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An Examination of Communication Sequencing in Enacted Support Interactions for People with Major Depressive Disorder

Madison Adams

University of Kentucky, adamsmadisonf@gmail.com

Author ORCID Identifier:

 <https://orcid.org/0000-0002-4014-0062>

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Madison Adams, Student

Dr. Jennifer A. Scarduzio, Major Professor

Dr. Anthony M. Limperos, Director of Graduate Studies

AN EXAMINATION OF COMMUNICATION SEQUENCING IN ENACTED
SUPPORT INTERACTIONS FOR PEOPLE WITH MAJOR DEPRESSIVE DISORDER

THESIS

A thesis submitted in partial fulfillment of the
requirements for the degree of Master of Arts in the
College of Communication and Information
at the University of Kentucky

By
Madison Adams
Lexington, Kentucky
Director: Dr. Jennifer A. Scarduzio, Associate Professor of Communication
Lexington, Kentucky
2021

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<https://orcid.org/0000-0002-4014-0062>

ABSTRACT OF THESIS

AN EXAMINATION OF COMMUNICATION SEQUENCING IN ENACTED SUPPORT INTERACTIONS FOR PEOPLE WITH MAJOR DEPRESSIVE DISORDER

Social support is integral to helping one manage Major Depressive Disorder [MDD], but enacted social support, or the supportive behavior itself, is not always beneficial. Using a normative theoretical perspective on social support and theory related to sequencing as guiding frameworks, in this thesis I examined common sequential patterns of enacted support between support providers and individuals with MDD. Moreover, I investigated how individuals with MDD evaluated the helpfulness of each of the different sequential patterns. To examine the sequential patterns and how individuals with MDD evaluated their helpfulness, I interviewed 20 participants who had been diagnosed with MDD. The results of this thesis revealed five sequential patterns and revealed instances when participants considered each pattern to be helpful or unhelpful. The results extend literature specifically on unsolicited support by showing instances when participants considered unsolicited support to be beneficial and needed. Furthermore, one of the five patterns, *forced support*, is a new concept that has not been discussed in sequencing literature. Practically, this thesis provides suggestions for loved ones aiming to support someone with MDD, such as listening without offering advice or providing specific types of unsolicited support, such as unsolicited instrumental support while avoiding other types of unsolicited support, such as unsolicited informational support.

KEYWORDS: Sequencing, enacted support, depression

Madison Adams

(Name of Student)

07/13/2021

Date

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By
Madison Adams

Dr. Jennifer A. Scarduzio

Director of Thesis

Dr. Anthony M. Limperos

Director of Graduate Studies

07/13/2021

Date

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CHAPTER 1. INTRODUCTION

Social support from family, friends, and loved ones is crucial in managing Major Depressive Disorder (MDD), one of the most common mental illnesses in the United States (U.S.; Almeida et al., 2011; Alpert & Fava, 2004; National Institute of Mental Health [NIMH], 2020c; Santini et al., 2015). However, this social support is not always adequate or helpful (Goldsmith, 2004; Krychiw & Ward-Ciesielski, 2019; Thompson et al., 2020). Indeed, many close, well-intended network members often struggle to support someone they know with a mental illness (Champlin, 2009; Gladstone et al., 2007). MDD may add additional challenges to providing and receiving social support as individuals with MDD may be sensitized to everyday actions of both social rejection and social acceptance (Steger & Kashdan, 2009).

Research on social support has traditionally focused on the quantity of support (e.g., Cutrona, 1990; Cutrona & Suhr, 1994) or examined perceived available support (e.g., Cohen & Wills, 1985; Sarason et al., 1990; Wang et al., 2018). While important, this research does not examine the supportive interactions themselves. In other words, this research does not commonly examine exactly what is communicated, or how social support is *enacted*. Researching enacted support is a conceptually different approach to studying social support because it focuses on the supportive talk or behavior itself (Goldsmith, 2004). Furthermore, while there is a consensus on the positive effects of social support on well-being (House et al., 1988), the effectiveness of enacted support is dependent on additional individual, relational, and situational factors (Dunkel-Schetter & Skokan, 1990; Goldsmith, 2004).

According to the normative perspective on social support, the effectiveness of enacted support is not only dependent on what the support providers or receivers say, how they say it, and the communication context in which support is provided, it is also dependent on how effective the support is in managing identity, relational, and task purposes (Goldsmith, 2004). Additionally, while the normative perspective on social support explains why some support is helpful and why other support is unhelpful (Goldsmith, 2001, 2004), further research is needed to understand how specific message features distinguish helpful from unhelpful support (Holmstrom, 2012).

Message features refer to “ordinary language descriptions of the words, propositions, speech acts, and rhetorical devices and strategies that appear in various [enacted] support messages” (Holmstrom, 2012, p. 80). While there are many theoretically based message features (e.g., message design logic, person-centeredness), this thesis will focus on the specific message feature of sequence. Sequence is a message feature that refers to the order or sequence of enacted supportive interactions. For instance, Feng’s (2009, 2014) integrated of advice giving [IMA] argues that advice is most effective when an advice provider first gives emotional support (e.g., expressions of concern, care, or empathy), then evaluates the advice recipient’s problem, and then based on that evaluation, offers advice.

However, recent research suggests that the order of supportive interactions may not be as important as the IMA suggests; rather, what may be more integral to the process is the quality or type of support offered (Danielson & Jones, 2019; MacGeorge et al., 2017; Malloch et al., 2020). Moreover, a portion of sequencing research utilizes hypothetical scenarios with less serious stressors, such as having a conflict with a parent

(e.g., Feng 2009, 2014; Feng et al., 2017; Malloch et al., 2020). The importance of sequencing may differ in real-life interactions with a more serious stressor, such as MDD (Feng, 2009). Taking this research into account, I chose to focus on the specific message feature of sequencing in order to extend this literature by understanding common real-life sequential patterns of supportive interactions; examining how individuals with MDD evaluate different real-life sequences of supportive interactions; and by investigating how individuals with MDD evaluate the sequence of other types of enacted support, such as instrumental support (e.g., offers to provide goods or services; Goldsmith, 2004).

Given this, the following research questions guided this thesis:

RQ₁: What are some common sequential patterns of supportive interactions between support providers and individuals diagnosed with MDD?

RQ₂: How do individuals diagnosed with MDD evaluate the helpfulness of the different sequential patterns of supportive interactions?

This thesis includes five chapters. In the current chapter, I provided an introduction to MDD, enacted support, and sequencing. In the next chapter I review literature on social support, enacted support, the normative perspective on social support and sequencing. In the third chapter, I outline the qualitative methods I used for data collection and analysis, and I describe the results of data analysis in the fourth chapter. In the final chapter, I discuss theoretical and practical implications as well as limitations and directions for future research.

CHAPTER 2. LITERATURE REVIEW

Major Depressive Disorder (MDD) is a mood disorder that affects 17.3 million adults in the U.S. (NIMH, 2020c). While there are many types of depression that may develop under unique circumstances (e.g., persistent, postpartum, psychotic), MDD is more than just “feeling sad,” and is an illness that affects the way individuals think, feel, and handle daily activities (NIMH, 2020b). Since sadness is a normal human emotion, when diagnosing patients with MDD, physicians are careful to distinguish normal sadness and grief from major depression (American Psychiatric Association [APA], 2013). To be diagnosed with MDD, an individual must have experienced depressive symptoms persistently for at least two weeks (APA, 2013). Depressive symptoms can include: (a) enduring feelings of sadness, emptiness, or hopelessness; (b) diminished interest in activities; (c) changes in eating habits and/or appetite; (d) trouble sleeping; (e) restlessness or lethargy; (f) fatigue; (g) feelings of worthlessness or guilt; (d) difficulty concentrating; or (e) thoughts of death or suicide (APA, 2013).

Those diagnosed with MDD experience a generalized sense of discomfort and can feel trapped or constrained by their illness (Apóstolo & Kolcaba, 2009). While support from healthcare providers, medication, a healthy diet, and exercise play an important role in healing from and managing MDD, these behaviors alone are insufficient. Indeed, additional social support from an individual’s support network of family and friends is crucial to heal from and manage MDD (Almeida et al., 2011; Alpert & Fava, 2004; Santini et al., 2015; Thompson et al., 2020). Since social support plays an integral role in helping one manage MDD, it is important to further understand how social support has been studied and further examine its role in the context of MDD.

2.1 Social Support

Research on the role of social support began in the 1970s with the work of Caplan (1974) and Cobb (1976). According to Caplan (1974), social support has three main functions: to provide individuals with a sense of worth, to act as a refuge where one can rest, and to serve as an “enduring pattern of intermittent ties” that play a significant role in maintaining physical and psychological well-being over time (p. 7). Caplan’s (1974) work focused on the support system, or sources of support. Furthermore, even though Caplan (1974) recognized support could come from multiple sources, he argued family should be the primary source of social support. As a result, Caplan’s (1974) work emphasizes the importance of specific relationships. Conversely, Cobb (1976) focused on the experience of receiving support. Cobb (1976) defined social support as information leading one to feel cared for, loved, esteemed, and valued, and information leading one to believe that they belong. Cobb’s (1976) work showed the power of social support under difficult circumstances. By showing this, Cobb (1976) hoped to explore how social support can facilitate coping and adaptation to change.

Following the work of Caplan (1974) and Cobb (1976), research on social support in the 1980s began to explore the relationship between social support and well-being (House et al., 1988). The relationship between social support and well-being is often explained by the main effects model, which suggests social support produces a direct effect on health and well-being, or the buffering model, which suggests that social support can buffer the negative effects of a stressful situation or event (Barrera, 1981; Cohen & Wills, 1985; Wheaton, 1985). Within the context of MDD specifically, Santini et al. (2015) systematically reviewed literature on the association between social support and depression. In their review of 51 studies, they found greater perceived social support

and larger, diverse social networks played important protective roles against depression in the general population. That is, social support buffered the negative effects of depression (Santini et al., 2015).

Even with the consensus that social support has a positive effect on health and well-being, when research on social support began, it was typically conceptualized and operationalized as a unidimensional construct (Cutrona, 1990). Recognizing the limitations of this conceptualization, scholars began to conceptualize and operationalize social support as a multidimensional construct. Since then, scholars have outlined social support using three (House, 1981), four (Hale et al., 2005), five (Cutrona & Suhr, 1994) or six (Weiss, 1974) components. For example, Cutrona and Suhr (1994) outline five types of support: (a) *informational* (advice, factual input, and feedback), (b) *tangible* (offers to provide goods or services), (c) *emotional* (expressions of caring, concern, empathy, and sympathy), (d) *network* (sense of belonging among people with similar interests and concerns), and (e) *esteem* (expressions of regard for one's skills or abilities and/or value as a person).

