14</td>
<td><strong>Advised</strong> or <strong>suggested</strong> specific actions that should be taken (i.e., “let’s go to Golden Corral where there is a salad bar”). Does not include referrals to other sources of help</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>Any statement along the message-based level that does not clearly fit into one of the above categories.</td>
</tr>
<tr>
<td>Action-based</td>
<td>1</td>
<td>Offered/provided tangible assistance in the form of a loan (including lending money, diet materials, exercise equipment).</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Offered/provided tangible assistance to perform a task directly related to the diabetic regimen (i.e., make-up meal plan, give insulin shots, baking a sugar-free pie, exercising together).</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Offered/provided tangible assistance to perform a task indirectly related to the experience of the illness (i.e., washing dishes, doing laundry, cleaning house, and watching kids).</td>
</tr>
</tbody>
</table>
4 Any paragraph along the action-based level that does not clearly fit into one of the above categories.

**Context**

Context refers to the setting, location, situation, or place where help or assistance is needed and given; desired and not received; or not wanted. A context code should be assigned only to paragraphs receiving a direction code of S or U. Choose the code that best reflects where the communication encounter occurred. It will be necessary to take the entire paragraph into account in making this judgement.

<table>
<thead>
<tr>
<th>Context</th>
<th>Symbol</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eating Out</td>
<td>EO</td>
<td>Utterance(s) suggesting that eating at restaurants make dietary adherence difficult/easy.</td>
</tr>
<tr>
<td>Eating Alone</td>
<td>EA</td>
<td>Utterance(s) suggesting that one prefers to eat foods when others are not around. Includes statements suggesting that the person lives alone and is solely responsible for preparing her meals.</td>
</tr>
<tr>
<td>Social Events</td>
<td>SE</td>
<td>Utterance(s) suggesting that parties, holidays, vacationing and other forms of socializing tempted/did not tempt one to overeat and make poor food choices.</td>
</tr>
<tr>
<td>Health Facility</td>
<td>HF</td>
<td>When the setting of a conversation appears to be in a doctor's office, a hospital, or clinic.</td>
</tr>
<tr>
<td>At Home</td>
<td>AH</td>
<td>When the setting is clearly the home front and the diabetic is in the company of family members and/or others in the course of everyday events.</td>
</tr>
<tr>
<td>Grocery Store</td>
<td>GS</td>
<td>When the encounter is clearly within a grocery store.</td>
</tr>
<tr>
<td>Other</td>
<td>OO</td>
<td>No specific setting, location, situation, or place is referred to. Use when the situation does not fit within one of the above categories.</td>
</tr>
</tbody>
</table>
SUPPORTIVE MESSAGES

Deterrence

If I order something that I know I shouldn’t because I’m in a bad mood, my mother will say, “Do you really think you should have that? You really should eat some fruit, you know, get you some peaches or something.” If I say they got sugar in them, she says, “Well, get you some Jell-O or something. You don’t need that piece of pie. It’s not going to do you any good.” She always brings me back to reality. “You know what can happen. You know what will happen, so stick with something good.”

“Well, you know, you can have a bagel.”

They tell me I shouldn’t fry it, I should stew it so I usually stew my chicken.

Her thing is that Chinese food is healthy, so if I want to go to Chilies, she’ll say, “Well, we’ll go to Chinese because Chinese is not as fattening as Chilies.”

They’re very amenable to suggestions about places to go that would allow me to have a salad or something that has less fat. (Eating out with co-workers).

I asked the doctor what could I drink. “They have plenty stuff that you can drink. Just shop around, you’ll find them and it’ll be better than that Sprite I’m telling you. It’ll be better on your kidneys.” I thought I’m not going to be a fool and let them go all together (Sprites).

I went to a wedding where they had all this food laid out and I kept going up to look at the hors d’oeuvres. She watched me and said, “They’ve got a whole plate of fruit over here that you can have. Just go over there and get some vegetables. You can get cucumbers, carrots, whatever you want.”

She said, “Do you want me to fix your plate for you or do you want to fix it?” I would choose to fix it with the vegetables and fruits and would get full on them.
They would say things like "Wouldn’t you rather have something else mom instead of that piece of candy? How about if I get you some celery or carrots or something? How about I get you an apple? Would you rather have some popcorn?" They would always seem to offer me something other than the naughty or food that I shouldn’t be eating.

"Would you like some Jell-O? I’ve got some sugar-free Jell-O."

"You’re not supposed to eat that."

She (diabetic mother) told me some things to do to cut down on the grease, like lemon juice over fish and baking it instead of frying it.

She tells me what I can and can not eat. (Based on her experience with a diabetic husband of 20 years).

I’ll ask my doctor permission to eat certain foods especially when I’ve lost some weight. He’ll go, "Yeah" and tell me my quota and what I can have.

