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Face Threats and Additional Reasons for Perceiving Support as Unwanted: A Study of Recently Diagnosed Cancer Patients

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ABSTRACT

This study investigated instances of support that were deemed unwanted by a recipient in the wake of a cancer diagnosis. The investigation was framed by politeness theory and considered the face threats evident in cancer patients' descriptions of unwanted support. Additional reasons for viewing support as unwanted, as well as the outcomes of receiving unwanted support, were also explored. Interviews (N = 15) were conducted with cancer patients who had been initially diagnosed within the previous 12 months. Analyses demonstrated that face threats are among the reasons for viewing some support as problematic; however, additional reasons beyond face threats also occurred. The most frequently occurring reasons for regarding support as unwanted were threats to the receiver's negative face and messages failing to convey empathy. Finally, the influence of receiving unwanted support on cancer patients is discussed in terms of recipients' ability to manage emotions, respond to the support, potentially view the support provider negatively, and assert greater control over future supportive interactions.

Cancer is a significant disease with potentially life-threatening ramifications; therefore, an increased need for social support may occur for the newly diagnosed individual. For many people, the increased need for social support following a cancer diagnosis is addressed through an outpouring of support from family, friends, coworkers, and others. It is also important to realize, however, that not all support is wanted or perceived as useful. This article seeks to extend the existing knowledge about support following a cancer diagnosis by investigating the face threats that occur when receiving unwanted support. The researchers also explore additional reasons beyond face threats for perceiving support as unwanted, as well as the subsequent outcomes of receiving unwanted support.

Social support

Particularly in times of distress, people turn to others for support in order to cope with and overcome the stressors they face. Support can come in many forms (Cutrona & Suhr, 1992) and can help recipients accomplish goals that they may not otherwise be able to accomplish on their own. It is possible, however, that not all support is helpful. Thus, a brief outline of research on sources of support and the potential drawbacks of receiving support is detailed next.

Sources of support

A first-time cancer diagnosis can be a stressful event, signaling an outpouring of social support from a multitude of people. Moreover, these support providers consist not only of family and friends, but also health care practitioners, neighbors, work colleagues, and other types of relationships. Cancer patients tend to value support more from close relationships, such as partners, family, and friends (Rose, 1990), than from their acquaintances (Nausheen, Gidron, Peveler, & Moss-Morris, 2009). Although the current study did not focus on support from any one type of relationship, the majority of responses in the current study focused on support from family members, coworkers, friends, and health care professionals.

Potential drawbacks of supportive communication

Although support has been shown to have many benefits for recipients (for a review, see Ditzen & Heinrichs, 2014), researchers have contended that some support is actually harmful (Albrecht, Burleson, & Goldsmith, 1994), and failed support attempts from significant others can have a negative effect on people under a great deal of stress (Coyne, Wortman, & Lehman, 1988). Much of the literature on negative outcomes of support focuses on the gap between desired support and the support that is actually received. Matsunaga (2011) argues that such a gap diminishes one's ability to reappraise problematic situations, which is pivotal to Lazarus and Folkman's (1984) appraisal-based conceptualization of the coping process. A more recent study specifically found that self-esteem was affected negatively when one received less emotional or esteem support than desired or more informational support than desired (McLaren & High, 2015). The desired-versus-received support gap has deleterious effects on various relational outcomes, too. In marriages, the existence of such discrepancies has been negatively associated

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with relational satisfaction (Brock & Lawrence, 2009), and has been presented as a reason to end romantic relationships (Baxter, 1986)

Politeness Theory and Managing Face

To understand instances of unwanted support better, the researchers have elected to pose their research questions within the framework of politeness theory (Brown & Levinson, 1987), which operates on Goffman's concept of face (1959). At its core, face is an individual's desired public self-image, which can be lost, saved, or preserved. More specifically, individuals are concerned with face needs that fall into distinct categories (Brown & Levinson, 1987). Positive face is a person's desire to be viewed favorably by others, while negative face is one's desire to act without imposition from others.

