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"Emotional Support Won't Cure Cancer": Reasons People Give for Not Providing Emotional Support

Colter D. Ray, Valerie Manusov, & Rachel M. McLaren

A major stressor faced by many people in their lifetime is a cancer diagnosis; however, cancer patients often report instances of people they know who never communicated emotional support regarding their diagnosis. The present study explored reasons potential supporters gave for not providing emotional support to others they knew who had recently been diagnosed with cancer. Sixteen reasons emerged and were categorized across four higher-order categories: Reasons related to the source, the recipient, the relationship, and the context. People providing source- and recipient-based reasons had higher relational closeness scores, and closeness was also related to greater expectation for providing support.

Keywords: *Cancer Patients; Closeness; Emotional Support; Expectations; Nonsupport*

When confronted with stressors, people often rely on support from others to resolve problems or reappraise the stressors. The support people receive occurs in various forms (Cutrona & Suhr, 1992), and certain forms of support, such as instrumental aid (i.e., support focusing on problem solving), are useful when facing a controllable stressor (Cutrona & Russell, 1990). When faced with a stressor that cannot easily be resolved, such as a cancer diagnosis, prior research has found emotional support

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messages to be particularly beneficial. High-quality emotional support messages occur when supporters communicate comfort, concern, and sympathy effectively (Cutrona, 1996). Although these messages may not resolve the stressor itself, receiving effective emotional support can improve one's emotional state and have other positive outcomes (Burleson & Goldsmith, 1998; Jones, 2004).

One context where people desire emotional support is after a cancer diagnosis. People who want support might not always receive it, even though emotional support can come from a range of people in their social networks, including those with strong/close relationships and those with weak/less close ties (Parks, 2016). Considering the potential inconsistency between what those with illness may desire (see Neuling & Winefield, 1988; Rose, 1990; Wortman & Dunkel-Schetter, 1979) and what others may (or may not) provide, it is important to understand why people do not offer emotional support.

The current study illuminates the reasons potential support providers give for not communicating emotional support messages to people they know with cancer. We begin by reviewing research on communicating emotional support to people with cancer and then consider studies on why people do not provide support.

Communicating Emotional Support to People with Cancer

A cancer diagnosis is a significant stressor, with 2012 figures estimating 14.1 million new cases occurring worldwide (International Agency for Research on Cancer, 2012) and a projected increase to 22.2 million new cases annually by 2030 (Bray, Jemal, Grey, Ferlay, & Forman, 2012). In addition to the physical health implications of a cancer diagnosis, between one third and one half of cancer patients report psychosocial or emotional distress (Carlson & Bultz, 2003). People with cancer consistently report emotional support messages (i.e., messages conveying care, concern, and sympathy) as more helpful than either instrumental or informational support (Chesler & Barbarin, 1984; Dakof & Taylor, 1990; Dunkel-Schetter, 1984).

Researchers have found that cancer patients who receive emotional support fare better than those who do not. For example, Arora, Finney Rutten, Gustafson, Moser, and Hawkins (2007) reported that helpful emotional support from family, friends, and providers at both 2 and 5 months postdiagnosis was correlated with health-related quality of life and perceived self-efficacy to handle health-related problems. Even though cancer patients desire significant support throughout their cancer journey, the amount of helpful emotional support drastically declines over the course of the first year following initial diagnosis. Moreover, in their test of constructs related to emotional support using a 17-year follow-up study of 6,848 adults, Reynolds and Kaplan (1990) found women in the study who developed cancer and who were socially isolated had higher rates of dying from cancer. Likewise, men who developed cancer during the study who had fewer social connections showed significantly lower cancer survival rates compared to those with vaster social networks.

Providing helpful emotional support for those with cancer can be a challenging endeavor. In some cases, cancer patients might not want to discuss their cancer (Goldsmith, Miller, & Caughlin, 2007). Cancer patients also contend that some supporters misinterpret their needs and provide support that fails to match what is desired (Peters-Golden, 1982). In particular, people with cancer report that providers sometimes fail to convey empathy (Ray & Veluscek, 2017), or providers' support attempts minimize the person with cancer's situation and experiences (Dunkel-Schetter, 1984). On the other hand, some supporters can be *overly* involved (Dunkel-Schetter, Blasband, Feinstein, & Herbert, 1992), creating an unwanted obligation for the receiver to respond (Ray & Veluscek, 2017). Together, the findings of these studies highlight the communicative challenges associated with providing emotional support to those with cancer.