"Stay away from the soft drinks."

If they have some cake, they say, "Well, you can’t have that. You know you’re not supposed to have that. You know we’ll get you something else." They look out for me.

"And you’re the person that has diabetes and you’re sitting there eating that? Well, go ahead. Don’t complain to me."

"You’re not supposed to be eating that. Y’all going to have to watch her. She can’t be eating that."

"Don’t eat those cookies." "You can’t have any cake."

You shouldn’t eat anything, it’s too late. You shouldn’t eat anything.
They always tell me, don’t eat cake and stuff like that. They’re good to tell me what I shouldn’t do and all. They always remind me of it.

They’ll ask me, “You supposed to have that?” You know, if I’m eating something I’m not supposed to because I love sweets.

“You’re not supposed to have that.”

My father had complications from diabetes so they (family members) say “We want you around, you don’t need to be eating that. You know you shouldn’t be eating that!”

Whenever I go to eat that, they will very quickly say, “No, you don’t need to do that. You don’t need to be eating that.”

At my father’s retirement party I got some potato salad. My sister said, “No, uh-uh, you know you ain’t supposed to have that. Just take it off your plate. Just put it back.” You better take it off. I’m going to go in there and tell Daddy. You know I’ll tell on you.” I’m like, “Oh God, I don’t want to hear him.”

There are candy jars on the desk, and I will go to them and pick up some candy. Someone (co-worker who knows I have diabetes) will say, “Are you supposed to have that?”

They watch me and if I have something like chips or something they will say, “Do you think you should have that?”

“You not supposed to have that.”

“You know you not supposed to have that. Let’s have something else.”

“Oh, Mom, you not supposed to have that.”

“Oh, you got pie, ooh. I’m gonna tell.”
"No, you don't need that."

"No, no, don't eat that."

My great granddaughter (a five year old) will say, "Now, you know you can't eat that candy because it'll run your sugar up."

They tell me I should not eat the candy I eat, the Pepsi's I drink and that I should do a lot better for myself because I am killing myself slowly but surely.

They'll tell me that I shouldn't have it, but if I want to go ahead and eat it, they'll let me have a little piece of it and say that that's enough.

When we are out somewhere they're like, "Mama, you're not supposed to have that."

One of them I told to get me a drink and he wouldn't go get it. He said I didn't need it. Some of his family members are diabetic too.

When we go to church dinners, she reminds me that I can't have cake. She reminds me that she is saying it because she really cares.

They would "police" my efforts to eat correctly.

I tell them (family) to leave me alone. "No, no, no, we're not going to leave you alone, no because we care about you and we love you and we want you to be around for us, so you got to eat right!"

My friend Donna, whenever she had ice cream, I wanted some and I asked her to give me some. She said, "Get it yourself." She knew that I had diabetes.

They're like, "You better do what the doctors say and you need to rest and you need to stop running, doing this and stop doing that." Because that is the type of person I am. I like helping people.

"I want you around for a long time. Be careful."
She says, "Mom, have you tested your sugar today?" If I say "no," she continues, "Well, you know that you're supposed to test your sugar every day."

They will ask me, "Did you eat? What did you eat?" This is good because sometimes I forget to eat.

They (friends) will ask me how my blood sugar is doing.

Every morning she (daughter) wants to know what it is when I take my sugar.

They show concern by saying "How you doing? Are you feeling alright?"

He asks me how I feel and tells me not to get stressed out.

She (doctor) would encourage me and spend time talking with me about diabetes. She would even go to the point of calling me two or three days after an appointment at home to make sure that I was doing alright or to see if I had any questions.

**Encouragement**

She always talked to me on a positive note. She would say things like, "Yesterday I really wanted to have a great big baked potato with lots of cheese and stuff on it and instead I just ate half of a potato. I don't know where I got the strength just to eat half of a potato." There was something inside of her that made her strong enough to resist. Leading by example is a way to work in life.

She’ll get something like fruit or Jell-O and she’ll do away with her dessert to try and help me, encourage me. "I’ll eat it if you eat it."

He said, "You have active adult type 2 and you can control this with your weight and exercise. You don’t have to be on insulin or pills or anything. This can be done."
The doctor told me that if I lost some of the weight and followed the diet plan and kept my blood sugar monitored and everything, that I probably would be fine. He said, "You probably won't even have to come back after awhile until you do this. You'll go years and years and you'll probably be just fine."

She (doctor) said that if I could lose a lot of the weight then it would help. And, I said okay because I could do that.

Dr. Wright was very encouraging. He would always tell me that I could lose the weight. He would say, "Well next summer you can put on your bikini."