Soon after the introduction of politeness theory, Lim and Bowers (1991) argued that positive face actually combined two distinct human desires: respect for one's abilities, and inclusion. Thus, Lim and Bowers asserted that positive face can be further delineated as either competence face, which concerns the need for respect for one's abilities and intelligence, or fellowship face, which is one's need for inclusion. Both categories of positive face are concerned in a broad sense with desirability; however, competence face is rooted in esteem needs, and fellowship face is more closely tied to belongingness needs (Maslow, 1943). Considering the deeper roots of competence and fellowship face, it is no surprise competence face is supported through positive evaluation, and fellowship face is supported through expressions of understanding, affection, and solidarity.

Face-threatening acts

Every interaction carries the potential for a face-threatening act (FTA) to occur to one or all people involved in the interaction. Indeed, a single message can create multiple types of face threats to either one or both people involved in the conversation (Wilson, Kim, & Meischke, 1991). Supportive messages are among those that carry the potential to create face threats for either conversational partner. Goldsmith (1992) determined that support providers and recipients must balance positive face goals of conveying acceptance without restricting either person's negative face desires for autonomy. A more recent study by Floyd and Ray (in press) had similar results, but demonstrated that these face threats occurred not only during enacted support, but also from merely being offered support.

Unwanted support, specifically in the context of a cancer diagnosis, remains understudied. Thus, the researchers asked the following research questions:

Research Question 1: What, if any, face threats are evident in cancer patients' descriptions of unwanted support received in the months following diagnosis?

Research Question 2: For what other reasons, if any, is social support perceived as unwanted by cancer patients following diagnosis?

Research Question 3: How, if at all, do these instances of unwanted support influence recently diagnosed cancer patients?

Methods

Participants

Participants (N = 15) were 8 men and 7 women ranging in age from 23 to 64 years (M = 45.21 years, SD = 15.80). The types of cancer diagnosed and severity of the diagnosis differed considerably across participants. Of the 15 patients interviewed, five had breast cancer, two had non-Hodgkin's lymphoma, and the remaining eight had cancer at various sites, including the throat, prostate, kidneys, brain, testes, stomach, and skin. Staging of the participants' cancers ranged from stage 0 to advanced stage 4; however, some participants had their cancer excised before staging could occur. Time since diagnosis ranged from 1.5 to 12 months (M = 6.37 months, SD = 3.03). Pseudonyms are used herein to protect participant confidentiality.

Procedure

Participants were recruited exclusively through snowball sampling procedures (Lindlof & Taylor, 2002). With one exception, all interviews were conducted over the phone and lasted between 19 and 140 minutes (M = 49 minutes, SD = 18). Participation in the study consisted of two components: an in-depth, structured interview, and a follow-up online questionnaire with 14 demographic questions. The interview focused on the role of support following participants' diagnosis. The first section overviewed the participant's cancer experience, including the site and severity of the diagnosis, and the participant's initial thoughts, feelings, and behaviors upon hearing the diagnosis. The second section investigated instances of both beneficial and unwanted support. Additional questions inquired why these instances were viewed as such, as well as the potential positive and negative effects of both positive and negative support interactions.

Data analysis and validity

The analysis of interview transcripts was accomplished through thematic analysis. To initiate the coding process, the coauthors read and reread the transcripts to engage in the process of data reduction (Miles, Huberman, & Saldaña, 2014). This allowed the researchers to focus on portions of the interviews that were most relevant to answering the research questions. Next, the coauthors conducted initial coding (Corbin & Strauss, 2015), with each author coding the same three interviews. During this process both coauthors made memos of emerging themes and categories (Glaser, 1978) for each of the research questions. The coauthors subsequently held a data conference (Braithwaite, Moore, & Abetz, 2014) to discuss and refine the

codebook (Tracy, 2012), comparing and contrasting codes against each other to group similar codes together. Then, the researchers engaged in focused coding (Charmaz, 2006), wherein they reviewed and consolidated themes. Once it was decided that both coauthors were utilizing similar coding strategies, the remaining transcripts were divided between the coauthors. The researchers engaged in cross-coding to eliminate bias (Barbour, 2001). Coding stopped after the 15th interview, as the co-investigators determined data saturation had been achieved on the basis that no new findings were emerging from the data (Corbin & Strauss, 2015).