Conceptualizing support as a multidimensional construct proved beneficial to furthering the understanding of social support. Using their five categories of social support, Cutrona and Suhr (1994) found informational and emotional support were the most frequent type of social support used by marital partners. With the goal of discovering what specific type of social support predicted perceived health among college students, Hale et al. (2005) illustrated that network support to be a key support component for the physical health of college students. More specifically related to MDD, tangible support, but not emotional or esteem support, may act as an indirect protective

factor against suicide and suicidal ideation in adults with autism spectrum disorder (Hedley et al., 2017).

Furthermore, Cutrona (1990) recognized individuals want to be supportive to people in distress, but often their support engenders more distress. Thus, Cutrona (1990) proposed the optimal-matching model (OMM), which sought to explain what types of support were most helpful in specific stressful situations. While the OMM has intuitive appeal and has been cited heavily in literature, it has not been supported by research (MacGeorge et al., 2011). For example, Cutrona and Suhr (1992) tested the effect of the controllability of stressful events among spouses to see what types of social support were provided and preferred. Results found partial support for the OMM, and Cutrona and Suhr (1992) argued further research was needed to incorporate the complex, interdependent processes of supportive interactions (Cutrona & Suhr, 1992). Likewise, Cutrona et al. (2007) tested the OMM among spouses. Their findings did not support the OMM, and they argued that there is no best type of social support for all situations; rather, it is more important to study the context in which support transactions occur (Cutrona et al., 2007).

However, other extant research offers support for the OMM, arguing supportive interactions generally appear to be most effective when the type of support offered matches the specific needs of the recipient (Burleson et al., 1994). More recently, the OMM has been tested and found to be supported in scholarship about cancer patients and cancers survivors (Merluzzi et al., 2016). Yet, even with some empirical evidence to support the OMM, the OMM only addresses the quantity or type of support and fails to provide a comprehensive explanation of why support is viewed as helpful or unhelpful. In

other words, the OMM does not explain exactly what is said or how support is communicated and the OMM does not explain how support is *enacted*—an issue I turn to next.

2.2 Enacted Support

Enacted support, also referred to as received support, supportive behaviors, support transactions, administered support, or objective support, describes exactly “what individuals say and do to help one another” (Goldsmith, 2004, p. 14). While much social support research has focused on the quantity of support provided, the social network, or the perception of available support (i.e., perceived support), enacted support is a conceptually different approach because it focuses on the supportive talk or behavior itself (Goldsmith, 2004). In other words, enacted support centers on the communication of social support. Similar to Cutrona and Suhr’s (1994) types of social support, common types of enacted support include *informational* (advice or information about a problem), *emotional* (expressions of caring, concern, or empathy), *instrumental* (offers to provide goods or services), *appraisal* (providing new perspectives on a problem), *esteem* (reassurances of worth), and *network* (sense of belonging) support (Goldsmith, 2004). Furthermore, enacted support can be evaluated in terms of helpfulness (assisting with some stressor), supportiveness (relational assurance), or sensitivity (emotional awareness; Goldsmith et al., 2000).

While there is an agreement on the benefits of social support on health and well-being (Barrera, 1981; Cohen & Wills, 1985; Wheaton, 1985), the relationship between enacted support and well-being is inconclusive (Goldsmith, 2004). For instance, a study among couples undergoing in-vitro fertilization found enacted emotional and

instrumental support had no effect on recipient well-being (Knoll et al., 2007). Moreover, Chen et al. (2012) focused on the effectiveness of enacted emotional and instrumental support based on data from a national midlife survey in the U.S. Their results indicated that emotional support exhibited a positive effect on well-being while instrumental support had a negative effect on well-being (Chen et al., 2012). Furthermore, relational satisfaction may influence the effectiveness of enacted support (Frazier et al., 2003). More specifically, individuals who had less relational satisfaction were more adversely affected by unhelpful enacted support behaviors than those who had more relational satisfaction (Frazier et al., 2003).

Within the context of mental health, enacted support from family members can be beneficial or harmful. For example, instrumental support from family and friends is crucial in recovering from a severe mental illness (Schön et al., 2009). In this case, instrumental support included behaviors such as offering cooked meals or advocating for help from psychiatric and social services (Schön et al., 2009). However, if the individual wanted more autonomy or a reciprocal relationship, not a relationship where one person fixated on the role of helper, enacted instrumental support had a detrimental effect (Schön et al., 2009). Additionally, family members can offer moral support and motivation to recover from a mental illness but can also lack understanding and make an individual feel stigmatized (Aldersey & Whitley, 2015). This research then suggested family plays neither a universally positive nor negative role in recovering from a mental illness (Aldersey & Whitley, 2015). Instead, additional individual, relational, and situational factors influence the effectiveness of support from family members and friends (Aldersey & Whitley, 2015; Dunkel-Schetter & Skokan, 1990; Goldsmith, 2004). Thus, it is

necessary to examine how these additional factors affect the effectiveness of enacted support, which the normative perspective on social support helps explain.

2.3 The Normative Perspective on Social Support

According to the normative perspective on social support, the effectiveness of enacted support is not only dependent on what the support providers or receivers say, how they say it, and the communication context in which support is provided, it also dependent on how effective the support is at managing identity, relational, and task purposes (Goldsmith, 2004). When an individual seeks, provides, or receives social support, they are also enacting an identity of themselves, portraying an image of the relationship, and achieving a specific task (Goldsmith, 2004). Individuals then evaluate the helpfulness of an enacted support behavior based on how effectively the behavior manages conflicting identity, relational, and task purposes. For example, if a family member wants to encourage a loved one to seek professional help for a mental health condition, they need to manage how to advise the loved on how to get support (task purpose) while also ensuring they do not imply the loved one is weak or flawed (identity purpose) and that they care about the loved one (relational purpose; Wilson et al., 2015).

Instead of measuring the type, frequency, or amount of support, the normative perspective on social support focuses on the interpretations, goals, and outcomes of enacted support (Goldsmith, 2001, 2004; Goldsmith & Fitch, 1997). The normative perspective on social support shifts from predicting and explaining the occurrence of a support behavior to predicting and explaining the evaluation of a support behavior as more or less effective or appropriate (Goldsmith, 2001). In broad terms, common effective support includes providing assistance, empathy, affection, honesty, reassurance,

respect for autonomy, and inclusion in social events (Goldsmith, 2004). Common ineffective support includes unwanted care, too much control, disagreement with decisions, lack of listening or attention, condescension, pity, or rudeness (Goldsmith, 2004).

The normative perspective on social support has been used to examine the effectiveness and ineffectiveness of social support in health-related contexts such as substance use disorders (Middleton et al., 2017), cardiac events (Goldsmith et al., 2006), young-adult cancer (Iannarino et al., 2017), lung cancer (Caughlin et al., 2011) and organ transplants (Scott et al., 2011). Additionally, health-related illnesses can add challenges to understanding if enacted support is effective or ineffective (e.g., Goldsmith et al., 2006; Iannarino et al., 2017; Wilson et al., 2015). For example, for those that experienced a cardiac event, expressions of caring and concern from a partner could be viewed positively but also threaten the individual's autonomy (Goldsmith et al., 2006). For young adult cancer survivors, instrumental support could be evaluated as helpful or overbearing (Iannarino et al., 2017). Similarly, for organ transplant patients, instrumental support was vital to recovery, but it also raised relational concerns about how stressful it was for caregivers to provide this type of support (Scott et al., 2011).

As these studies show, health-related illnesses complicate the effectiveness of support. MDD may add additional challenges to understanding if enacted support is effective or ineffective since MDD affects an individual's perception of social interactions (Coyne, 1976; Steger & Kashdan, 2009) and can contribute to strained interpersonal relationships (Knobloch et al., 2016; Sharabi et al., 2016; Thompson et al.,

2020). Because of these additional challenges, it is necessary to examine how specific message features influence the evaluations of enacted support in the context of MDD.

2.4 Sequence

While much research has used the normative perspective on social support to examine how and why enacted support behaviors are evaluated as helpful or unhelpful, additional research is needed to examine what specific message features distinguish helpful from unhelpful support and why (Holmstrom, 2012). Indeed, specific message features matter the most in determining whether a supportive message was helpful or unhelpful (Holmstrom, 2012). As previously mentioned, message features refer to “ordinary language descriptions of the words, propositions, speech acts, and rhetorical devices and strategies that appear in various [enacted] support messages” (Holmstrom, 2012, p. 80). While there are many theoretically based message features (e.g., message design logic, person-centeredness), in this thesis I will focus on the specific message features of sequence.

Sequence is a message feature that refers to the order or sequence of enacted support interactions. For example, a support provider may first offer emotional support by listening and validating another’s feelings, and then later in the conversation offer network support by inviting one to a social gathering. Although facework is not a focus of this thesis, sequence is a message feature that relates closely to facework. Based on politeness theory, face refers to “the want to be unimpeded and the want to be approved of in certain respects” (Brown & Levinson, 1987, p. 63), and face has two components: positive and negative face. Positive face refers to the need to be seen as an acceptable and respectable person, and negative face refers to the desire to not be imposed upon or

treated as inferior (Brown & Levinson, 1987). Politeness theory then theorizes about face threatening acts, those acts that threaten either one's positive or negative face. Facework, then, refers to the communicative acts that attempt to manage these face threatening acts (Brown & Levinson, 1987).

While one specific communicative act can involve facework, Goldsmith (2000) argued facework analysis should also examine how the sequence of speech acts (e.g., the conversation about a problem) affects facework. Based on this rationale, Goldsmith proposed six types of sequence patterns in the act of soliciting advice: (a) advice recipient asks for advice (e.g., "I need advice", "What should I do?"); (b) advice recipient asks for opinion (e.g., "What do you think of this?"); (c) advice recipient identifies a problem (e.g., advice recipient mentions a problem, advice provider volunteers advice); (d) advice recipient announces a plan of action (e.g., recipient states some plan of action, and in response, provider volunteers advice); (e) advice provider identifies recipient's problem (advice provider identifies and brings up a problem, but does not offer advice); and (f) advice provider volunteers advice (advice provider volunteers advice without identifying the problem). Overall, these sequence patterns differ along three dimensions: the explicitness with which the advice recipient asks for advice, the degree which the advice recipient acknowledges there is a problem, and who introduces the problem (i.e., recipient or provider; Goldsmith, 2000).