She (physician) would say to me every time I went in practically, "You can't be prefect. So if something happened this week that you know you shouldn't have done, it is okay. Think of it as you rewarded yourself for your other good days." And that is probably the one thing that keeps me going.

"You know it must be hard for you, Marsha, because you are diabetic to be thinner or to regulate your weight."

I had a friend who was diabetic and we used to talk about it. You could call us a mini-support group.

They (diabetic friends) understand how you feel about having to make certain kinds of choices when it comes to eating and exercising.

They (health professionals) listen to me.

(In referring to a "mean" statement made by a relative) He says, "Well, she just didn't realize you know that you don't have pizza. That's something that we don't do very often."

I went out with a girlfriend to celebrate my birthday and had a glass of wine for the first time in three years. When I got home I told my husband and he goes, "Well, it was your birthday. You deserved that." He lets me make my own choices.
She (dietician) said I could always call her if I have any problems. "If you need something, call us and tell us."

Sometimes when we go out I want to have a dessert. I will ask him if he wants some. He'll say, "Yeah, I'll split a piece." It's planned. I've already made in my mind the unit of insulin I'm going to take to cover.

She knows what we want when we go out. "They want a salad, but I don't want that. I want..."

I can inject in front of her now.

She allows me to put on my plate what I feel I should have.

**Compliment**

My eye doctor told me "I can't believe that your eyesight is as good as it is for your age and you're a diabetic too. Your eyes are in great shape!"

My doctor told me that I have good circulation in my legs and feet.

They would say things like, "Oh I really like this chicken. I really like fried chicken but this grilled chicken is very good."

When I lost the 40 pounds everyone would say, "gosh you look great." They would tell me that my skin was even glowing because I was eating so healthy.

The people I work with would say, "Wow, that diet plan's really great. I think I'll get on that! Just because you know, you're looking great!

"You know, you're on your diet and you stayed away from that stuff. You look great and you just have so much energy!"
I put on some pants that I had gotten for Christmas and my son told me I needed a belt. I told him that the doctor said I had lost three pounds. He said, "That's good. I can tell mama. I can tell cause your pants they won't stay up like they used to and they are baggy. I wish I could lose like that but it's hard, it's hard."

I see the nurse over here on Wednesdays. She told me that I had lost two more pounds. She said, "Girl, you losing! You coming down, aren't you? Alright now."

"My God your skin texture is so great" or "God, you look so good."

People compliment me. My friends say that's a good-looking salad or that's a good looking dish.

People compliment me on how I set up my food. I use different colors like bright red, orange, yellow and white, all mixed together. It makes you want to eat it.

My family members notice the fact that I've lost weight. They say, "Mom, you're looking smaller. You're looking thinner."

She said you got the prettiest face. You need to lose weight. She didn't say it in a mean way and she's right, I do need to lose weight.

The doctor told me that I'm doing so much better.

My doctor said, "your blood pressure is like a young girl's!"

The doctor gave me a good report. He said I don't have to come back for three months.

I don't test myself everyday because I had it so monitored that the doctor said, "You're fine, you don't need to buy one of those monitors."
Refrain

They don’t say anything anymore after all these years. I think it is because they recognize that these comments make me angry or they have seen an improvement in the way that I make my own choices about diet.

My kids never say anything to me. I think they know me well enough to know that I make my own choices.

When they don’t say anything when I’m depressed is good because they say something later on (about food choices).

At the all-you-can-eat buffet I can sense that they are like, she shouldn’t be doing that but they not would say it. Maybe because they know I was in such a bad mood that I don’t need to hear any negative things.

The kids don’t say “Oh, Mom, what are you doing? You know you’re not supposed to have that piece of cake.” I think they trust that I’ve got judgment.

I will eat any desserts I want, candy, anything and they just laugh at me and kinda roll their eyes sometimes. Most of the time they don’t even do that cause they know me. I eat what I want.

They don’t say, “gee that is so little.” They have learned that I put on my plate what I can eat for that meal and that’s it.

They don’t say anything. They know I know what I’m doing.

Other

Humor

My younger sister said, “I know I’m gonna have to give you a kidney!” I said no you’re not! I thought it was funny. I told my other sister (who is diabetic) later and she just laughed and said you might have kidney failure, you might have several things, you know like lose of limb. But I heal well and it doesn’t scare me.
I have one friend; she was just asking me this morning, "Are you still drinking those Pepsi's? Well change to diet Pepsi's." I told her that they give me headaches because of the nutrasweet. She responded laughingly, "Take some Tylenol and drink them anyway."

(In reaction to comments made by co-workers that she eats too much, the husband tells his wife) "Well, you see how you make a salad. That's probably why they are making those remarks, honey, because nobody eats salads like you! It's not normal!" And he is right, my salads are huge. If they say free salad bar, you better watch out.