In addition to describing the general coding process, it is important to be transparent about the coding process for each individual research question. RQ1 was specific to face threats and thus an *a priori* set of themes based on the tenets of politeness theory could be applied in a deductive manner. Specifically, instances of unwanted support were coded for various types of face threats to both the support recipient and the support provider. The coding for RQ2 was guided less by prior literature and therefore utilized an inductive data analysis technique. The process for RQ2 began with open coding (Corbin & Strauss, 2015) of the data, which led to the creation of numerous themes. The second step in the process was axial coding, in which relationships among open codes were discovered and themes were collapsed into categories (Corbin & Strauss, 2015). These categories were discussed between the researchers and the data were recoded into these categories.

Finally, RQ3 was originally concerned with the affective, behavioral, and cognitive outcomes of receiving unwanted support. During the initial coding process, it became evident that affective, behavioral, and cognitive categories were too broad to capture and represent the diverse experiences of the participants. The lead author spent substantive time reflecting on the data before attempting open coding for a second time. During the second attempt at open coding four new themes began to emerge. After a data conference with the coauthor to discuss these themes, these four themes were retained as categories.

Unitizing reliability was established using Guetzkow's (1950) *U*. Because RQ1 and RQ2 both looked at reasons for perceiving support as unwanted, a single *U* value was calculated for both questions combined ($U = .09$). A separate *U* value was calculated for RQ3 since it was analyzed separately from RQ1 and RQ2 ($U = .10$). Similarly, Cohen's kappa was calculated to demonstrate interrater agreement for both RQ1 and RQ2 combined (kappa = .72) and for RQ3 (kappa = .79). These kappa values suggest substantial agreement, according to Landis and Koch (1977).

The study's validity was strengthened through member checking. As suggested by Creswell (2009), the researchers provided a brief overview of the themes that emerged from the data, rather than the full transcripts of their respective interviews. The coauthors contacted three participants who had different experiences in terms of time since diagnosis, type of cancer, and severity of the diagnosis. Craig found the analysis to be reflective of his individual experience, and replied, "I wish I could have this in front of me when I talk to people about my experience as it does a far better job at summing things up than I do." Another participant, Sarah, replied saying, "I would agree with this summation." The third participant contacted did not respond.

Results

Reasons cancer patients perceive support as unwanted (RQ1 and RQ2)

RQ1 asked what face threats were evident in instances of unwanted social support, and RQ2 asked what additional reasons beyond face threats people had for viewing support as unwanted. The results are categorized across three different face threats to the support recipient: negative face, fellowship face, and competence face. The researchers also note instances when support was viewed as unwanted by the receiver because accepting it could pose a negative face threat to the provider. Four additional themes beyond face threats also emerged: Support messages failed to convey empathy, support did not match the receiver's needs, support invaded the receiver's privacy, and support was perceived as self-serving.

Threats to the receiver's negative face

The most common reason for perceiving support as unwanted was a threat to the recipient's negative face. One participant, Valerie, who lives near her elderly parents, mentioned that "my mom was going through illnesses at the same time, and it's like they want to help, but for them to help would have been more work on my part than them not helping." Another participant, Jennifer, discussed this in broader terms, commenting, "I want somebody to help me if I ask them, but I don't want somebody on me all the time."

Support attempts failed to convey empathy

Other instances of support were considered unwanted because the messages failed to convey empathy. This category emerged in nearly every interview, but in different forms. For some participants, providers tried to demonstrate empathy, regardless of the fact they had never been through cancer themselves. For example, Valerie commented, "You know, if people say I know how you feel or I know what you're going through … they really don't." Other participants explained failed empathic messages as being trite or generic. Hannah recalled members of her faith community using cliché messages. She shared, "If one person says, 'God saves his hardest battles for his toughest soldiers,' like that's the dumbest thing ever."