Testing these sequence patterns, Goldsmith (2000) found each had different effects on perceived regard for face. While none of the sequences showed a high regard for face, the sequences did have different implications for positive (e.g., need to be seen as acceptable) and negative (e.g., the desire to not be inferior) face. Providing advice was

less threatening to negative face when the advice recipient asked for the advice, acknowledged the problem, or introduced the issue. Providing advice was more threatening to negative face when the advice provider identified the problem or volunteered advice. On the other hand, advice was least threatening to the advice recipient's positive face when advice followed the recipient's disclosure of a problem or announced a plan of action.

Even though Goldsmith (2000) focused on the sequencing of advice, advice is never just advice (Goldsmith & Fitch, 1997). In other words, in addition to providing an expert opinion or another view in deciding, advice can also convey relational caring or closeness, which are expressions of emotional support (Goldsmith & Fitch, 1997). Indeed, even though the types of social support (e.g., informational, appraisal, emotional, network, esteem, and instrumental) are conceptually different, they often complement each other and may co-occur within the same conversation (Feng, 2009; Goldsmith & Fitch, 1997; MacGeorge et al., 2017).

With the idea that multiple types of support can occur within the same interaction, Feng (2009) proposed the integrated model of advice giving (IMA). Based on theory and research from supportive communication and counseling, the model proposes that advice is most effective when the support provider first provides emotional support, then analyzes the recipient's problem and assesses the relevance of advice, and then based on the assessment, offers advice (Feng, 2009). When testing the IMA, Feng (2014) and Feng et al. (2017) found that the provision of emotional support had a significant role in how participants evaluated the supportive interaction. For example, when advice followed

emotional support, participants had a greater intention to implement the advice compared to when emotional support followed advice (Feng et al., 2017).

While the IMA involves the sequencing of advice and emotional support, others have begun to examine the sequencing of other types of support, such as esteem support (e.g., Malloch et al., 2020; Shebib et al., 2020). For instance, Malloch et al. (2020) proposed an extended integrated model of advice giving to include esteem support. However, there was not a statistically significant difference between the sequence of emotional support–problem inquiry and analysis–advice–esteem support and the sequence of emotional support–problem inquiry and analysis–esteem support–advice. That is, the sequence of esteem support did not affect how participants evaluated the quality of advice or their intention to follow the advice (Malloch et al., 2020).

Furthermore, Danielson and Jones (2019) examined the sequencing of emotional, informational, and network support. In their study, they examined the sequence of hypothetical supportive messages teachers provided to students who experienced bullying by manipulating the order and types of support (e.g., only emotional support or only network support; network then informational support; informational, emotional, then network). Their results indicated that participants evaluated conversations with multiple types of support (e.g., informational and network) as more supportive than conversations that included a single type of support (e.g., informational). Contrary to the IMA, their results showed that participants did not evaluate conversations that included emotional support first as more supportive than those that did not, and conversations that did not include emotional support were not significantly more supportive than those that did include emotional support. Furthermore, the sequence of support did not influence the

evaluation of supportiveness. Participants evaluated the conversations that included network and informational support as most supportive, regardless of the order. That is, what mattered most in their study was the type of support the teacher provided, not the order or sequence (Danielson & Jones, 2019).

In sum, research on sequencing has typically studied the sequence of advice and emotional support by testing hypothetical scenarios with less serious stressors, such as having a conflict with a parent (e.g., Feng 2009, 2014; Feng et al., 2017; Malloch et al., 2020). Given that the sequence of different types of support may not be integral to its helpfulness (e.g., Danielson & Jones, 2019; Malloch et al., 2020) and that the importance of sequencing may differ in real-life interactions with a more serious stressor, such as MDD (Feng, 2009), it is worthwhile to extend research on the sequencing by investigating common real-life sequential patterns and the sequence of other types of support within the context of supporting an individual with MDD. Thus, the following research questions are posed:

RQ₁: What are some common sequential patterns of supportive interactions between support providers and individuals diagnosed with MDD?

RQ₂: How do individuals diagnosed with MDD evaluate the helpfulness of the different sequential patterns of supportive interactions?

2.5 Summary

In this chapter I introduced MDD and explained the important role social support plays in helping an individual manage MDD. I then reviewed literature on social support, enacted support, the normative perspective on social support, and the specific message features of sequencing. I discussed why it is important to extend theory on sequencing in

the context of MDD and offered the research questions that guided this thesis. In the next chapter, I detail the research methods I used to answer these research questions, and I explain the data analysis process.

CHAPTER 3. METHODS

Qualitative research methods have both the ability to provide insight into stigmatized populations and to understand the stories people attach to interactions (Tracy, 2020). Thus, I used semi-structured interviews to gain greater insight into the meanings individuals with MDD attach to different sequential patterns (Taylor et al., 2016). Semi-structured interviews enabled participants to describe, in their own words, the specific helpful and unhelpful interactions they have experienced related to MDD (Taylor et al., 2016). Finally, I conducted interviews and not focus groups to protect participant confidentiality since MDD is a stigmatized topic and focus groups cannot guarantee confidentiality (Pescosolido et al., 2010; Tracy, 2020).

3.1 Participants

To participate in this study, participants had to be between the ages of 18 and 65 and had to have been diagnosed with MDD. I recruited participants using a combination of convenience and snowball sampling (Tracy, 2020). Convenience sampling is cost and time efficient (Tracy, 2020), which was important because it helped me complete this thesis in a timely manner. Participants were recruited via a call for participants posted on the National Communication Association's (NCA) listserv, COMMNotes; Volunteer Science, which is an online platform for behavioral and social science researchers that allows researchers to recruit participants from a network of volunteers around the world; the School of Information Science's Research Subjects Pool (RSP), which is a student research pool at the University of Kentucky (UK); and posts on my personal Facebook and Instagram pages. I also recruited participants via my personal network of friends and

family. After each interview, I sent a thank you email and asked participants to forward study information to anyone they knew who fit the inclusion criteria.

The final sample resulted in 20 participants. Participants ranged in age from 19 to 50 years old, with a mean age of 32 years old. Ten participants were cisgender females, nine participants were cisgender males, and one participant identified as non-binary. The majority of participants identified as heterosexual ($n = 15$), followed by bisexual ($n = 2$), pansexual ($n = 1$), and asexual ($n = 1$). One participant did not feel comfortable describing their sexual orientation. Participants identified as White ($n = 12$), White and Hispanic ($n = 3$), Jewish ($n = 2$), Latina ($n = 1$), British ($n = 1$), and Serbian ($n = 1$). Of the 20 participants, 12 were single, five were married, and three were in a relationship. Participants had been diagnosed with MDD anywhere from a few months to 30 years ago.

3.2 Procedure

After receiving IRB approval, I posted the call for participants on COMMNotes and my social media pages, reached out to my personal network of friends and family, and posted the study on RSP. After recruiting in these ways for three months and posting on my social media pages a second time, eight participants volunteered to participate. While I tried to recruit via RSP, those eight participants were recruited via COMMNotes or my personal network. That is, none of the participants were recruited from RSP. Then to recruit more participants, I submitted an IRB modification request to recruit from Volunteer Science. Upon IRB approval, I posted the study on Volunteer Science and 12 additional participants volunteered to participate.

Interested participants emailed me to set up a Zoom interview at a time that worked best for them. Prior to the interview, I emailed the participant the informed consent form and asked them to review it before the interview. Due to COVID-19 protocols, all interviews took place on Zoom. Participants had the option to mute their video if they preferred. They were allowed to skip any question(s) and end the interview at any time during the interview without a penalty. At the beginning of the interview, I discussed the informed consent form (asking them to verbally consent), asked participants if they had any questions about the consent form and/or thesis, and if they would like to proceed. Participation was voluntary.

I conducted the semi-structured interview with the participant one-on-one. The type of interview I engaged in was a combination of respondent and narrative because all participants had experiences that related to the research goals, and I encouraged participants to tell stories about their experiences (Tracy, 2020). Initially, I intended to focus on the message features of sequencing, accommodation, and nonaccommodation in this thesis. Thus, I created the interview guide by referencing sequencing, accommodation, and nonaccommodation literature. I was careful to include a variety of question types that asked about the participant's support network, why and how specific message features were helpful or unhelpful, and their general experiences with MDD (Tracy, 2020). I wrote questions that were simple, avoided academic jargon, and related directly to sequencing, accommodation, and nonaccommodation (Tracy, 2020). In addition, given the current times, I included a question about how COVID-19 has impacted their experience in receiving social support.

The final interview guide was about 30 questions. Sample questions included, “What’s been the best advice someone has given you? Why do you say it’s the best?”, “Can you describe a time someone offered support or advice that made it seem like they were talking down to you?”, and “What are some of the most helpful things your support system says or does?” After completing 19 interviews, I submitted another IRB modification request and added three questions with probes. I added the questions, “Can you tell me about a time when you explicitly asked someone for help? How did the person respond?” and “Did your opinion of this person change after they talked down to you?” because I realized the initial interview guide did not ask about explicitly asking for help or about how the participant viewed the support provider after they offered support.

Lastly, I added one question to conduct member validation. Member validation refers to “taking findings back to the field and determining whether the participants recognize them as true or accurate” (Lindlof & Taylor, 2011, p. 279). Because many participants in the first 19 interviews discussed feeling annoyed and grateful about the same supportive interaction, the member validation question asked, “In the other interviews I’ve done, some participants have said that they sometimes feel annoyed but also grateful when someone helps them. Can you tell me about a time when someone helped you and you felt annoyed in the moment, but were also grateful?” While I made an effort to conduct member validation, I was only able to interview one participant using the revised interview guide. See Appendix 1 for the complete interview guide.

During the interview, I took a combination of deliberate naïveté and responsive interview stances (Tracy, 2020). I took a deliberate naïveté stance because I was new to interviewing and it was best for me to drop any presuppositions and judgement while

maintaining openness to new and unexpected findings. I took a responsive stance because interviews were about MDD, an emotional and stigmatized topic. A responsive stance allowed me to treat “interviewees with unfailingly respectful behavior,” to reflect on my own biases, and to participate in the emotional effect of interviews (Tracy, 2020, p. 161). In addition, as Tullis (2013) mentions, not showing emotion in emotionally laden research experiences could be seen as unprofessional, and a responsive stance allowed me to express feelings. For example, during one interview, a participant explained how the police forced them to go to the hospital against their will. While they explained the situation, I could tell they were angry. Because I took a responsive stance, I was able to empathize with them and express how frustrating that situation must have been for them.

The interviews lasted between 10 and 45 minutes, with a mean time of 28 minutes¹. To protect confidentiality, no personally identifying information was used from the participants. All participant names were changed to pseudonyms to ensure confidentiality. All interviews were audio recorded. A third-party professional transcription service (i.e., temi.com) transcribed the audio files. The data resulted in 238 single spaced pages.