Choosing Not to Provide Support

The American Cancer Society (ACS) asserts that people should provide emotional support when they hear that others have cancer, regardless of how close they are to that person ("When Someone You Know Has Cancer," 2016). This support can be in the form of asking how the person with cancer is doing or letting the person with cancer know the supporter cares. The ACS's advice assumes that potential support providers want and/or feel obligated to offer support. In actuality, however, potential supporters have a choice regarding whether or not to provide such support, and this may be affected by relational closeness, especially for those with weak ties (Parks, 2016). Relationships are characterized as having weak ties when two people provide only certain resources for one another or their interactions are infrequent (Granovetter, 1983). Consequently, those who are not relationally close to the person with cancer may not feel an obligation to communicate support.

Researchers, however, have rarely investigated instances when potential supporters—both those with strong and weak ties—do not provide emotional support messages. Dakof and Taylor's (1990) study is an exception. By investigating unhelpful instances of support from across different relationship types (e.g., family, friends, medical providers) the investigators found that social avoidance (i.e., not providing support) was prevalent in friendships and, to a lesser extent, acquaintances. Conversely, cancer patients rarely reported a lack of support provision from family members and other intimate relationships. Dakof and Taylor note, "Whereas friends, acquaintances, and co-workers may gradually or abruptly decrease their contact and communication with cancer patients, it is unlikely that spouse, children, and health professionals can withdraw in quite the same ways" (p. 80). In the context of chronic disease, problematic support from family members and close relationships often occurs due to overinvolvement rather than avoidance (Coyne, Wortman, & Lehman, 1988), though avoiding emotional support still occurs.

Just as providing problematic support can be an issue, not providing support can also be consequential. Ray and Veluscek (2018) recently investigated the effects of failure to provide supportive messages on women diagnosed with breast cancer. The authors found that instances of not receiving support from those expected to provide

it created negative relational ramifications (i.e., distrust, disliking, and viewing the relationship as weakening) and low levels of emotional improvement. Interestingly, these scores were similar to instances when participants received low-quality emotional support messages.

Ray and Veluscek (2018) looked specifically at *nonsupport*, which they defined as "the decision to not provide support to someone perceived as needing aid" (p. 2). This construct does not include, for instance, those people who may be waiting for a specific opportunity to provide emotional support or intend to communicate such support at a later time. Furthermore, their study focused on support recipients and did not investigate reasons *why* potential supporters do not communicate emotional support.

Although no published studies have assessed the reasons why people fail to offer support, possible explanations exist elsewhere in the literature. For example, research has found that providing emotional support to cancer patients may distress the provider by forcing him or her to confront the situation (Wortman & Dunkel-Schetter, 1979) and create anxiety over saying something unhelpful (Parkes, 1975). Researchers have also contended that potential support providers may be reluctant to discuss cancer with the person out of fear of upsetting him/her (Garfield, 1977; Kalish, 1977). Moreover, those with weaker ties may not believe that providing emotional support is their responsibility, or they have fewer opportunities to offer such support (Granovetter, 1983).

Overall, the question of why people do not provide emotional support, particularly in the context of a cancer diagnosis, remains largely unanswered. This study addresses the gap in the research literature by investigating the reasons people offer for failing to provide emotional support to people who have been recently diagnosed with cancer. As such, we provide the following research question: *What reasons do people give for not providing emotional support to someone who has been diagnosed with cancer*?

As noted, patterns of emotional support tend to vary based on relational closeness (Dakof & Taylor, 1990; Hobfoll & Lerman, 1988). This may be due, in part, to social expectations that people closest to a person in need feel the greatest obligation to provide support (Berkowitz, 1972). Given these contentions, we offer three hypotheses: (H_1) *There is a positive correlation between relational closeness and expectations for offering support to a person with a cancer diagnosis*; (H_2) *Controlling for expectations, those who offer certain reasons for forgoing support differ in their reported closeness from those who do not offer those reasons*; (H_3) *Controlling for relational closeness, those who offer certain reasons for forgoing support differ in their reported expectation to offer emotional support from those who do not offer those reasons.*

Methods

Procedures

Participants were recruited using the Amazon.com web services crowdsourcing marketplace Mechanical Turk (MTurk) and compensated USD1.05 for completing the questionnaire. Research has shown that samples recruited using MTurk are more representative of the U.S. population than studies using in-person convenience samples (Berinsky, Huber, & Lenz,

2012). Participants had to (a) be at least 18 years old, (b) be able to read and write English fluently, (c) have known someone diagnosed with cancer in the past 6 months, and (d) have not communicated emotional support to this individual. This time frame was chosen based on Arora et al. (2007), who report emotional support from social networks is highest at initial diagnosis and declines over the first few months following diagnosis. Thus, we believe that those who would provide emotional support would most likely do so at some point in the first 6 months following diagnosis. If respondents did not meet all the eligibility requirements, they were sent to a termination page explaining that they were not eligible to participate in the study. Participants who met the eligibility criteria completed the rest of the questionnaire.