Support did not match the needs of the receiver

Many of the instances of unwanted support were viewed as such because they did not meet the recipient's support desires. For example, one participant Mitchell recalled one acquaintance who provided a daily inspirational message. In response he asserted, "I'm not the type of person who needs someone to tell me, 'keep my head up and it's a beautiful day' and all that crap. I don't need people telling me that. I kind of get that myself." Some instances of mismatched support offers were viewed as such because those particular needs had already been met. For example, one participant named Marissa recounted, "My mom mentioned to someone I like crosswords, so now I have like ten thousand books of crosswords! When am I going to get to these?"

Threats to the receiver's competence face

Under the umbrella of positive face lies the subcategory of competence face, or the need for one's abilities and intelligence to be respected. Kristin, who works full-time and has two daughters, reflected on support providers who did too much, saying, "You can't strip us of everything. You have to allow us to do what we believe we can do without overdoing it." Others saw informational support from nonmedical professionals as threatening their competence face because it challenged their chosen course of treatment. For example, Craig commented on his aunt, saying, "My mom's sister would write statuses or whatnot expressing doubt in my course of action. But it's not like I was going to sell my kidney on the black market."

Threats to the receiver's fellowship face

The underlying concept of fellowship face is being accepted by others. In terms of a cancer diagnosis and the subsequent treatment, this can include instances of wanting to be treated normally, but also the desire for others to accept your situation as unique. It was not uncommon to see both desires emerge from a single interview. Marissa recalled, "A lot of people assume that because it's cancer you all have the same treatment," but later expressed the desire to be not be singled out, saying, "I feel like people tiptoe around me. Just treat me normal. Ask me how I'm doing every so often." Jennifer expressed a similar desire for people close to her to recognize and reaffirm their acceptance of her following diagnosis. She recalled, "I was upset some people didn't even reach out to me or acknowledge it when they knew [of the diagnosis]. It wasn't that I needed them. I just wanted people that I cared for to acknowledge that I was going through that."

Support was viewed as an invasion of privacy

Some offers of support were considered invasions of privacy. For example, Hannah stated, "People heard the message, but because they believe they are saving my life they will cross the personal boundary about what I want from them. People genuinely motivated out of compassion and feeling that they know you desperately need to hear this will flat out ignore this and do it anyway." Mitchell preferred to keep his cancer experience as private as possible and recalled what amounted to a multitude of minor privacy invasions in the form of the same people asking him every day how he was feeling. Instead, he wished they "just let me contact them and didn't bug me. I found it very annoying."

Support was perceived as self-serving

Some participants reported perceiving a supportive interaction as self-serving to the provider. Andrew remarked, "I feel like they were trying to make themselves look better because, you know, they thought that they were doing the right thing. They were acting like they were being such a big help to me, when in reality, they really didn't communicate with me before that point."

Threats to the provider's negative face

Finally, some cancer patients said that receiving support might be too burdensome for the provider and lead to a threat to the provider's negative face. A participant named Derek viewed this in general terms across his cancer journey, saying he "would be taking the responsibility for putting the burden on somebody else by telling them what's going on."

The influence of unwanted support on cancer patients (RQ3)

RQ3 examined what influences receiving unwanted support have on recently diagnosed cancer patients. The coauthors contend that unwanted support influences cancer patients in regard to four aspects of supportive interactions: themselves as the support recipient, the support provider, the support message, and the context of future supportive interactions.

Addressing one's own emotional reactions

Recipients reported needing to attend to the emotional reactions they experience as a result of experiencing unwanted support. These emotions varied greatly, ranging from disappointment to annoyance. Kristin noted that receiving unwanted support "doesn't make you angry, it just adds to that profound sadness because you're trying to find a resolution and it's confusing." Valerie had a distinct reaction to receiving unwanted support, noting, "It was a bit of a burden that I had to say no to them and feel a little guilty that I wasn't allowing them to do what they wanted to do to support me."

Negative effects on perceptions of the support provider

Receiving unwanted support messages caused many participants to adjust their thoughts about their relationship with the support provider, as well as the person's abilities to provide support. In reference to her boss of many years, one participant, Sarah, recalled, "I no longer valued them as much as I would have had those behaviors not taken place." Participants also discussed adjusting their perceptions of people's ability to provide quality support. Jennifer summarized these instances in saying, "These people just don't know what to say, they just don't have a clue."