3.3 Data Analysis

I analyzed data using a multi-step iterative approach, meaning data analysis altered between an emic, or inductive, analysis and an etic, or deductive, analysis using existing theories (Tracy, 2020). While both inductive and deductive approaches to studying message features have their strengths, both have their limitations (Burlinson, 2003). For

¹ The interview that lasted 10 minutes occurred because the participant did not have responses to the majority of interview questions.

instance, inductive approaches provide rich insights about the properties of more or less supportive messages directly from the data but lack internal coherence and “provide little principled basis for distinguishing effective from ineffective support efforts” (Burlison, 2003, p. 563). On the other hand, deductive approaches are useful for testing theory, but provide a narrow examination of support messages (Burlison, 2003). Thus, since both approaches have their strengths and weaknesses, combining the two by using an iterative approach (Tracy, 2020) allowed for data analysis to be guided by theory (e.g., the normative perspective on social support or the integrated model of advice giving), while still providing rich insights about helpful or unhelpful message features present in the data.

To familiarize myself with the data, within 36 hours of the interview, I listened to the audio recording while editing the transcriptions for accuracy (Tracy, 2020). Then, I printed out the transcriptions and engaged in primary-cycle coding, which included open and line-by-line coding, by writing descriptive first-level codes in the page margins (Tracy, 2020). I coded about 20% of the data with primary-cycle codes. Then, I developed a preliminary codebook that included the list of descriptive codes and brief descriptions/definitions of each. Example codes included “Characteristics – helpful,” “Characteristics – unhelpful,” “Pestering,” and “Instructions.” At this time, I made sure codes were occurring across interviews and determined if any codes needed to be shifted or collapsed. For example, the codes “Instructions” and “Prescriptions” were collapsed into one code since both described advice that made it seem like the participant could “fix” MDD. I then used this codebook to code the remaining data. See Appendix 2 for the full codebook.

Then, I imported the data to NVivo, a qualitative data analysis software. As previously mentioned, I initially sought to examine the message features of sequencing, accommodation, and nonaccommodation. However, I only reached theoretical saturation for sequencing, which is when new data add little, if any, new value to the emergent analysis (Tracy, 2020). I did not reach theoretical saturation for accommodation and nonaccommodation, thus, I chose to focus solely on sequencing in this thesis. Then using NVivo, I engaged in secondary-cycle coding to explain, theorize, and synthesize codes related to sequencing (Tracy, 2020). Since I used an iterative approach, I referenced literature on sequencing, but I did not force the data to fit into this framework (Taylor et al., 2016; Tracy, 2020). I then added these secondary-cycle codes to my codebook. Example codes included, “Support provider reaches out,” “Unsolicited support,” and “Forced support.” Lastly, throughout data analysis, I used a constant comparative approach to compare the data applicable to each code, and then modified code definitions to fit new data (Charmaz, 2014).

3.4 Reflexivity and Ethics

From a personal standpoint, I was interested in studying enacted support within the context of a specific mental health topic like MDD because I have family and friends who have been diagnosed with mental health disorders, one of them being MDD. Some of the stories I have heard about my loved one’s experiences with enacted support both deeply sadden me and give me hope that it is possible to adequately support someone with a mental health diagnosis. As a communication scholar, I realize there is still much to learn about the role of enacted support in the context of mental health, specifically MDD.

My familiarity with MDD had both its strengths and weaknesses. A strength was that I am familiar with how to support and interact with someone diagnosed with MDD. This was helpful in interviews with participants because it helped me develop rapport and trust with participants. For example, because I am familiar with MDD, I am acquainted with topics like suicide, self-harm, and involuntary hospitalization. When participants discussed these topics, my experience allowed me to empathize and understand what they experienced in ways that someone who was not familiar with MDD may not have been able to do.

A weakness of my familiarity and recruiting participants from my personal network was that I needed to critically reflect on how my personal experiences affected data collection, analysis, and interpretation. For example, because some participants were from my personal network of friends and family, they sometimes discussed instances when I had supported them. During data analysis and interpretation, I attempted to look at the situation while being cognizant that my understanding was partial.

One ethical consideration of this thesis was that MDD is still a stigmatized topic and talking about it may have triggered or worsened symptoms for participants (Pescosolido et al., 2010). To account for this, the following steps were taken to ensure the comfort and safety of participants. First, this thesis received IRB approval. Second, I employed relational ethics (Ellis, 2007). Relational ethics, also called ethics of care, ensured that I treated all participants with respect, conducted interviews at a time best for the participant, and helped me focus on always protecting the participant's confidentiality. Finally, if a participant had become upset, I would have followed a distressed interviewee protocol (see Appendix 3) and provided them with crisis hotline

numbers or the counseling center contact information if they were a student at UK.

However, while the distressed interviewee protocol was helpful to have, I did not need to use it during any interview.

3.5 Summary

In this chapter I outlined the qualitative research methods I used to investigate sequencing in the context of MDD. First, I explained why qualitative methods were appropriate to use in this thesis. Second, I described the participants in this thesis as well the research procedures I used. Third, I outlined my data analysis process. Fourth, I offered insight into my own self-reflexivity and described the ethical considerations of this thesis. In the next chapter, I discuss the results of this thesis.

CHAPTER 4. RESULTS

As mentioned in the previous chapter, I used an iterative approach to analyze data related to sequencing. In this chapter, I describe the answers to the questions, “What are some common sequential patterns of supportive interactions between support providers and individuals diagnosed with MDD?” and “How do individuals diagnosed with MDD evaluate the helpfulness of the different sequential patterns of supportive interactions?” In response to these questions, the data reflected five sequential patterns: (a) Support recipient explicitly asks for support; (b) Support recipient discloses problem; (c) Support provider reaches out; (d) Unsolicited support; and (e) Forced support. Notably, the pattern of *forced support* is a pattern that differs from existing literature on sequencing. For each pattern, I discuss instances when participants evaluated each sequence as helpful or unhelpful. When applicable, I discuss face threats and discrepancies participants describe between how they felt about a supportive behavior and what they intellectually knew, such as feeling annoyed by being forced to complete chores while acknowledging the fact that they needed to be done.

4.1 Support Recipient Explicitly Asks for Support

The sequential pattern of *Support recipient explicitly asks for support* occurred when a participant explicitly asked someone for support or explicitly told someone they needed help to manage MDD. For example, a participant could have explicitly asked someone to provide network support by spending time together or asked someone for instrumental support with completing chores. This pattern was helpful when the support

provider was able to provide what the participant needed. For instance, Melissa explained:

After the second time I was hospitalized, [I] met with [my friend] and I said, “You know, I really need somebody who’s going to be help me be accountable, help hold me to some of the things that I’m learning and some of the improvements I’m making.” And, um, she said, “If I do this, I may not always be nice,” and she said, “but I will be honest with you.” Um, and of course the, um, the, the nice and the honest, uh, wasn’t necessarily what I needed. It was more like, “Can you correct me with love?”

In this example, Melissa specifically asked her friend to help her manage MDD by holding her accountable and correcting her unhealthy patterns. Her friend responded by saying that she would be able to hold Melissa accountable, but cautioned Melissa that she may be blunt. Melissa then articulated how she recognized she did not need someone to be nice, but instead needed someone with good intentions to correct her. Overall, this example illustrates that even though her friend gave blunt advice and corrections, Melissa evaluated this pattern as supportive because she knew her friend had sound motives and perceived that this type of support would be effective.

Esther also recalled times where she specifically asked her friends to support her when she said, “My friends are more, um, processing outlets, people that I talk to, to kind of say, like, ‘I was struggling with this. Is that normal? Or is that like my brain being messed up the way that it is?’” In other words, there are times when Esther will reach out to her friends and ask for emotional (e.g., expressions of care, concern, or empathy by

listening) and appraisal support (e.g., providing new perspectives on a problem) by asking them to talk through her problems and assess her thought patterns.

Likewise, Rock explained a time when he asked someone for advice on how to manage MDD:

She's said several times that cooking is something that she struggles with, too, finding the motivation to do it. And, you know, she's got three kids and a husband, and she cooks for them. And so, you know, if she can manage her depression good enough to cook for five people, you know, how can she help me understand how to cook for one?

In this example, Rock explains how he asked a friend who also has MDD on how to manage a specific symptom (i.e., finding the motivation to cook). He specifically chose to ask this friend for advice because of their similar conditions, and he perceived that she could give him helpful advice on how to cook because she is able to cook for her family even when she is managing her depression.

Other times participants explicitly asked for support from their co-workers, specifically when they would need time off of work to manage MDD. For example, Judy said:

I told [my supervisor] about the fact that I had to go to ketamine treatments for the severe depression I had, and that the ketamine treatments would require that I be out of the office for four hours a day, starting twice a week and then tapering down. And he was very supportive. He said, "That's totally fine. We'll work around it." And then he confided in me that he understood mental illness because it ran in his family and his father had had mental illness really bad. And some of

his children had suffered really bad depression. So, he was able to empathize and treated me like I wasn't stupid, and it wasn't my fault . . . [I felt] really relieved and grateful, relieved that he was supportive and grateful that he could understand.

In this example, Judy explicitly told her supervisor that she would need time off from work to get treatment for MDD. In response, her supervisor responded with esteem support by treating her with respect and supporting her medical needs. In addition, he confided in her that he understood MDD and provided emotional support by empathizing with her. Judy positively evaluated this sequence of support when she articulated how it made her feel relieved, grateful, and understood.

While the examples above illustrate instances when the pattern of a participant explicitly asking for support was helpful, there were other times when this pattern was unhelpful. More specifically, the pattern was unhelpful when the support provider dismissed the participant or did not provide support. For example, Rachel explicitly asked for network support from her friends. She recounted:

I've had friends in the past where I've like reached out and been like, "Like I'm really doing badly. Like, can we, can we please just like, hang out today, even just talk on the phone for 30 minutes?" And they were like, "I don't have time for you." So, that wasn't great . . . [I felt] crushed. That, that's the day the friendship ended. Um, it was horrible.

In this example, Rachel explained how there have been times when she has reached out to her friends and explicitly asked them to support her by spending time with her or talking on the phone. In response, there have been situations where her friends dismissed her by

telling her they did not have time for her. This dismissal was a threat to Rachel's positive face (e.g., the need to be seen as respectable), and Rachel described how the dismissal caused her to feel hurt and ultimately, the friendship ended.

While some participants recounted instances when they had explicitly asked for support, it is interesting to note that often when I asked participants to tell me about a time they asked for support, they could not think of an example unless it was asking for support from a health care provider, such as a therapist. Ann expressed why she does not explicitly ask for help:

I don't really ask for a lot of support because it, it, the way that my brain works, especially when I'm depressed, I feel like I'm a burden, [and] that if I ask for help, that people are just going to look at me like I'm crazy. So, I generally do not ask for help until it gets bad when I am in the lowest of my lows.