Participants

There were 286 participants who started the survey, but 89 participants failed to meet the eligibility requirements. We also removed five people who reported on a stranger, as that was outside the bounds of our study. The remaining participants ($N = 192$) were 98 males and 94 females who reported that they knew someone diagnosed with cancer in the past 6 months but had not communicated emotional support to this person. Participants ranged in age from 19 to 64 years ($M = 33.62$ years, $SD = 9.37$). Most participants (82.29%) reported that they came from 35 U.S. states. The remaining participants came from Australia, British Virgin Islands, Canada, Czech Republic, Denmark, France, Germany, India, Indonesia, Japan, Malta, Pakistan, Poland, Singapore, Sweden, Thailand, Venezuela, Vietnam, and the United Kingdom.

The majority (73.4%) of participants reported being Caucasian, 7.8% said they were Black/African American, 6.8% Hispanic/Latino(a), 6.3% Asian/Pacific Islander, 2.1% Native American/Alaskan Native, and 3.6% identified with two or more ethnicities. The most frequently reported relationship type reported by participants ($n = 74$, 38.5%) was a friend, whereas 42 (21.9%) discussed a coworker/business associate, 37 (19.3%) a member of their extended family, 11 (5.7%) a nuclear family member, 20 (10.4%) an acquaintance, and 8 (4.2%) a neighbor/community member. The average time since the patient was diagnosed was 3.62 months ($SD = 1.87$). A few participants (5.2%) were unsure of how many months it had been since the person was diagnosed, but responded that the diagnosis occurred in the past 6 months. Participants were asked the type of cancer with which their contact was diagnosed. Nineteen cancer types were reported; however, five types (breast, lung, hematological, colorectal, and skin) comprised a majority (51.6%) of the diagnoses. In our sample, 16.7% of participants lacked adequate detail to provide an informed response about the diagnosis.

Assessments

Reasons for not communicating emotional support

Participants received the following prompt: “In the spaces below, please write reasons why you did not provide emotional support to the person in regard to their cancer

diagnosis." They were asked to provide one reason per text box and were given the opportunity to provide up to five reasons. This choice to delimit the data appeared to work, as most respondents (n = 144, 75.0%) did not fill in all five boxes. Among the 192 participants, 575 reasons were generated (M = 2.99, SD = 1.97). The questionnaire was structured so each text box consisted of only one reason, so there was not a need to unitize the data before coding.

The first author read all the responses to understand their general nature. During a second read of the data, the first author created analytic memos (i.e., notes taken throughout the analysis process that help to record interpretations, ideas, questions, and the like) as instructed by Glaser (1978) to track and refine ideas related to conceptualizing and comparing incidents mentioned within the open-ended responses. The first author's analytic memos initially identified 12 emergent themes from participant responses; however, additional analysis by the first author highlighted the need for further delineation, resulting in the creation of four additional themes. After reading the full data corpus independently, the other two authors confirmed the face validity of the 16 themes.

To establish reliability, an outside researcher familiar with social support research coded 33% of the responses. She used the codebook of the 16 categories created by the first author but was asked to provide suggestions for additional categories or revisions to the codebook. The coder did not recommend any new categories; however, she did recommend revising how some categories were defined. Although the nature of the survey design was to capture one reason per box, some entries included more than one reason. These were judged by the first author with help by the other authors to determine the primary reason in that entry. For example, one respondent included this response: "I should give emotional support, but sometimes I give too much and the other person affected may feel like a 'woe is me individual.' I really want them to stay positive." Whereas she referenced her own competence, the primary reason appeared to be her concern for other (given her lack of competence) and was coded as such.

After agreement from the other authors for the categories, the first author further organized the categories into the four higher-order categories based on the focus of the reason provided: source-focus, recipient-focus, relationship-focus, and context-focus. The term "recipient-focus" was used even though the person in need did not receive support. This decision was made strategically so that our higher-order categories reflect the major foci of social support research offered by Burleson (2009), adding to the face validity of the category scheme.