Responding to the unwanted support message or offer

Whether unwanted support comes in the form of a message or a tangible resource, the recipient is placed in a quandary in choosing how to respond. Hannah summarized her need to address all supportive messages, saying, "I'm a box closer. I return communication. So I feel those things stay in my brain. They don't go away until I close the box." Marissa mentioned a pitfall of receiving unsolicited gifts, saying, "I think it just puts a lot of pressure on you to use it in a good way."

Increasing control over future supportive interactions

Some participants responded to unwanted support by asserting increased control over future supportive interactions. Jennifer, in addressing an overbearing friend, disclosed, "She would call constantly so I would start avoiding her and not answer her phone calls or anything." Finally, Sarah bluntly

expressed that, in regard to people who previously provided unwanted support, "I quit sharing with those people. I was no longer interested in what they had to say."

Discussion

This analysis aimed to illuminate recently diagnosed cancer patients' experiences of receiving unwanted social support. Through interviews, the researchers examined the face threats accompanying unwanted social support, additional reasons for viewing some support offers as unwanted, and the influence unwanted social support has on recently diagnosed cancer patients.

The first research question asked about the face threats occurring during instances of unwanted support following a cancer diagnosis. Results revealed that face threats occur in four categories: threats to the receiver's negative face, threats to the receiver's fellowship face, threats to the receiver's competence face, and threats to the provider's negative face. Threats to the receiver's negative face were the most commonly mentioned reason for perceiving support as unwanted. This is not surprising, given that cancer diagnoses pose a threat to patients' autonomy as they transition to their new identities as a patient, face the uncertainty of their future, and anticipate the future risks of their diagnosis (Bergsma, 2002).

Threats to both forms of positive face also occurred. Regarding threats to the receiver's fellowship face, or one's need for acceptance, many recently diagnosed cancer patients stated they did not want to be viewed as different. Instead, they wished to be included and treated as they always had been; however, at times this desire stood in opposition to the need to be recognized as having a unique set of stressors due to cancer. Threats to the receiver's competence face, or one's need to be recognized as having ability and intelligence, were also reported by recently diagnosed cancer patients. Some of these threats were attributed to supporters questioning the patient's chosen path of treatment. Others viewed threats to competence face as stemming from the provider attempting to do too much for the patient. During one interview, the participant likened the journey to running a race. People can support them, but it is ultimately their job to keep running and complete their treatment.

Threats to the provider's negative face included the participants' descriptions of how receiving social support might be burdensome for the providers. Although much research has focused solely on the receiver's desires for acceptance and autonomy, many of the participants explicitly noted their mindfulness toward the negative face of the provider of the unwanted social support offers. In considering the provider's negative face, recently diagnosed cancer patients may actually be preserving those resources until they need them so as to not fully deplete their social support resources or demand too much of the providers of social support.

Beyond face threats, there were other reasons cancer patients viewed some support as unwanted (RQ2). For one, differences between the support desired and the type of support received accounted for many instances being labeled unwanted. Research on the matching hypothesis has explored the negative outcomes of mismatched support types (Cohen & Wills, 1985) or differences between desired and received amounts of support (Xu & Burleson, 2001). Another noteworthy reason why support attempts were viewed as unwanted is because they failed to convey empathy. Some low-empathic messages were viewed as such because they were trite or generic. Perhaps, these low-quality offers of empathy are guarded reactions to the fear and ambivalence the providers feel toward the cancer situation.

Finally, the coauthors analyzed the influence unwanted social support has on cancer patients (RQ3). Results signaled that outcomes occur in four categories: addressing one's own emotional reactions, negative effects on perceptions of the support provider, responding to the unwanted support message or behavior, and increasing control over future support interactions. Most prior research on supportive communication has focused on the receiver, provider, message content, or the context (Burleson, 2009). The researchers find the four categories for RQ3 are closely related to these four focus areas, thereby demonstrating the potential influence of a single unwanted support message on more than just the recipient.