In other words, when deciding whether to ask for help, Ann has both positive and negative face concerns. She is concerned about others perceiving her negatively (e.g., her positive face) and does not want to bother people (e.g., the support provider's negative face). Because of these concerns, Ann communicated that she does not ask for help unless she is significantly struggling.

As these examples show, when a participant explicitly asked for help, participants explained how they specifically asked for support from certain support providers, such as a friend, someone with a similar condition, a supervisor, or a health care provider.

Participants considered it supportive when the support provider was able to provide what the participant asked for, and participants found it was unhelpful when the person dismissed or was not able to provide what the participant needed, which rationally makes

sense. In addition, participants sometimes communicated positive and negative face concerns when explicitly asking for help, such as needing to be seen as respectable and valued.

These examples illustrate that the pattern of explicitly asking for help described when a participant specifically asked for support to manage MDD. However, there were other instances when participants disclosed they had MDD or disclosed a specific problem, a theme I discuss next.

4.2 Support Recipient Discloses Problem

The sequential pattern of *Support recipient discloses problem* occurred when the participant disclosed a problem or specific symptom of MDD and then the support provider offered support. For example, a participant may have communicated that they were feeling down, and then a support provider could have offered advice or emotional support. That is, in this example, the support recipient introduced the topic or problem, not the support provider.

Frequently, participants articulated that it was important to have someone listen to their problems without offering solutions. For instance, TJ explained:

I do struggle with suicidal ideation on top of the depression. So, you know, when somebody can just listen and they don't immediately jump to, "We have to find a way to make you be safe" . . . Like somebody just being able to sit quietly with me when I'm struggling, makes all the difference in the world. And it, um, it actually lightens the burden to just have somebody sitting there.

Likewise, Sara said:

Whenever I initiated [talking about MDD] they're always very receptive of that and always open to listen . . . They've never really questioned anything that I've told them. They're just always like, "We're here for you. I'm here to listen to you whenever you need it" . . . I think mental health can be very lonely and very isolating, um, and it doesn't feel so lonely when they're there to listen.

In these examples, both TJ and Sara consider it helpful when a support provider can listen to their problems when they disclose. TJ articulates how it is important to them that someone does not try and offer solutions and can provide network support by spending time together, which, according to them, helps them feel better. For Sara, she described that having someone who can listen causes her to feel less alone.

When I asked Eva about a time someone gave her helpful advice to manage MDD, Eva recounted an experience when she told a co-worker she was taking medication for MDD:

I think there was a coworker who I had just told her, like out of the blue, that I was taking medication, and she said, "Oh yeah, for what?" And I told her, and she said, "Oh, I'm taking those, those, too and for the same condition." So, like, she gave me some advice about like what medications that have helped her a lot and like what routines she did to kind of sleep better to try and manage her day better. Most of the advice I get is like medical professionals, I guess, but that was one thing that I really liked.

In this example, Eva, unprompted, disclosed she was taking medication for MDD to her co-worker. In response, before giving Eva advice on how to manage MDD, her co-worker disclosed to Eva she also was taking medication for the same condition. Eva

explained how even though most of the advice she gets to manage MDD is from medical professionals, she evaluated this sequence support, which was emotional and then informational support, from her co-worker as beneficial.

While some participants described that it was helpful when support providers responded to a disclosure with emotional support and then advice, participants also explained that it was unhelpful when the support provider simply provided advice. For example, Jeremy said:

I told [my friend] all my problems, and then she gave me solutions, and I was pissed off. I was like, I can't stand that. I can't stand when people will just give you solutions. Like there's no comfort in solutions.

That is, when Jeremy told his friend his problems, she immediately gave him advice on how to fix his problems without him asking for advice. Jeremy then expressed his frustration about unsolicited advice by explaining how advice does not comfort him.

Like Jeremy, Samantha encountered a similar situation when she disclosed a problem to her advisor. She explained:

I was talking to my student government advisor, and she was like, "Oh, you know, maybe you need to just go get help" And I was like, "Who says I don't already have help? Like, you don't know." But, and I think she was trying to be helpful, but she didn't understand how it came across. And that was kind of what hurt more because I looked up to her, and then I lost a lot of respect for her that day.

In other words, Samantha disclosed a problem to her advisor. In response, her advisor gave her advice on what she should do by suggesting she get professional support. Even

though Samantha considered the advisor's response to be insensitive, she perceived that her advisor had good intentions. Ultimately, Samantha explained how the advisor's response of unsolicited advice damaged their relationship and caused her to lose respect for her advisor.

In addition, at times participants described challenges they experienced when trying to decide who to disclose their problems to. For instance, Emily said:

So, my mom's the first person I will go to with a lot of it, if it gets that bad. But on the flip side of it, I don't talk to her as much as I probably want to because I don't want her to worry too much. I keep a lot of it in. Um, I'm sort of one of those people, really I keep too much in, um, I don't want to upset people.

Likewise, Ann said:

My mom suffers from [MDD]. And, you know, especially in a household with two people that have depression, they kind of feed off of each other. So, um, the dynamic between me and mom is, you know, if I'm in a bad mental state, something that I say could jumpstart her, one of her depressive episodes. So, it's kind of a catch-22 with, um, how, how I interact with her because sometimes she can help. And other times my circumstances will make her depressive episode jumpstart or worse if she's already struggling.

In these quotes, Emily and Ann reveal that they do not disclose their problems to their mothers because they do not want to upset them. This places them both in difficult situations because even though they may need their mothers to listen to their problems, they perceive that if they disclose, it will only engender further problems by upsetting their loved ones.

As these examples show, participants disclosed their problems to support providers such as friends, family, or co-workers. Some participants explained how in general, it is helpful to have someone listen to them without a support provider offering solutions. When a support provider did offer advice, participants explained how this was beneficial when a support provider responded by providing emotional support first and then advice. However, even though participants considered it insensitive when a support provider responded by giving advice, at times some participants perceived that the support provider had good intentions and was trying to be supportive. Lastly, some participants revealed difficulties they experience when deciding whether to disclose a problem. Although this pattern described times when participants disclosed a problem, meaning they introduced the topic, there were other times when a support provider introduced the topic by recognizing the participant was struggling, reaching out, and offering support.

4.3 Support Provider Reaches Out

The sequential pattern of *Support provider reaches out* occurred when a support provider asked the participant how they were doing or recognized the participant was struggling and offered support. This pattern contrasts with the pattern of *Support recipient discloses problem* because in this pattern the support provider, not the support recipient, introduced the problem. For example, this pattern would have occurred if a participant's friend reached out to them and asked them if they wanted to talk about how they were feeling or how they were managing MDD.

When I asked TJ how it made them feel when someone reached out to them to offer support, they said:

At first, I want to push it away. Like, I don't know if I feel angry or scared, embarrassed, like just the whole mix of go away kind of feelings. Um, but that very quickly subsides, and I feel gratitude for it. And, um, it just helps me to feel seen and like it's okay to have needs. And it makes me feel cared for, which is something I haven't had a lot in my life. So, it's valuable and greatly appreciated.

In this example, TJ explains the emotions they feel when someone reaches out and offers support. They explain how at first, they feel negative emotions, such as embarrassment and anger, but those emotions quickly turn to gratitude. Overall, TJ describes that when someone reaches out to them, it makes them feel cared for, and they greatly appreciate it when someone recognizes they need help and reaches out.

When I asked Rachel to tell me about the most helpful things her support system says or does, she explained how it was helpful when people checked in on her by asking her how she was doing. I then asked her if people ever checked in on her so much that it became annoying. She responded by saying:

Like another person who I sometimes talk to will like reach out and just be like, "How are you?" And I was like, "Fine. Don't really want to talk right now." Um, but I wouldn't want [people checking in on me] to stop because it's, [them checking in on me] is consistent. And just because something is annoying for you one moment doesn't mean it not very helpful the next.

In other words, Rachel considers it to be helpful when her support system reaches out to her by checking on how she is doing, though sometimes she considers this behavior to be annoying when she does not want to talk about MDD. Thus, Rachel experiences a

discrepancy with this sequence of support because even though she feels annoyed at times, she cognitively recognizes that overall, this type of support is helpful to her.

Participants explained how it was helpful when people reached out to them, but some participants described how the helpfulness of this sequence depended on the characteristics of the support provider. For instance, Catherine said:

My mother-in-law sometimes calls me and asks me how I'm doing to be supportive, but like she even called today, and I know she's calling to see how I'm doing . . . So, she's reaching out without me asking for it, and sometimes I just don't really want to talk about that . . . But only probably because it's her, and my mother does the same thing. So, when it's my mother or my mother-in-law it's unhelpful. If a friend called me [it would be helpful], but it has to be the right friend. I'm very picky about who calls me and asks me how I'm doing.

In other words, Catherine only considers it helpful when specific friends reach out to her and ask how she is doing. Otherwise, she views it as unhelpful when someone asks how she is doing because she does not always want to talk about MDD, especially if it is her mother or mother-in-law who reaches out. This demonstrates that some participants may prefer not only the type of support (e.g., emotional support or network support), but also have a preference for who is providing support (e.g., a trusted friend versus a parent).

As these examples illustrate, participants found it helpful when others recognized they were struggling and reached out to them to ask how they were doing or to support them. Some participants considered this behavior to only be helpful when specific support providers reached out, such as certain friends. In addition, participants sometimes found this behavior to be annoying, especially if they did not want to talk about MDD.

Lastly, participants described how that even though they consider it annoying when support providers reach out, overall, they feel grateful for this pattern of support.

However, participants also described times when support providers recognized they were struggling, and instead of asking how they were doing, offered unprompted support.

4.4 Unsolicited Support

The pattern of *Unsolicited support* occurred when the support provider recognized the participant was struggling and gave unprompted or unsolicited support. When unsolicited support occurred, the support provider took an active role by learning to recognize when the participant needed help, and then took the initiative to help the participant without them asking for help or disclosing a problem. The participant then had a more passive role because they did not have to do anything—they simply had to receive the unprompted support. For example, a person with MDD might struggle to complete daily chores, such as washing dishes. A support provider would provide unsolicited support if they recognized the participant was struggling to wash the dishes and then voluntarily cleaned the dishes without the participant having to say or do anything.

Sara explained an instance where she considered unsolicited support to be useful: [My roommate] was like, “Hey, you know, there’s campus resources, right?” Just like out of the blue one day and [in] the kindest, most gentle way that she could . . . At the time I was like, that was kind of strange. But maybe I’ll, you know, like maybe I’ll look into what she said. Um, and so yeah, she, I mean her, just her saying that, and her like showing me how to access those resources was really helpful when I had no clue that that’s what I needed . . . And now I feel like forever indebted to her. So now it’s a totally different feeling.