Advice

One Saturday I was feeling really bad, and the dietician said that I was eating too much fruit and it was running my sugar up. She told me, "Don't eat more than three fruits a day and don't drink any fruit juice whatsoever and if you have to then put water in it."

I called the nurse and she said, "Well, if you - you can just soak it. Come over here and we will do it." But I didn't have a way to get there. So she told me to use some Epsom salt and soak it (toe) and then put some Neosporin on it and keep it covered. So that's what I did.

I called the doctor because my stomach was really hurting at night. She said, "Well, you absolutely have to have a piece of meat." That along with a little carbohydrate keeps me through the night.

Temptation

They'll say, "Well, aren't you going to have a little piece of the cake, Mom? It isn't going to hurt you."

Mixed Bag

One man was telling me that if he ate a corn muffin that his sugar would jump way up every time he eats one. So, I began to think that maybe it isn't necessary to count calories. Sometimes different foods effect people in different ways. I think I can figure this out for myself.
He (doctor) said "Mary, I don’t see how you gain like you do as little as you eat."

They asked me, "Why you not eating any pizza? You love pizza!" I told them I am diabetic and they said, "Oh, okay, we understand, we understand. Okay, that’s good, that’s good. We’re proud of you, you know, we’re proud of you."

If I’m stressed they will say "leave her alone, she’s going to eat."

**SUPPORTIVE ACTIONS**

**Tangible Assistance -- diet**

My doctor put me on a 1600 calorie a day diet. But I told my dietician that I wasn’t losing any weight so she gave me a diet with two 1200-calorie days.

My dietician gave me a plan to go by that told me how many carbohydrates and everything to eat.

He put me on diet drinks.

I talked to the dietician and she gave me this diet and I stayed on it for a month and lost 40 pounds. And I did that without eating any vegetables or fruits.

They put me on that Phen-fen diet for well over a year and I lost a lot of weight.

They gave me the prescription for the pills (diet).

The dietician mapped out a meal plan for me with so much of this and that.

They (doctors) gave me the plan, 1200 calorie plan.

We discussed milk content. She (dietician) said a woman of my age should drink two glasses of milk every day. Instead of starting me on whole milk, she had me try the 2% and then the 1%.
They put me on a 1200-calorie diabetic diet which I found is a lot like the Weight Watcher diet.

They (doctors/dieticians) gave me this book to explain to me and she gave me a list of like 2000 calories of the foods and stuff that I could have and about how much.

He (doctor) didn’t put me on a real stringent diet for losing weight but he did put me on a diet.

They would get me some fruit.

My kids and husband were big ice cream lovers. They completely stopped buying that and bringing it into the house for a five or six month period because ice cream was one of my favorite things. They also looked for alternatives to that like freezing sugar free yogurt or going to the yogurt place and getting the sugar free ice cream or yogurt.

My husband buys fruits and stuff like that so I can eat between meals, you know to help me to not eat so much fattening stuff.

My husband cooks sometimes. He’ll cook.

He doesn’t bring it (it refers to candy or sweets).

And you know, if I tell them, stop by the store, and they say, “you want anything?” I say, “yeah bring me two ginger ales.” They’ll bring me diet cokes.

(The people that I go out with) They’ll try to choose a place that I can get fruits or vegetables or a salad or something of that nature.

My mom tries to cook what’s in my diet.

She knows the places I can and can’t eat so we go to the places that I can find something that I can eat.
At a friend of mine’s birthday party, they had pizza and all kinds of stuff I shouldn’t eat, but they had a veggie tray that suited me better.

They will catch me at my weakest point like when I want a piece of candy or something. They will investigate to see if it’s sugar free.

He’ll (husband) leave out of the kitchen and go upstairs and eat it (something I’m not supposed to have) so I won’t see it. I tell him thank you because that’s helping me stay on my diet.

We’ll (group of diabetic friends) select things that we can all eat.

Knowing that I don’t use salt or pork in seasoning food, my daughter will fix her own the way she likes it.

My sister-in-law fixes her own food when she gets ready.

We picked fresh vegetables together.

At departmental meetings they will provide a fruit plate or salad lunch for me.

When someone else cooks for me, I lose weight.

If I’m late coming home every couple of weeks, he’ll have supper ready.

Russ (son) will go out and get supper for us.

There are maybe three diabetics in our department. My supervisor will order special meals with salads, fruits and things like that for us.

She always has fruit available.

When we would have family get-togethers, she (mother-in-law) would make sure that she bought low fat, low sugar ice cream for me.

120
Whenever we (mother and son) make kool-aide now he tries
not to put as much sugar in it.

He will drink kool-aide with the sugar substitute.

He (diabetic husband) watches what we eat. He makes sure
that I don’t eat sweets or drink regular soft drinks.