Implications for cancer patients and support providers

One group that can benefit from this study is made up of those who provide support to recently diagnosed cancer patients. When formulating a support message, it is important to consider the reasons why support may be viewed as unwanted. For example, support messages intended to reinforce the recipient's positive face could instead threaten the recipient's negative face by creating an obligation to respond. Replying to one message may not take much time or effort; however, receiving a multitude of messages each week combined with limited energy due to undergoing treatments may make responding a burdensome task.

In crafting a support message, a provider would be wise to express empathy, but not to exaggerate the applicability of his or her life experiences, particularly if the provider has not personally been diagnosed with cancer. Even support providers who have had close relatives or friends experience cancer ought to consider how experiences differ based on the type and severity of cancer, combined with personal factors such as financial resources, personal support networks, access to medicine and treatments, and experiences navigating the complexities of a health care system (Kreps, 2006).

Support providers should also be aware of the outcomes related to providing unwanted support. Although it is possible that only some of the outcomes discussed in the preceding occur in response to a particular instance of unwanted support, the authors see the potential for a chain reaction to occur. For example, the receivers of unwanted support may experience negative face threats as they feel obligated to respond to the support provider. Simultaneously they may also experience positive face threats related to the content of the unwanted support message. This in turn could lead to reevaluating the support provider as unable to provide effective support. Finally, this reevaluation of a support provider may influence whether or not to seek support from this person in the future.

Implications for politeness theory

The study's findings have theoretical implications as well. The researchers propose that this study constitutes an extension of positive fellowship face. As previously discussed, fellowship face can be supported through expressions of solidarity that emphasize the person as an in-group member (Lim & Bowers, 1991). Prior research suggests solidarity is demonstrated through empathic understanding and emphasizing commonalities (Scollon & Scollon, 1983); however, within the context of a cancer diagnosis, attempting to highlight commonalities may become face threatening rather than face preserving.

Specifically, when one is diagnosed with cancer one is likely placed in a different life situation than the vast majority of one's support network. This carries a potential for fellowship face threats, as a cancer diagnosis could challenge the person's status as an in-group member since that person's daily life is fundamentally different from those without cancer in the support network. In this case, stressing commonalities could be damaging because it suggests the supporters do not recognize or accept the new unique experiences brought about by a cancer diagnosis.

With this in mind, those supporting someone with cancer ought to demonstrate empathic understanding of how the person's life has changed since their diagnosis, but also reassure the person that they are still an in-group member in light of these new circumstances. Solidarity, in this case, could occur by embracing the cancer patient's new life situation and could be expressed through a network of friends rallying around the person's fight with cancer. Therefore, the coauthors propose in a broader sense the inclusion needs associated with fellowship face can be met both through an emphasis on similarities, and through recognition and acceptance of a person's unique experiences and perspectives.

Strengths, limitations, and future directions

This study both benefited from certain strengths and withstood certain limitations. One strength was the opportunity to extend research on unwanted supportive communication to an understudied yet important context: the experiences of recently diagnosed cancer patients. Moments of unwanted support in this context contained both similarities to and differences from prior research on unwanted support in the general population. The study also accounted for the influences of receiving unwanted support on both the recipient and provider.

Among the limitations for the study was the rather homogeneous sample. Of the 15 participants, most were Caucasian, college educated, and working full-time. However, the participants did show diversity in terms of the site of their cancer and the severity of their prognosis. Although the coauthors did not interview anyone who has been given a terminal prognosis, they are confident the range of experiences with cancer captured by the sample is broad enough to see themes that hold across a large segment of the spectrum of possible cancer experiences.

Although the current study provides an overview of reasons for viewing support as unwanted, many questions concerning problematic support messages and interactions remain unanswered. For one, subsequent research should investigate how support needs change across turning points throughout one's cancer journey. Additionally, although the current study focused on unwanted support that actually occurred, many participants reflected on the experience of not receiving support they expected. Researchers ought to see whether the findings from the present study also apply to instances of nonsupport.

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