In this example, Sara's roommate recognized she was struggling and thought she might benefit from professional support. In return, her roommate took the initiative to look up how to access professional resources and then kindly and gently showed Sara how to access those resources. At the time, Sara considered this instance to be odd, but over time her feelings shifted to gratitude when she recognized how much she needed that support.

Other times participants explained when a support provider gave unprompted instrumental support. One participant, Andrew, revealed that unsolicited instrumental support was helpful when he was hospitalized. He explained:

When I was in the hospital, they knew what was up, and then they just helped me without me even asking. They knew how to recognize when I was angry . . . I didn't have to tell them. They already knew versus me having to sit there and try to fumble with my words to tell you, "Hey I'm pissed. Fix it."

In this instance, the hospital staff took an active role to support him because they supported Andrew without him needing to explain his problem or ask for support. Andrew considered this unsolicited support beneficial because he did not need to try to articulate his feelings, and instead was able to receive the support he needed without directly expressing it.

Additionally, Rock recounted an instance when he considered unsolicited instrumental support to be helpful. Rock explained:

There would be occasions where [my mom] would just like clean up my room, and it would be simple stuff like just making my bed and vacuuming the carpet, or folding clothes and putting them on my bed, and things like that, that I had zero motivation to do, but I still like knew it needed to be done were incredibly helpful

. . . I got the sense that she could see, “Okay, he’s struggling to do these basic things for whatever reason. Let me kind of help him have a clean environment.”

And that was really nice for me because when I had no motivation to clean my own environment, to have somebody there literally and figuratively by my side to help me live in a space that is clean was nice.

As this quote shows, Rock’s mom recognized he was struggling to do basic chores, such as cleaning his room or doing laundry. His mom then took the initiative and supported him with instrumental support by cleaning his room without Rock asking or disclosing a problem. Rock regarded this unsolicited instrumental support as beneficial because it was something he needed, which allowed him to live in a clean environment and feel less alone.

Like Andrew and Rock, Emily described how she receives unsolicited support from her mother:

I think my mom is the main one mainly for doing things like [randomly baking something] for me, or just sending me, I think I’ve got it up there actually. Yeah, just a card with a poem on it or something. Just sort of, you know, saying that she loves me or she’s there for me and that kind of thing . . . [It makes me feel] like she’s the only person who’s ever really loved me properly.

In other words, Emily’s mom will take an active role to support her by providing her with unsolicited emotional and instrumental support. Emily has a passive role in this interaction because she only must receive the support—she does not have to say or do anything. Emily then articulated how this unsolicited support makes her feel properly loved.

While some participants described instances when they experienced unsolicited instrumental and emotional support, other participants experienced unsolicited informational support. For instance, Liam explained:

[My partner's] parents gave me a couple books on depression and stuff, and it's like, no, this no . . . They knew [I had depression], and you know, they're trying to help, and they try to be nice and, and, you know, I understand, I get it, but it didn't. Yeah. It, it, it's just, it's not helpful.

In this example, Liam's in-laws knew he struggled with MDD. In return, in an attempt to support him, they took an active role and gave him books on MDD (i.e., informational support). Liam, who had a passive role since he only had to receive the books, described that he considered this unsolicited informational support to be unhelpful. However, Liam also perceived that his in-laws had good intentions.

As these examples show, participants considered unsolicited support helpful when the support provider recognized the participant was struggling and then supported them in the ways they needed, such as with cleaning or by providing resources for professional support. One participant in particular explained how unsolicited instrumental and emotional support from her mother caused her to feel loved. At times, participants evaluated unsolicited support as unhelpful when the support providers gave the participant the kind of help they thought the participant needed (e.g., a book about MDD). However, even though participants evaluated this support negatively, they described a discrepancy between considering the support unhelpful while recognizing the support provider had good intentions.

Overall, unsolicited support occurred when the support provider took an active role by recognizing the participant needed support and then offering support. In this pattern, the support recipient took a passive role because they simply had to receive the support without having to say or do anything. However, there were other circumstances when support providers forced support the participants to take an active role by initially making them do things against their wishes, a type of sequence I discuss next.

4.5 Forced Support

Forced support is a type of sequence that is different from the types of sequential patterns discussed in existing literature. Forced support occurred when the support provider forced support on the participant by making them do something against their will in order to manage MDD, such as support provider forcing an person to exercise. This pattern of forced support is similar to and differs from unsolicited support in a few ways. As previously discussed, unsolicited support is unprompted support that occurs when the support provider takes an active role by noticing the support recipient is struggling and then voluntarily supporting them without the recipient having to say or do anything. Similarly, forced support occurred when a support provider took an active role by recognizing a support recipient was struggling.

However, forced support differs from unsolicited support because while the support recipient took a passive role in unsolicited support because they simply had to receive support, with forced support, the support provider forced the support recipient to also take an active role. That is, forced support occurred when the support provider forced or made the support recipient do something against their will. In other words,

forced support is more intrusive or imposing than unsolicited support because it threatens the support recipient's self-freedom, or free will.

For instance, someone with MDD may want to spend the day in bed. Unsolicited support would occur if a support provider took the initiative to clean or cook meals for the individual. In contrast, forced support would occur if a support provider recognized this and then forced the individual to get up out of bed and clean or cook meals together. In other words, in this hypothetical example, the support provider took an active role by recognizing the individual needed support and then forced the participant to also take an active role in managing MDD. By forcing the individual to also take an active role, the support provider gave support that intruded and imposed on the individual's free will and freedom of choice.

For example, Esther described an instance of forced support when she explained when her roommate recognized she needed to go grocery shopping:

[My roommate] would also like show up to my room and literally like pull me out and make me do things. And these would not be like making me go to a party. It would be like making me go to the store and buy something other than like the Costco sized box of Cheez-Its that I've been working on . . . Even though, like, I was pissed at her for pulling me out of my funk, like, I knew it needed to happen. And so, it was this interesting tension.

In this example, Esther's roommate recognized she needed to go grocery shopping. In response, the roommate provided forced support by intruding into her room, pulling her out of bed, and forcing her to go grocery shopping against her will so that she would have something to eat besides Cheez-Its. When her roommate forced her to do this, Esther

described how she felt a discrepancy between knowing she needed to go to grocery shopping and feeling angry at her roommate forcing her to do so. Even with this discrepancy and feelings of anger, overall, Esther evaluated this instance of forced support as helpful.

In addition, Ben articulated instances where he considers forced support to be helpful:

[One helpful thing is] specifically an order. Um, saying, “Hey, I want you to call me at this time and let’s talk, you know? I wanna, you know, meet up, whether it’s online or in person at this time and let’s talk. And just, you know, maybe it’s not talking about anything important, maybe it’s just, you know, play a board game online. But, just maybe, maybe it’s just cause I’m not a very good planner. Maybe it’s because I feel like when I have, occasionally when I do have free time, I don’t feel like I want to spend a bunch of it . . . taking responsibility for doing a bunch of stuff. So, I guess that would be, you know, if somebody else just kind of takes the reins on that one, you know, and says, “Hey, we’re gonna put this on the calendar right now. Like, at this time, give me a call. Or, at this time I’m coming over.”

In this example, Ben explains how it is helpful to have someone to impose network support on him. He reveals that he is not good at planning. So, he finds it helpful when people in his support network force him to spend time together, even if they do not end up talking about MDD and instead just play a game online.

Other times, participants evaluated the helpfulness of forced support based on the identity of the support provider. For example, Samantha explained:

[My friend] knew I was just having a rough day and she ended up like forcing me to get up and get out of bed. And like we went and walked around the mall for two hours and just talked. And it was just her making me get up and get out that changed my perspective. And like I ended up instantly being in a better mood because I was up and doing something and not just laying [*sic*] there, like wallowing in self-pity. But there were also days where she knew that it was one of those like more worse days that she would just leave me alone and I tended to be better, faster.

However, later in the interview Samantha explained:

My dad was like, “Here, like we’ll get in the car and go do something.” And I was like, “No, I don’t want to go anywhere” . . . He’s trying to get me out of the house and like make it better, but it made it worse. So same kind of premise, but opposite reaction.

In other words, both Samantha’s friend and Samantha’s dad forced her to get out and do something together. However, Samantha only found the forced support from her friend to be useful, and when her dad forced her to do the same thing, she described how it made her symptoms worse.

Samantha then revealed why she may have evaluated the instances of the same form of forced support differently:

My parents, you know, sometimes they’ll leave me alone. Sometimes they won’t like, they don’t necessarily know when, but [my friend] made it a point to like learn to make sure she knew how to help me, which was super nice and comforting.

That is, Samantha's friend took the initiative to understand when Samantha needed to be forced to get up and out of bed and when she needed to be alone. On the other hand, Samantha explained how her parents have not learned the difference. Because one support provider (i.e., the friend) learned how to best help Samantha and the other support provider (i.e., her father) had not (at least from her perspective), this may explain why Samantha appreciated forced support from her friend but not her father.

Additionally, Judy explained how her husband provides forced support:

My husband checks in with me about how I'm doing on a daily basis. And when I'm not doing well, he knows the things that can help me, and he suggests them to me and pushes me to do them even when I don't feel like doing them. So, um, for example, if I am really doing poorly and need to go get another ketamine treatment, he will encourage me and push me to get the appointment. And he'll drive me there and take me home.

When I asked her how it made her feel when her husband pushes her to do things she does not want to do, she responded by saying:

Sometimes in the moment [him forcing me to do things] can actually be irritating or frustrating. Because it, the depression can get so painful that it's almost physically painful and you just want people to leave you alone. Just go away and leave you alone. But in the back of my mind, I always know that he is trying to help me. And over time I begin to remember that it is going to make me feel better. So that when he does suggest the things that I need to do, I also feel grateful to him and, you know, I try to not get irritated.

In this example, Judy described how her husband, like Samantha's friend, has learned how to best support her and makes her do things he knows will help her. Even though he suggests and forces her to do things she does not want to do, Judy's husband also supports her by going with her to medical appointments. Furthermore, when Judy experiences forced support, like Esther, she revealed that she experiences a discrepancy between what she feels and what she knows. That is, when her husband forces her to do things to manage MDD, Judy described how she feels irritated while at the same time she cognitively knows her husband is supporting her.

Other times, participants described times where they considered forced support to be deleterious. Even though Judy revealed she considered forced support from her husband to be beneficial, she also described an instance when she found forced support to be harmful:

One of my psychiatrists involuntarily hospitalized me, and that I think was the, the single most damaging experience to my recovery. And I think it set me considerably back in my treatment because it destroyed the relationship of trust and felt like punishment.