She (daughter-in-law) brought me diet coke, caffeine free.

She (sister who is a nurse) watches what I eat.

They (teenage children) got accustomed to not looking for
sugar in the house.

They (children) ate what I prepared.

If they wanted something different from what I was eating
then they would go out and buy it.

**Tangible Assistance - Monitoring**

She (new podiatrist I was using) would massage my feet and
legs and explain why she was doing it. When she cut my
toenails, she was very careful and didn’t rush. She would
put rich creams on my feet. She really had my feet feeling
good.

My daughter checks my blood sugar and pressure. She will
actually stick my finger and all that.

He’ll rub my feet for me.

She (doctor) had me coming like every two weeks until she
could find out how I was. She checked my blood sugars,
drew blood and found out that my cholesterol level was very
high.

She’ll (daughter) take my pressure when I get home from
work.
Usually I just go over to the doctor's office at 8:30 in the morning and they check it (blood sugar) and call me the next day to let me know if it is either up or whatever. Once my sugars were under control, he took me off of insulin injections and put me on the pills. I've been on the pills ever since. It's been three years now.

I stayed on the insulin for six months. It (blood sugar level) got back under control. They put me on the pills and I've been on the pills ever since.

My daughter comes down and takes out her little pouch with the days of the week and she looks at it and says, "You didn't take your Saturday medicine yet!" I told her that I was trying to get ready for the baby shower. "Well here." She opens it up (the pouch) gives it (pill) to me and says, "Go ahead, take them." She makes sure that I take care of myself.

I don't like needles and I take two different kinds of diabetic pills to keep it under control. They (doctors) increased my pills and everything. I can tell the difference and I feel a lot better.

When I over-sleep for lunch or dinner or medicine time, they will come and wake me up and remind me to take my medicine. They will have saved me some food and fixed me a plate.

He'll put my glucose in his pocket or stick it in his sock to make sure I have it when I need it.

They did the basal metabolism rate on me and found that mine is normal but it's a low normal.

My aunt works for a university in Virginia and they do some kinds of studies on diabetes. She got me a new meter to check my blood sugar with.
Tangible Assistance - Diabetes Education

The Diabetes Association sends me a lot of information on new products on taking care of your feet, controlling your blood sugar, exercising, and what to look for. He sent me over to a 3-day class on diabetes at the Nalle Clinic. I learned a lot.

They (diabetes education center) would have oranges at the class and they would show you how you can get the air out of the syringe and all this. They would show you how to pick an area, alcohol it down, stick it and put the insulin in you and stuff.

They (dieticians at Nalle Clinic) educated me about diabetes.

We (patient and doctor) will sit down and go over the test and see what we have to do. She explained the diabetes, how it affects the body, your organs and all that, and the important role of diet and exercise.

Tangible Assistance - Other

Exercise

When I worked for AT & T, we (self and co-workers) walked every day. We walked both breaks and at lunch hour. So I walked about an hour a day. I loved it!

My husband goes to the Y with me to exercise.

My daughter would go walking with me.

Mixed Bag

I asked for them (tootsie rolls) and she brought them to me. If I hadn't asked for them she would have brought me something else like the donuts she brought me yesterday or the cake she brought me on Saturday.

When I hurt my foot, my friend picked me up and took me to work because I could hardly walk out to the car.
When I was out of work because of my illness, my church members paid my bills for me.

When I was home ill, they (church members) came to visit me.

They (church members) took me to the grocery store and let me pick out what I wanted and then they paid for it.

He'll clean up.

**NONSUPPORTIVE MESSAGES**

**Deterrence**

Pro-health

"You don’t really need that extra piece of cake, you had your slice and that’s all. You want vegetables, go back and get those."

They say I shouldn’t be eating, and I shouldn’t eat so much, and I don’t need to eat that, it’s fattening, and all things like that.

Don’t eat that.

I can handle constructive criticism but if they’re just like, “don’t eat that,” that doesn’t help me.

"Don’t eat that." The way he said it just made me feel bad.

If I want to eat something like on a holiday, there is always somebody there to say, “don’t eat that.”

I’ve been told (by a nurse), “if it tastes good, don’t eat it.”

When people tell me that I shouldn’t eat something I just want them to shut up.

I can remember growing up and mother would go, “You don’t need to eat that.”
I grew up hearing don't eat that, don't eat that, don't eat that.

We’ll go to the Outback and I’ll get something and she’ll say, “Mommy we don’t need it. She won’t say, I don’t need it. She will say, “we don’t need it.” And that’s usually with me and my four kids, all of us and we will vote her down, three to one.

My grandchildren say, “You know you should not have that. They also say, “don’t eat that.”

They say, “Is that okay for you to eat?” They don’t really say, “you shouldn’t be eating that.”