Intercoder reliability was established using Cohen's kappa. Following established guidelines for interpreting agreement (Landis & Koch, 1977), it was determined there was substantial agreement between the author and the secondary coder. Kappa values for the four higher-order categories ranged from .78 to .83 (source-focused reasons, k = .83; recipient-focused reasons, k = .78; relationship-focused reasons, k = .81; context-focused reasons, k = .81).

Relational closeness

Relational closeness was measured using the well-validated inclusion of other in the self (IOS) scale (Aron, Aron, & Smollan, 1992). This single-item pictorial measure presents the participant with seven Venn-like diagrams, varying in the degree that two circles overlap. In this study, one circle represented the self (i.e., the participant) and the other circle represented the target individual (i.e., the cancer patient), and the degree to which the two circles overlap signifies the degree of relational closeness between them. The sets of circles were assigned a number ranging from one to seven (1 = two circles with no overlap; 7 = two circles almost completely overlapped). Participants were asked to select the set of circles that represents their relationship with the person with cancer, and the number assigned to the chosen set of circles was used as the data (M = 2.44, SD = 1.29).

Perceived expectation to provide support

To assess this variable, participants were asked on a 7-point Likert scale (1 = *Strongly Disagree* and 7 = *Strongly Agree*) the extent they agreed with the statement, "The other person expected me to provide emotional support for them in regard to their cancer diagnosis." This single-item measure had a mean of 2.84 (SD = 1.71).

Results

Research Question

The research question focused on participants' reported reasons for not providing emotional support to someone they know who had been recently diagnosed with cancer. Notably, 61.5% of participants reported reasons from more than one of the higher-order categories, with the most frequent combination being at least one source- and one recipient-focused reason. The sections below contain descriptions and examples of each of the 16 categories, organized within their higher-order category. We also report the frequencies for each higher-order category (frequencies for lower-level categories appear in Table 1).

Source-focused reasons for not providing emotional support

The most frequently occurring category of reasons (n = 214, 37.22%) concerned the potential provider (i.e., the participants expressed concerns related to themselves). Six different reasons comprise the source-focused higher-order category.

Low self-efficacy. One of the most commonly reported reasons for not communicating support was not knowing what to say. Some participants viewed this in general terms (e.g., "I do not know what to say. Even if I did I would not know how to say it"), and others based this perception on past failed support attempts. For example, one person recalled the decision not to communicate emotional support to a friend with lung cancer, saying, "I am really bad with emotional situations. I feel like I often make things worse when I have a delicate conversation like that." Conversely, others

Table 1 Frequencies and Reliabilities of Reasons to Not Provide Emotional Support (N = 575).

Focus of Reason	Reason	κ	Frequency
Source-focused reasons	Low self-efficacy	0.89	74 (12.9%)
	Lack of emotional control	0.87	56 (9.7%)
	Feeling uncomfortable	0.84	25 (4.3%)
	Other priorities	0.80	25 (4.3%)
	Belief emotional support is not useful	0.75	19 (3.3%)
	Concerns of appearing insincere or self-serving	0.91	15 (2.6%)
Recipient- focused reasons	Person does not desire support	0.91	51 (8.9%)
	Person does not deserve support	0.90	48 (8.3%)
	Person would experience negative emotions	0.85	44 (7.7%)
	Person already has adequate support	0.86	16 (2.8%)
Relationship-focused reasons	Lack of relational closeness	0.80	89 (15.5%)
	Providing support would create privacy issues	0.85	38 (6.6%)
	Support provision would violate relationship norms	0.79	32 (5.6%)
Context-focused reasons	No opportunity to provide support	0.92	24 (4.2%)
	No way to contact the diagnosed individual	0.80	10 (1.7%)
	Physical distance	0.77	9 (1.6%)

reported being comfortable with providing emotional support but were not confident in their ability to communicate about additional topics that may arise. For example, a participant also reporting on a friend battling lung cancer said, "This friend is heavily religious, while I am not. I would anticipate that his expectation for empathetic support include talk of faith, which I'm unable and unwilling to provide."

Lack of emotional control. Whereas some participants noted a lack of self-efficacy about their ability to communicate an effective support message, others reported fears of losing composure while delivering such a message. Some cited traumatic experiences with others diagnosed with cancer, stating,

> Almost two years ago my best friend from high school was diagnosed with final stage leukemia. I watched her go through some of the most horrific days and nights. When I heard my aunt was diagnosed the thought of watching her like that is so terrifying I cannot face her.