Likewise, TJ disclosed when they experienced involuntary hospitalization:

I let [the crisis hotline] talk me into having the police come over, and they hauled me to the hospital. And I was like, "You guys, this is going to make it so much worse. I have no money. Like I am scrambling for gas money all the time." And so, they took me, you know, they patted me down, they dragged me there, and I had no option, and it was terrible.

Similarly, Max revealed a time when he considered forced support to be unhelpful:

After my second [suicide] attempt, my sister flew over to [city], which is where I'm located, and she stayed with me for a week . . . She was, she, she was, uh, the right intention. Like she wanted to make me feel better by staying with me . . . And, um, while that was mildly helpful, just like having somebody that was more connected to me, she insisted that I sleep in the Airbnb that she was at . . . There was a whole argument where like, "Oh, why don't you, why don't you sleep in this place? You only live 20 minutes away." And it's like, "Well, I'm more comfortable here." Um, so her . . . tangible attempts at helping me turned out to be unhelpful, I guess. And, uh, she didn't seem to understand that.

In each of these circumstances, Judy, TJ, and Max were forced to go somewhere against their wills – Judy and TJ were involuntarily hospitalized, and Max's sister insisted he stay with her instead of at his apartment where he felt more comfortable. According to Judy, this type of forced support felt like punishment and, in her words, damaged her recovery process. For TJ, when they described when the police forced them to go to the hospital, they revealed how this experience was gruesome and made their symptoms worse. And for Max, he considered his sister's forced support to be unhelpful. Yet, Max experienced a discrepancy between considering the forced support to be unhelpful and knowing that his sister had good intentions.

Lastly, while some participants did not have a specific example of a time they encountered forced support, Rachel communicated that she would appreciate forced support when she said:

I've been saying no, like a lot, a lot lately [to going to get dinner]. And honestly, it would actually be helpful if they pushed me a little bit more to do things.

Because usually, you're like, you don't want to get pressured into doing things. And they're always very understanding. But it's, I've noticed that like when they're like, "Come on, just like do it. Like you're always at home." It actually like pushes me to do it, and I always feel better.

In other words, Rachel wishes her support network would force or push her to get out and go to dinner. She wishes they would push her or impose this on her because while she does not like getting pressured into doing things, she explained how being forced to do them ensures that she is actively managing MDD and overall, this makes her feel better.

As the examples illustrate, forced support is an intrusive form of support where a support provider forces a support recipient to do something against their will, such as being forced to get out of bed, being forced to make medical appointment, or being involuntarily hospitalized. Sometimes support providers forced multiple types of support, such as forced network and instrumental by going grocery shopping together. Often with forced support, participants experienced a discrepancy between what they were feeling and what they cognitively knew. For example, participants may have felt anger or frustration by being forced to do something while simultaneously recognizing the forced support was necessary. On the other hand, participants described instances when they considered forced support to be unhelpful, notably when they experienced involuntary hospitalization. Participants explained how, at times, forced support made symptoms worse and damaged the relationship between the participant and the support provider. In addition, one participant articulated how, for her, the helpfulness of forced support depended on the identity of the support provider, and one participant revealed how she wished her support network would force more support on her.

4.6 Summary

In sum, I discussed the five types of sequential patterns present in this thesis. I explained instances where participants found each pattern to be helpful and instances where the participants found each pattern to be unhelpful. At times, participants described how their evaluation of the sequence depended on characteristics of the support provider, such as explicitly asking for advice from support providers who also had MDD. A few participants described face threats, such as not asking for support because they did not want others to perceive them negatively or they did not want to impose on the support provider. More often, there were instances when participants articulated a discrepancy between their feelings and what they intellectually knew, such as feeling irritated about receiving unsolicited advice while cognitively recognizing the support provider was attempting to be supportive. Furthermore, results revealed how participants sometimes needed and valued unsolicited support, and one sequence, forced support, is a new concept to add to the existing literature on sequencing.

CHAPTER 5. DISCUSSION

Utilizing the normative perspective on social support and theory on sequencing (e.g., the integrated model of advice giving) as guiding frameworks, I examined common sequential patterns between support providers and individuals with MDD. Furthermore, I examined how individuals with MDD evaluated the different sequential patterns as helpful or unhelpful. In this chapter, I first discuss the theoretical implications of this thesis. Then, I discuss practical implications. Lastly, I discuss limitations of this thesis and directions for future research.

5.1 Theoretical Implications

As previously discussed, sequence is a message feature that refers to the order, or sequence, of supportive interactions between the support recipients and support providers, such as a family member or friend. For instance, if a participant disclosed they were taking medication for MDD, and then the support provider listened to the participant and then offered advice, the sequence would be participant disclosure-emotional support-informational support. Unlike some past research on sequencing that tests hypothetical situations with less serious stressors, like failing an exam, (e.g., Danielson & Jones, 2019; Feng 2009, 2014; Feng et al., 2017; Malloch et al., 2020), in this thesis I examined sequencing with a more serious stressor (i.e., MDD) in real-life interactions that participants recalled. To do so, I took an iterative approach to compare the data to existing literature on sequencing. By taking this approach, the results reflected patterns and phenomena that are both consistent with and differ from existing sequencing literature.

The first research question asked about common real-life patterns of supportive interactions between individuals with MDD and support providers. The results reflected five sequential patterns: (a) Support recipient explicitly asks for support; (b) Support recipient discloses problem; (c) Support provider reaches out; (d) Unsolicited support; and (e) Forced support. In addition, the second research question asked how individuals with MDD evaluated the helpfulness of each sequential pattern. The answers to the second research question qualitatively detail instances where participants evaluated the same sequential pattern as helpful or unhelpful. Often, participants described how the helpfulness of a sequential pattern depended on several distinguishing features, most frequently on the characteristics of the support provider.

Participants often described how the helpfulness of a sequence was dependent on who provided the support. For instance, when a participant explicitly asked for help, participants explained how they specifically asked for support from certain support providers, such as a close friend, someone with similar experiences, a supervisor, or a health care provider. These findings imply that individuals with MDD may explicitly ask for support from support providers who are experts (e.g., doctors); who have similar characteristics or experiences (e.g., also experience MDD); or with whom they have a close relationship (e.g., a trusted friend; Feng & MacGeorge, 2010; Goldsmith & Fitch, 1997). In addition, people with MDD may explicitly ask for support when they perceive that support from that specific support provider would solve or alleviate their problem (i.e., support efficacy), such as explicitly asking for time off work to manage medical appointments (Feng & MacGeorge, 2006).

For the pattern *Support recipient discloses problem*, participants described how they chose to disclose problems to certain support providers, such as friends, and not to disclose to others, such as a parent, which suggests individuals with MDD may prefer to talk about MDD with certain support providers over others. Also in this sequential pattern, participants described situations when they disclosed a problem and then a support provider offered emotional support and then informational support. Other times, participants explained their frustration when support providers only gave advice. Both of these findings align with the integrated model of advice giving [IMA] (Feng, 2009, 2014). However, the results of this thesis extend the IMA and other research on sequencing (e.g., MacGeorge et al., 2017) by showing the importance of network and esteem support in response to an individual disclosing a problem. This implies that when an individual with MDD discloses a problem, it may be important for support providers to first provide emotional support by listening and then offer network or esteem support, paying careful attention to avoid providing informational support.

Regarding the pattern *Support provider reaches out*, which occurred when a support provider noticed a participant was struggling and offered support, participants explained how they found this pattern helpful if certain people reached out, such as a close friend. Furthermore, participants explained how sometimes they found it annoying when people reached out to them, especially if they did not want to talk about MDD or how they were doing at that time. The negative evaluations participants had for this pattern may have happened because when a support provider introduces the problem by reaching out, it threatens the support recipient's negative face (Goldsmith, 2000). However, while some participants considered this pattern unhelpful at times, the finding

that this pattern can be helpful and needed in some cases does extend past research (e.g., Goldsmith, 2000). The finding highlights that even with the threat to the support recipient's negative face, it can be helpful when a support provider introduces a problem or topic, if it is the right support provider at the right time (e.g., a preferred friend when a support recipient is willing to talk about how they are doing).

Additionally, the results of this thesis have interesting implications for unsolicited support. Like past research that suggests unsolicited advice is unhelpful (e.g., Feng & MacGeorge, 2006; Miller-Ott & Durham, 2011; Servaty-Seib & Burlison, 2007; Song & Chen, 2014), the participant who received a book about MDD (i.e., informational support) considered this to be unhelpful. However, this participant who thought receiving the book was unhelpful also acknowledged and understood the support providers were trying to help. In addition, another participant described how her feelings towards an act of unsolicited informational support changed over time. This finding may extend theory on unsolicited advice by showing how the experience of receiving unsolicited informational support appears to be a complicated process for individuals diagnosed with MDD. That is, a support recipient's evaluation of one specific instance of unsolicited advice may be more complex than the dichotomous labels of "helpful" or "unhelpful" suggest, and a support recipient's evaluation may change over time as they have more time to reflect on the interaction. Overall, this finding illustrates that unsolicited advice is not inherently all good or inherently all bad. Rather, a support recipient's evaluation may be a combination of positive and negative thoughts and feelings that may change over time.

In addition to unsolicited advice, the results extend theory on other forms of unsolicited support, namely unsolicited instrumental support. Some current research suggests unsolicited instrumental support is generally viewed as unhelpful and can cause further stress because it implies the support receiver is incompetent (e.g., Carlson, 2016; Deelstra et al., 2003; Goldsmith, 2004; Smith & Goodnow, 1999). However, other research suggests unsolicited instrumental support can engender positive emotions and enhance a support recipient's self-esteem because it implies social ties and relational closeness (Mojaverian & Kim, 2013). Additionally, a support recipient's evaluation of the helpfulness of unsolicited instrumental support may depend on their need for support (Deelstra et al., 2003). For example, someone with MDD may be lethargic and find it difficult to be motivated to complete chores (APA, 2013). Thus, they may need someone to help with completing chores. In this thesis, participants communicated that they received instrumental support to help them lead functional lives from support providers with whom they had a close relationship, such as a parent helping with completing chores. This then suggests that in the context of MDD, individuals may have a more positive evaluation of unsolicited instrumental support when they have a close relationship to the support provider or when they have a need for that instrumental support.

Furthermore, the concept of *forced support* is a new concept that has not been discussed sequencing literature. Forced support occurred when a support provider forced a participant to do something against their will in order to manage MDD. Forced support is important to add to sequencing literature because it shows how support providers can give intrusive and imposing support in a valuable way. This means that support providers

were able to threaten a participant's free will and freedom of choice by forcing them to actively and effectively manage MDD, such as forcing them to exercise.