When my 17-year-old sees me eating something that I’m not supposed to eat, she’ll grab it. “Now you’re not supposed to eat that.” She’s like “no.” She’ll grab it and just take it.

And my mom will sometimes say, “should you be eating that?”

My daughter actually comes over and grabs me and says “No, you not eating this.”

When I stopped (eating right) it was like “You supposed to do that?”

They’ll look and see what you’re doing (when going out to dinner with friends).

To me she’ll say things like, “Oh, you eat ice cream?” or “You allow yourself to have ice cream?”

They look at me kind of funny.

We went to a restaurant out at the Arboretum and we went out that birthday night and she said, “Oh, I just couldn’t have anything else to eat. We had such a huge lunch.” I didn’t think it was huge because we only had a piece of chicken, a vegetable and a salad. So I said it wasn’t huge and she said, “Yes, it was.”
I drove past Krispy Kreme and had to get a box of donuts. I brought it home and ate one. He goes, "Now, what are you going to do with the other eleven?" I told him that he was free to have some. He said, "I don't need them." "I've seen you back up there 3 or 4 times getting refills."

When I went back for my physical I had gained back 30 pounds. The doctor said, "You gained that much back?"

I was trying to hide all this bacon on my plate at Shoney's so my elder and his wife would not see it. My daughter laughed at me and said, "Well, you didn't have to put the whole hog on your plate."

While on vacation at my sister's beach house I got a slice of pizza and a tossed salad and she said, "You just love to eat, don't you?"

A coworker said, "Oh, I've never seen you cheat before." I had a little sliver of cake and that remark hurt.

They're very conscious of how I'm feeling and say, "What you done ate that you had no business eating?"

When I am depressed I will stay away from people and if I want my carrot cake, I will have it. But then they will know later because I will start feeling bad, and they'll immediately say, "Well, did you eat something you weren't supposed to eat?"

Sometimes they aggravate me when I've already taken my medicine. I will tell them that I've taken my medicine and they will say, "No you haven't."

When my daughter was little she said, "Mom, when I get your age, am I going to be your size?" She didn't mean to hurt me but now she is 19 and weighs maybe 105, and she's tiny.

My husband told me the other day that I was eating more than I have ever eaten and that I really needed to start losing weight. Of course he was nice enough to say, "And I need to lose some too."

I just naturally get hurt whenever people say anything about my weight.
I got some literature from the druggist on the new medication the doctor gave me and it said you should have your liver checked when using it. I mentioned it to her and she got snippy and reminded me that I needed to take the medication no matter what.

She (dietician) told me what I could eat and what I should not eat. She told me to drink water and eat rice. I told her that I don’t like this and she said, “Well, you need to change your eating habits. You need to eat to live instead of live to eat.” And I told her but I don’t like this stuff and I’m not going to eat it. I checked off all the stuff I didn’t like and it didn’t leave anything to eat. She said, “stay on it and come back to see me.” I didn’t stay on it and I didn’t go back. And she is about this big (indicating a very small woman).

Once my friends were more aware and educated about what I should be doing, they would often say to me “Are you supposed to have that now? Are you allowed to have that now? Do you need something now? They were very over caring. Sometimes it gets on your nerves when they overdo it and say, “Is this really the time you should be having this now?”

Con-health

My diabetic girlfriend says, “I don’t even know—I don’t know why you buy that stuff. I mean that’s not good. I don’t like that.” I asked her to just try some diet drinks. “That stuff is nasty. I don’t want that stuff. I don’t even know why you eat that stuff. Why you buying that?”

I have substitute sugar that I have to use for cereal. It tastes the same as real sugar to me but they say “ugh.”

My sister is very thin and she makes comments like “You really do eat a lot,” or no, “You really have to eat a lot real often, don’t you?” Then she brags about herself eating a little bit.

At work about three weeks ago a couple of my co-workers said “My God, we’ve never seen anybody eat so much.” I eat a great big salad, soup and crackers and a fruit, and I’m thinking where do they get that I eat so much?
When I first became diabetic my husband did not like me to inject in front of him. He would say, “Oh, do you mind just maybe going in the restroom doing that?”

In reference to injecting insulin, my daughter would say, “Mom, do you have to do -you know, can you do that somewhere else?”

**Indifference**

My friends don’t say anything.

They have kind of backed off in their “policing” efforts.

They didn’t recognize the efforts I was putting in (trying to lose weight).

They did stop, not stop, but they weren’t as acknowledgeable that “oh yeah, you’re still losing weight or whatever. You’re still following your diet.”

The comments and the compliments and the acknowledgement that I was doing what I was supposed to do kind of stopped.

They never did say anything to me about it (eating things not apart of diet).