Others reported fear they would lose their composure or become a burden. For instance, one participant who reported previously losing a sibling to cancer wrote, "I am afraid I will lose my composure and make him feel worse or have to comfort me."

Other priorities. Some participants expressed they had more pressing matters and therefore were unable to provide emotional support. One shared that s/he had "been

struggling with a bone infection and trying to earn extra money for the $4000 treatment" and added that "someone talking to me on the phone for an hour causes me to lose an hour of pay." A participant lamented, "I was in a busy time of my life balancing school and finishing up school. I wasn't around enough as I could have been."

Feeling uncomfortable. Participants also expressed communicating emotional support could make them feel uncomfortable. Regarding her/his own child who had been diagnosed but with whom s/he had not spoken to for years, one participant said, "Getting back in touch would make me feel uncomfortable." Another respondent reported, "We aren't super close friends. I was sorry for her, but I would feel awkward talking about cancer with her."

Belief that emotional support is not useful. Others said that they decided not to communicate emotional support because they viewed such messages as futile in a battle with cancer. One participant asserted, "Emotional support won't cure cancer," and another respondent claimed, "My sympathy would not help."

Concerns of appearing insincere or self-serving. The possibility of sounding inauthentic or self-serving was another factor in the failure to provide support. A participant contended that "empathetic expressions from people dealing with serious illness, especially when people are not close friends or family, are often perceived as hollow, benefiting the conscience of the well-wisher more than the emotional health of the afflicted." Another commented on a distant relative, saying that "posting comments via Facebook would feel insincere, so I remained silent."

Recipient-focused reasons for not providing emotional support

The next category of reasons focused on the diagnosed individual (n = 159, 27.65%) and included four reasons. Three of the four reasons are evaluations made by the participants about the person they know with cancer. An additional recipient-focused reason was concerned with the potential negative psychological outcomes of broaching the diagnosis with the patient.

The person does not desire support from me. One reason was that participants perceived the other as not desiring support. Some participants noted that the diagnosed individual wanted to maintain a sense of normality: "My friend prefers to not have any special treatment or have people behave differently because of their diagnosis." Participants also reported a belief that the other had no desire for support generally (e.g., "She didn't want support from anyone"). Alternatively, some reported that the person with cancer specifically did not desire support from them personally. For example, one participant said of a coworker with ovarian cancer, "This person does not like me at all and I feel if I tried to provide support it would be rejected."

The person did not deserve support. Another reason was the belief that the person with cancer did not deserve emotional support. Some participants recalled years of past transgressions when deciding not to provide support. For example, one participant asserted, "She was an asshole about her cancer, just as she had been her whole life. I'm not going to suddenly be your best friend and treating you like a good mother

because you have cancer." Others noted a cancer diagnosis was deserved because the person "has been inconsiderate in the past about other people and their illnesses" or that cancer was "karma giving him payback." Additional respondents blamed the other person for their diagnosis stating, for example, "She smoked, and I felt she sort of brought it upon herself." Participants also recalled prior observations of how the diagnosed person treated others. One participant said of a family friend, "I found out he told my grandmother horrible things on her deathbed and then blamed my mother for her death."

The person would experience negative emotions if cancer is discussed. Participants feared that bringing up the cancer diagnosis could evoke negative emotions for the recipient. One participant remarked, "I felt that if I offered emotional support, it would remind them of their diagnosis and make them think about it and make them sad." Another participant said regarding a friend battling bone cancer, "I don't want them to think about it more than they have to. We have plenty of more positive things to talk about."

The person already has adequate support from others. The perception of the cancer patient's overall support network also served as a reason for forgoing communicating emotional support. Specifically, one participant recalled, "A ton of people already had written messages on Facebook. I didn't think I could say anything that hadn't already been said." Another person said regarding a coworker battling lymphoma, "This person was overwhelmed by messages from others. I felt my message was not needed."

Relationship-focused reasons for not providing emotional support

Occurring equally as often as recipient-focused reasons were relationship-focused reasons (n = 159, 27.65%). Relationship-focused reasons differ from source- and recipient-focused reasons in that they focus on the nature of interactions between the source and recipient, the participant's opinion of closeness of the relationship, and privacy issues concerning third parties known by both relational partners.

A lack of relational closeness. Across all 16 types of reasons reported, the second most frequently occurring reason was viewing their relationship as lacking the requisite closeness or intimacy to warrant the provision of emotional support. Explanations included growing apart (e.g., "Although she's my cousin we are not close anymore") or not having communicated for long periods of time (e.g., "I didn't provide emotional support because I haven't seen him in over 4 years"). Still others reported that their relationship had never been close. For example, one participant said of a grandson, "I didn't provide support because I never felt too close to him."

Providing support would create privacy issues. Participants reported that they failed to provide support because doing so would be seen as an invasion of privacy or would breach the confidence of a third party who informed the participant of the cancer diagnosis. For example, one participant did not feel comfortable giving support to a family member until the person disclosed her illness: "She did not inform me directly of her diagnosis. I am still waiting for her to acknowledge that I know of her illness." Still others worried about "outing" a third party as having shared private information.

One participant reported on a friend's mother who had been diagnosed, "This person may not even be aware that I know they have cancer. I would not want to strain the relationship between them and their child if their child was not supposed to tell me they had cancer."

Providing support would violate the norms of the relationship. Perceived relationship norms influenced some to refrain from providing emotional support. For example, one participant discussed her relationship with her mother, saying "We have never been emotionally touchy-feely." Another commented on a member of a church group who was recently diagnosed, reporting, "Our relationship is not like that. We always joke and talk superficially. To ask about his cancer would be out of character for us."

Context-focused reasons for not providing emotional support

Situational obstacles to providing support was the category with the fewest responses (n = 43, 7.48%). The three reasons within this category are issues of logistics.

No opportunity to provide support. Some focused on not having the opportunity to provide emotional support. For example, a participant said,

> We volunteer at the same charity. We know each other by name and chat, but not outside of the charity. She has not been to any meetings since June. The charity sent her a card that everyone signed, but that was done at a meeting I missed.

No way to contact the diagnosed individual. Some people reported that they had lost touch with the diagnosed person and were unable to reconnect, as demonstrated in the response that "I don't have a way to contact this person, so it would be difficult to talk to them." A second participant specifically cited the cancer patient's lack of social media presence, saying, "She is basically unplugged and off of social media and rarely out of her house."

Physical distance. Other participants cited distance as a substantial factor for not providing support. For example, one person knew of a family friend who had been diagnosed with lung cancer and stated, "The main reason why I have not provided support is that I am far away from this person and not able to be physically near them." Even though they could provide support through a mediated channel, some potential providers reported feeling it is important to be physically present to provide emotional support.

Hypothesis One

Our first hypothesis predicted a positive correlation between relational closeness and perceived expectation for providing emotional support. A one-tailed Pearson correlation found support for the hypothesis, $r = .25$, $p < .001$, meaning that the closer people were, the more they believed the cancer patient expected them to provide support.

Hypothesis Two

Our second hypothesis predicted that, when controlling for perceived expectation to provide support, participants offering different types of reasons (source, recipient, relational, or context) for forgoing support will differ in their reported relational closeness. Using the first reason provided by the participants, which we judged to be the respondents' primary reason, results of a one-way ANCOVA were significant and supported the hypothesis: $F(3, 187) = 5.00$, $p = .002$, partial $\eta^2 = .07$. The expectation to provide support covariate was also significant. Bonferroni pairwise comparisons determined that relational closeness was significantly greater for those who provided a source-focused reason ($M = 2.78$, $SD = 1.37$) in comparison to those who provided a relationship-focused reason ($M = 1.94$, $SD = 1.07$; $p = .003$). Additionally, those who provided a recipient-focused reason ($M = 2.71$, $SD = 1.30$) also had significantly greater relational closeness than those who provided a relationship-focused reason ($M = 1.94$, $SD = 1.07$; $p = .02$). Thus, H2 was supported.

Hypothesis Three

Our final hypothesis predicted that, when controlling for relational closeness, participants who provide different types of reasons for not providing support (source, recipient, relational, or context) will differ in their perceived level of expectation to provide support. Using the first (primary) reason provided by the participants, a one-way ANCOVA was not significant, $F(3, 187) = 1.68$, $p = .17$, observed power = .44. When controlling for relational closeness, there were no significant differences in expectation to provide emotional support depending on the type of reason provided by the participant. H3 was not supported.

Discussion

The study uncovered a wide range of considerations that went into the decision not to provide emotional support, as evidenced by the 16 themes across four higher-order categories (source, recipient, relational, and contextual). Overall, our findings speak to the complexity and challenges that face potential support providers. For example, sometimes people desire to provide emotional support but encounter a number of barriers limiting their own ability to do so, including perceived low self-efficacy, fear of feeling uncomfortable, concerns for seeming insincere, or the belief that providing emotional support is futile. In addition, the results showed that potential providers report that they are afraid to bring up a person's cancer because they worry that the other person does not want to talk about the issues or will experience negative emotions.