They won’t say anything you know like don’t eat that, not when I’m getting it.

They (friends) don’t say anything.

No one (family) says anything.

In the beginning, he would offer alternatives for things that were not good for me, but now he doesn’t watch anymore.

He (son) doesn’t take any interest in, you know, mom, what you eating, or you know you ain’t supposed to have that.

You can go a week and you do perfect and nobody was saying anything like how well I was sticking with it.
We will eat Chinese and she’ll eat just as much as I do. She doesn’t say anything. She just pigs out and I will too.

She used to talk about how fat I was, but now since I’ve lost weight, come to think of it, she hasn’t mentioned it (my weight).

“Well you can always get a fruit or something. Get an order of fruit.” But it’s just not there. (When eating in a restaurant).

I went to a dietician and she told me to change my eating habits by drinking tea, eating tomatoes, chicken livers and other things I don’t like. I try to eat them but I get sick, so I stop. But I feel good! I have energy.

He said, “I want some gravy to eat with my rice left over from the pork chops.” I said, “Well, I was fixing steak, baked potato and salad. But if you want rice and gravy, I’ll fix you some rice and gravy.” He said, “No, it’s okay.”

I used to find recipes without sugar for carrot cakes and chocolate cakes and make them for my father (diabetic) and I would try to find stuff that would replace the things that he used to eat all the time. I don’t feel like people do that for me.

For the kids I have to fix their breakfast with their type of food. Then I fix mine. It’s hectic.

I cook without salt or pork for seasoning. They (family) will not eat the food without it.

I cook cakes, pies and cookies but they won’t eat it. It will stay here until I give it to somebody. I’m excluded from things like that.

They told me to write down everything I eat. I’ve got so much to do that I just hate to do that.
My husband will come in, take a shower, and sit down and wait for me to get his supper ready.

Sometimes, when I would want to go to lunch at a reasonable time. They would have a meeting and it would go on and on and on and on. And I would be off my eating schedule.

She (doctor) doesn’t have any time to sit and listen. She wants you to volunteer things rather than having a conversation that leads to things.

He (doctor) says, “come in, sit down, how you doing, let me see your blood sugar, nice to see you, we’ll see you in three months.” It’s hard to talk to him. I always feel lost when I go out of there.

**Temptation**

He said, Nicom do you want some pizza? Just a little piece.”

"Here, you have a piece of dessert. I’ll half it with you and everything will be fine.”

"Just a little piece won’t hurt you.”

"One little glass of wine won’t hurt you. One little sip of this drink isn’t going to hurt.”

Mike was like, “Here get a donut.” And I reminded him that I have sugar diabetes and couldn’t eat it, and he said, “Oh one is not going to hurt you.”

"You know you can cheat every now and then,” or “you can have just a little bit.”

I kept candy in my desk and people would always come up, “Can I have some?” I got tired of going into the drawer so I put a little candy dish on my desk. They’ll come ask me, “Do you have some candy today?”
"Let's go get pizza," or "Let's go get something like a hamburger or hotdogs."

"Gee Mom it has been a long time since we had bacon. Would you buy some and cook it for us this weekend?" I would do that for them and of course I would have a piece. I want to keep my family happy. Harmony is worth it.

My friend said, "But I can't have a drink if you don't have one. After all it is your birthday. Go ahead and have one. This is a special occasion." And it was difficult to argue back to that.

She (sister) said, "Why we always gotta go to Wendy's. I don't want any salad all the time. Come on y'all. Can't you just give in one day? I want to eat some real food. Y'all eat like rabbits."

People come up to me and say, "Do you want this? Uh-oh, I forgot you were a diabetic."

She will say, "I just made a pound cake and I'm coming out there and bring you half of it."

They will get candy apples when we go to the fair and ask me to taste it. "This is a good piece of candy. Oh mom you got to taste this."

When we went to conferences, we would go to these elaborate kinds of dinners with all kinds of desserts. They would say, "try this, try that."

After dinner everyone was going to a co-worker's home for dessert, and I declined to go. A very good friend reacted negatively and couldn't understand why I wasn't going. She said, "Oh, your family will be fine. You can go. You know your family won't mind."
Other

I will walk into the house after work and they'll go, "What’s for supper?" I will fix something fast and fast is usually not healthy.

"What’s for dinner?" I squawk, "What’s wrong with you? Do you not know how to cook?" He’s a better cook actually than I am.

I had my plate and I had to sit and wait fifteen minutes before eating (had taken medication) and everybody was sitting and eating and looking at me and said, "Why you not eating?"

I had back surgery and the incision was about three inches long. It had popped open and it drained. The nurse looked at it and said, "This looks just like a diabetic wound. Are you diabetic?" And I went "yeah." I mean, diabetic people do have a problem with healing. I know all this.