Implications for Social Support and Facework

The findings have implications for the scholarship on social support and face threats. Providing and receiving social support is inherently face-threatening (Goldsmith, 1992). This study revealed that potential supporters have a sensitivity toward face issues for

recipients. For example, one reason for not giving emotional support was the perception that receiving more support would be burdensome to the cancer patient (i.e., a negative face threat). These concerns are not unfounded. Cancer patients report that they might not want social support because of face threats against their own and the provider's autonomy (Ray & Veluscek, 2017). Furthermore, receiving unwanted support presents additional challenges for support recipients, as they determine how to politely reject unwanted offers of social support (Floyd & Ray, 2017).

In addition to concerns about face threats to the recipient, the findings of this study highlight the myriad face concerns that potential support providers experience. People reported being worried about positive face concerns and how their identity would be presented in a supportive interaction. Potential support providers were concerned about their own self-efficacy in providing emotional support, their ability to control their emotions, and the potential of appearing insincere or self-serving. That is, they did not want to be judged negatively (by themselves or others) if they attempted to provide emotional support and were not able to do so effectively. For some people in our sample, these concerns were great enough to result in a decision not to provide emotional support to those in their networks with a cancer diagnosis. Yet, Sullivan (1996) found that recipients of unhelpful emotional support frequently offer positive attributions for unhelpful support messages (e.g., "the person was just trying to help").

The findings highlight the possible need for communicative interventions focused on increasing people's self-efficacy and comfort in providing emotional support. Interventions might be based on the scholarship on support gaps (Xu & Burleson, 2001), which emphasizes the need for support providers to take the recipients' desires into consideration when offering social support. For example, one aspect of providing guidance to potential providers might be for them to check in with the person about his or her desires for more or less of certain forms of social support. Although "emotional support won't cure cancer," it may decrease some of the other negative conditions that often occur alongside it. Communication scholars have a vital role in better understanding—and promoting—the ways in which would-be providers can be more comfortable with and competent in assessing another's support needs and providing useful support.

The Roles of Closeness, Relationship Type, and Expectations

In addition to highlighting the challenges that potential support providers face, the findings also point to the role that relational context plays in the support process. For example, we found that the closer participants felt to the cancer patient, the more they believed the person expected them to provide emotional support. The findings add to the existing work that has examined how societal and relationship norms (Schwarz, 1977), relationship history (Dunkel-Schetter & Skokan, 1990), and degree of intimacy in the support-provider relationship (Hobfoll & Lerman, 1988) affect the social support process. Those who were close to the potential recipient provided more source- and recipient-oriented reasons for not offering support, as compared to people

who were not close with the recipient, who often noted relationship-oriented reasons (i.e., that the nature of their relationship suggested the support was not required nor desired), or reasons based on context (i.e., not having a chance to interact). These findings show that potential support providers who feel closer to the potential recipient may be most affected by their own sense of limited communicative competence and/or a belief that the recipient would be burdened by receiving such support. Likewise, potential supporters with "weaker ties" might be influenced more by factors such as limits to the resources they can provide to another or to the amount of interaction they have with the other (Granovetter, 1983).

Our findings also uncovered some negative motivations for why participants did not provide emotional support. For example, some recipient-focused reasons maligned the potential recipient by claiming that the person did not deserve support. Although it seems unlikely that potential providers would go as far as to directly tell the person that they do not deserve emotional support, this finding does highlight the possible ambiguity that might arise for cancer patients when people fail to provide support. That is, research shows that it can be difficult for cancer patients to interpret accurately why others may be avoiding opportunities to support them: As one participant from a different study on how cancer survivors manage communication about cancer noted, "It was very hard for me to discern who was not talking to me about it because they didn't know how to, or because they cared, or because they didn't care or matter" (Donovan-Kicken, Tollison, & Goins, 2011, p. 322). If a cancer patient perceives his or her partner as avoiding the topic of cancer out of self-protection or believing talking about cancer is inappropriate, relational satisfaction can be negatively influenced (Donovan-Kicken & Caughlin, 2010). Future research could examine the explanations that cancer patients provide for other people's failure to give them social support when it was expected.

Although we did not examine the relational consequences of failing to provide emotional support, other work suggests these instances can have a negative influence on relationships. For example, Ray and Veluscek (2018) found that breast cancer patients viewed instances when they expected to receive support but did not get it to be equally damaging to the relationship as instances of receiving low-quality support. Furthermore, McLaren and High (2015) reported that people felt hurt when they received less emotional support than they desired. Taken together with our results about concerns over face threats, potential providers might feel caught between two difficult options: Should they attempt to provide emotional support even if they only feel capable of giving low-quality support, or should they forgo a support attempt altogether? If they do eventually decide to provide support, future research could examine what types of accounts or explanations people give recipients about why they took so long to be supportive. Failure to provide support when it was expected is considered a type of relational transgression (e.g., Metts, 1994) that requires account-giving behavior. Future research should investigate how would-be support recipients respond to these accounts.

One factor that might affect the attributions that cancer patients make for the failure of others to provide social support is their relationships with the potential

provider. Lehman and Hemphill (1990) argue that attributions are less a function of message content and more likely a function of the perceived underlying motivations of the provider's message and the relationship between the recipient and provider. This perspective suggests expectations and relational closeness play an important role in the attributions cancer patients make regarding a person's decision to not communicate support. The present study, by identifying reasons for not providing emotional support and investigating the role of expectations and relational closeness, provides a foundation to test Lehman and Hemphill's assertion in the context of not providing emotional support to those who have been recently diagnosed with cancer.

In other instances in our data, participants reported the recipient-focused reason of perceiving that the person already had enough support. This may occur in a way similar to diffusion of responsibility in emergency situations (Darley & Latané, 1968). Just as bystanders in emergencies may not act due to believing others are providing help, it is possible potential supporters have assumed incorrectly that others in the cancer patient's network are providing adequate support. In emergency situations, the bystander effect is combatted through direct requests to individuals (Staub, 1974). Likewise, cancer patients and others who find themselves in need of support may benefit from asking individuals in their network to provide support. Using a direct strategy increases the likelihood of receiving emotional support (Williams & Mickelson, 2008), and support quality may also increase or at least be perceived to be of higher quality (Burleson & Goldsmith, 1998).

Limitations and Additional Future Directions

As with all research, the present study has limitations. Although our sample represented the full range of relational closeness, most of our participants reported on someone diagnosed with cancer with whom they did not have a close relationship. Although we do not believe more people reporting on a close other would change the set of reasons provided, the nature of our sample may have affected the frequency of the reasons provided. Moreover, as part of their own sense-making, the respondents may have reduced their sense of closeness—and responsibility to/expectations from—the other to "justify" their decision not to provide emotional support. In any event, that the respondents were reporting generally on people with whom they may have had weaker ties limits the generalizability of our data, even though prior research (Dakof & Taylor, 1990) has shown issues of social avoidance in the cancer context occurs more frequently with friends and acquaintances than family and spouses.

Additionally, the results only address instances in which emotional support was not provided and do not account for other forms of support that may have occurred. It is possible some participants provided instrumental or informational support while forgoing emotional support provision, and we did not assess this. None of our participants noted that they had done so as a reason for not providing emotional support, however.

Importantly, the study's sample was diverse in terms of age and type of relationship with the cancer patient. The sample was geographically diverse as well, with participants from 20 countries across five continents. The sample size was also considerable given the restrictive eligibility requirements of both knowing someone diagnosed with cancer in the past 6 months and not having communicated emotional support. The number of responses from this study and the frequency of social avoidance behaviors by friends reported in a prior study on emotional support and cancer (Dakof & Taylor, 1990) suggest it is a common experience for recently diagnosed cancer patients to have some people in their network fail to support them. Despite these strengths, the nature of survey research using the methodology employed here may not be wholly representative and may also affect the degree of attention to which respondents gave to the study given that most participants complete surveys relatively quickly. The detail and nature of the responses to the open-ended question, however, led us to believe that our research choices provided useful variability in and face validity for the reasons people give for forgoing the provision of emotional support.

Future research should consider how a person's perception of someone's intentions when choosing not to provide emotional support moderates the negative effects associated with not receiving support. Our data also suggest that people weigh costs and rewards in deciding whether to provide emotional support, so applying a social exchange perspective to this situation might prove a fruitful avenue for future research.

Additionally, the unexpected reason of some cancer patients "not deserving" emotional support warrants further exploration, and researchers may wish to consider the relational history between supporter and person in need, particularly regarding the role of reciprocity (Antonucci, 1985), transgressions (Metts, 1994), and forgiveness (Waldron & Kelley, 2005). Finally, because many respondents cited anxiety and a perceived skills deficit regarding emotional support provision, researchers can develop interventions aimed at providing best practices for providing support during difficult life events.

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