Excessive Questioning

The one thing that really bothered me the most was people around me knowing that I was diabetic asking me if I was okay. "Are you okay? How are you feeling? Are you okay? Do you need anything?" That constant...it sure got old after a few days.

Mixed Messages

My primary doctor said, "Well, it’s not - it’s no puss or nothing under there now." But then when I saw the podiatrist he said there was puss and that he was going to have to cut it, take the nail out and get something to put in there.

I’m on Regimen and there are so many people that have died from it, so I asked my doctor if it was safe to continue on it. He’s like, "As long as we do the liver test you’ll be fine." But it was making me sick so I asked if I could try the new Regimen. "No, we better keep you on this one." When I said please he finally gave in, "so let’s try it."
Questionable Offering

My brother takes some kind of African herbs. He offered to bring me some but I said "oh no." It works for him.

Encouragement

"Come on Mom, come on. Do some more. You can keep doing it. You got to do another mile." (Statement made by daughter when walking with diabetic mother).

NON SUPPORTIVE ACTIONS

Enticements

I keep a candy dish on my desk for everybody (they know about the diabetes) and they'll come by and dump candy in there, usually chocolate like Hershey kisses.

When I go to their homes for dinner and you know how the hostess will serve up your plate and bring it to you. There is always twice as much there than I should be eating.

He brought me a bar of candy. He brought me a bar of candy and said, "I know you don't need this but I brought it because I know you like it."

And for Valentine's Day, he used to bring me candy.

She'll take me to the pancake house.

I went out of town to my niece's birthday party. She didn't have diet sodas there and it was like 2 or 3 miles to the store.

He offered me a coke.

She brought me a slice of pizza last night and wrapped it up and said, "I didn't bring you any." The next morning she said, "I brought it, but I didn't want you to eat it last night."
Somebody gave me a ham for my birthday. I didn’t eat it.

She bakes and brings me pound cakes.

We are all diabetics and they eat the wrong things in front of me.

She (diabetic friend) will eat anything in front of me.

At work, there is candy everywhere. They keep a big stash right here on the receptionist’s desk.

They (immediate family) would cook mashed potatoes and fried pork chops, or something like that which is very tempting.

They will eat candy bars, potato chips and all this right there in my face.

They fixed like Sundays and had cake and stuff and I was like, “Oh, why y’all torturing me?”

He knows I am diabetic and he brings donuts to work.

He (son) eats candy in front of me and offers it to me.

**Cause-effect**

I go to him (podiatrist) for him to take care of me because he told me don’t cut your toenails, but when he did it, he cut it too close that I can hardly walk. The toe got infected and I have to go back so he can numb and take the piece or something.

My dad bought this new orange juice and gave me a cup. I felt tired so I took my blood sugar and it was 234. I looked at the sugar content on the cartoon and it was way too much.

I was on this diet and I lost a lot of weight, and my sugar was like nonexistent. It was down as low as 50. But, then they took me off this diet, and I started climbing back up slowly and slowly.
The doctor stopped my insulin injections and put me on pills for about six weeks and I was as sick as a dog. I thought give me back that insulin, because when I took it I felt more normal, more myself and I've been on it ever since.

I thought about the Glucotrol I'm on, he (doctor) had me double it, but since I've doubled it, I'm taking three pills in the morning, two Glucotrols and one Resilin. Maybe that is too much. Maybe that blurred by vision.

She (doctor) increased the medication and the medication has harsh side effects.

She (nurse) took me to another room, got a needle and an orange, showed me how to insert it, gave me a diet plan and sent me home. I went out of there not understanding anything.

I don't understand the diet they gave me, especially about exchanges of foods.

They sent me to the diabetes center at CMC but it was closed for the weekend. There was no one available in the hospital that could teach me about diabetes. So I was simply sent home with strict instructions to not eat anything with sugar over the weekend and come back on Monday.

My doctor sent me to a six-hour diabetes class. It was too time consuming and I was bored to death.

Nonevents

If I am walking I want someone else on the track with me. They couldn't do that because of a lot of stuff and the weather got hot and they would just find excuses.

My mom keeps saying she will (walk) but she's 68 years old and she doesn't walk that well on one of her legs so she's not able to do it as much.

My daughters are very active but have different work schedules so I don't have anyone to exercise with.
He's got a bad leg and can't do a whole lot of walking himself, so he can't walk with me and I don't like to go by myself.

My son doesn't get home until 6:00 p.m. when it's getting dark and he runs off and leave me (in reference to exercising).

My walking buddy (co-worker) and I try to get out and walk at least three times a week (at work during lunch), but since we've moved into this new building, we have found it more difficult to maintain that schedule.

We say we are going to walk and we don't do it. It's always too hot or too cool. There is always an excuse.