The findings of the benefits and helpfulness of forced support diverge from existing research. For instance, according to the normative perspective of social support, support that interferes with a support recipient's freedom of choice should be unhelpful and ineffective (Goldsmith, 2004). In addition, according to sequencing literature, it can be unhelpful when a support provider introduces the topic or problem because it threatens the support recipient's negative face (Goldsmith, 2000). The findings that forced support, which occurred when a support provider noticed there was a problem and then eliminated the support recipient's free will, extends this research by showing how, at least in the context of MDD, support recipients may need and want support providers to understand when they need help and then pressure them to act. Overall, because MDD can cause feelings of lethargy and a diminished interest in activities (APA, 2013), forced support is valuable to know about because it may be a crucial form of social support within the context of MDD. That is, individuals without MDD may not need motivation to complete chores, exercise, or socialize, but because of the symptoms of MDD, individuals with MDD may need to be pressured or forced to do so.

However, there are some caveats to forced support. First, it may only be realistic for certain support providers with a close relationship to the support recipient to force support on an individual with MDD. For example, it may be more reasonable for a partner or parent to be able to force more support than a friend since they usually have a closer relationship. Second, it may be beneficial for support providers to simultaneously

provide multiple types of forced support rather than one type, such as instrumental, network, and informational versus just instrumental.

Overall, in this section of the chapter, I discussed how the findings of this thesis aligned with and extended literature on sequencing. In the next section of this chapter, I discuss practical implications.

5.2 Practical Implications

Practically, this thesis has implications for people diagnosed with MDD and for loved ones supporting an individual with MDD. First, for people diagnosed with MDD, participants in this thesis described how advice was often unhelpful. However, if a support provider first listened to their problem or offered network support alongside the advice (e.g., spending time together after talking about a problem), they found this to be helpful. This suggests that if someone offers unwanted advice, people with MDD could respond by explaining how the advice is unsupportive, but that the advice may be more supportive if it is coupled with emotional or network support.

Second, participants sometimes articulated a discrepancy between their feelings and what they cognitively knew, such as feeling annoyed but recognizing the support provider was trying to be supportive. In addition, sometimes when participants encountered unhelpful support, they perceived that the support provider was trying to be supportive. Practically, this implies that even if individuals with MDD consider a supportive behavior to be annoying or unhelpful, they could recognize a support provider is trying to help or that the support provider may not fully understand MDD. While an individual with MDD may still feel annoyed or angry, this recognition may alleviate some frustration.

Moreover, this thesis has implications for loved ones supporting an individual with MDD. Participants in this thesis often described how advice was unhelpful. Even when participants considered advice to be useful, the participant asked for the advice, the advice came from expert sources (e.g., a therapist), or the advice was coupled with another type of support (e.g., emotional support). Based on this, it may be beneficial for support providers to avoid giving advice unless the individual asks for it, or if they do give advice, such as exercising, offer to exercise with them. Additionally, participants described how they considered it unhelpful when a support provider tried to fix their problems, but helpful when a support provider listened and validated them. Given this, it would be beneficial for support providers to listen without offering solutions.

While participants articulated unsolicited advice was unsupportive, some participants described how other forms of unsolicited support, such as instrumental support, were supportive. This suggests that it may be beneficial if support providers take initiative to help an individual with chores or other daily tasks if they are struggling to do so themselves. Support providers could even perform some of these tasks without being asked to by the person with MDD.

Furthermore, participants described how it was helpful when support providers reached out to them to offer support, but that it was only helpful when certain people reached out. In addition, sometimes participants found this behavior to be annoying because they did not always want to talk about MDD. This suggests that if a support provider reaches out and the individual seems annoyed or does not disclose how they are doing, it may mean the individual does not want to talk about MDD with that specific support provider or that they may not want to talk about MDD at that time. From this,

support providers could learn to ask the individual with MDD if they would be comfortable talking about MDD with them. Additionally, when reaching out and asking how an individual with MDD is doing, support providers could also ask if the individual wanted to talk about MDD or would rather talk about another topic.

Lastly, some participants described instances where support providers forced them to do something against their will. Some participants described that they felt irritated with the support provider even though they understood the support provider was trying to help and that they needed the support. Practically, this suggests that if a loved one forces an individual to do something they need to do, such as grocery shopping or laundry, the individual may feel angry. Even though they may get angry, the loved one should know this support is still necessary and needed.

In sum, this thesis offers several theoretical and practical implications. In the next section of this chapter, I discuss strengths and limitations of this thesis, as well as directions for future research.

5.3 Strengths, Limitations, and Directions for Future Research

Because I recruited participants from my personal network and Volunteer Science, one strength of this thesis is the sample. The sample represented almost an even percentage of males and females, which is notable considering women are twice as likely to experience MDD than men (Brody et al., 2018). In addition, participants were recruited from around the world via Volunteer Science. Thus, the participants in this thesis came from diverse backgrounds. Furthermore, participants had been diagnosed with MDD anywhere from a few months ago to decades ago. Because of this, a strength is that the data reflected a wide range of experiences with supportive interactions.

Even with these strengths, like all research, this thesis is not without limitations. First, I did not screen participants for MDD. Rather, they had to be willing to self-identify as someone who had been diagnosed with MDD. Because of this, it is possible some participants may not have had MDD. Indeed, two interviewees indicated in the interview that they had not been formally diagnosed but knew that they had MDD.

Second, even though the sample represented a variety of ages and cultures, the majority of the sample was White. However, the prevalence of MDD may be higher and more debilitating in underrepresented populations (e.g., people of color; Blumberg et al., 2015; Brody et al., 2018; Hankerson et al., 2015). Thus, future research could continue to explore enacted support, giving careful consideration to the voices of underrepresented populations.

In addition, six participants had co-occurring conditions, such as generalized anxiety disorder (GAD), post-traumatic stress disorder (PTSD), or attention-deficit/hyperactivity disorder (ADHD). I did not explicitly ask about these in the interview, rather participants voluntarily disclosed this information. While it is common for MDD to occur alongside GAD, PTSD, or ADHD (Anxiety & Depression Association of America [ADAA], n.d.), it is possible that these co-occurring conditions may have affected how participants evaluated supportive interactions.

Lastly, future research could investigate the role of sequencing in other mental health contexts, such as schizophrenia, bipolar disorder, or eating disorders. This research could be useful to better understand how individuals with different conditions evaluate supportive interactions. In addition, theoretically this thesis illustrated how unsolicited support can be beneficial and revealed the concept of forced support. Future research could

continue to explore these concepts in the context of other mental health conditions and to check for transferability, which is when the findings of one study transfer to another context (Tracy, 2020). For example, bipolar disorder is a condition where an individual experiences depressive episodes as well as manic episodes (NIMH, 2020a). Because MDD and bipolar disorder can at times have similar symptoms (e.g., depressive episodes), forced support may transfer to supportive interactions within the context of bipolar disorder. Also, this thesis investigated interpersonal interactions between individuals with MDD and any support provider (e.g., a friend, a partner, a medical professional, and/or an acquaintance). Studies investigating how forced support manifests in a specific interpersonal relationship (e.g., between an individual with MDD and a medical professional) could be fruitful to better understand this concept.

5.4 Conclusion

In summary, in this thesis I investigated how individuals diagnosed with MDD evaluated the different sequences of supportive interactions. To do so, I interviewed 20 participants who had been diagnosed with MDD. The participants in this thesis had diverse experiences, though future research should continue to understand enacted support in the context of MDD in underrepresented populations. Theoretically, this thesis contributes the finding that unsolicited support can be beneficial and the concept of *forced support* to theory on sequencing. Practically, this thesis provides implications for individuals with MDD and support providers, such as providing emotional or network support alongside advice. In the future, researchers should continue to study this topic because understanding how to provide effective support is crucial to helping an individual manage and heal from MDD.

APPENDICES

APPENDIX 1. INTERVIEW GUIDE

Demographics

1. What is your preferred pseudonym?
2. What is your race or ethnicity?
3. What is your biological sex?
4. What is your gender identity?
5. What is your sexual orientation?
6. What is your age or age range?
7. What is your marital or relationship status?
8. What is your professional occupation?
9. When were you diagnosed?

Social Support System

1. I'd like to get a better understanding of the people who give you support. Could you tell me about the people in your life that help you manage your depression?
 - a. Probe: How does your family support you?
 - b. Probe: Are you a part of any online support groups? Do you get any other online support from friends or other people?
 - c. Probe: If yes, what do you like about online support?
 - d. Probe: Has the COVID-19 pandemic affected how people support you? If yes, how so? If no, why not?
2. What characteristics make these people helpful people to have in your support system? What characteristics make these people unhelpful to have in your support system?

General Support Experiences

1. What are some of the most helpful things your support system has said or done that feels helpful? How are these things helpful?
 - a. Probe: Can you tell me about a time when someone said or did something that felt particularly helpful? For example, what did they do or say specifically that made you think, "that was helpful?"
 - b. Probe: How did this make you feel?
2. What has your support system said or done that has not been helpful? How are these things unsupportive?
 - a. Probe: Can you tell me about a time when someone said or did something that felt particularly unhelpful? Do you remember what they specifically said?
 - b. Probe: How did you react and/or what did you reply back to them?

- c. Probe: How did this make you feel?
- 3. In an ideal world, what's one thing you wish people would never do to try and help you feel better? Why?

Support Experiences Related to Sequencing, Overaccommodation, Underaccommodation

- 1. Can you tell me a story of a time when someone gave you advice that you found helpful?
 - a. Probe: What specifically did they say?
 - b. Probe: What happened first?
 - c. Probe: What happened next?
 - d. Probe: How did the conversation end?
 - e. Probe: Why was this advice helpful?
 - f. Probe: How did you respond?
- 2. What is the best advice someone has ever given you? Why do you say it is the best?
- 3. Can you tell me a story of a time when someone gave you unhelpful advice?
 - a. Probe: What specifically did they say?
 - b. Probe: What happened first?
 - c. Probe: What happened next?
 - d. Probe: How did this conversation end?
 - e. Probe: Why was this advice unhelpful?
 - f. Probe: How did you respond?
- 4. What's been the worst advice someone has given you? Why do you say it's the worst?
- 5. Can you tell me about a time when someone provided you with tangible, physical support but this support was unhelpful? This could be something like bringing you food, paying for a medication or appointment, offering to run an errand for you, or making an appointment for you.
 - a. Probe: What specifically did they do?
 - b. Probe: What happened first?
 - c. Probe: What happened next?
 - d. Probe: How did you respond?
 - e. Probe: Did this person offer to provide you this support? Or did you ask for this type of support?
 - f. Probe: How was this unhelpful to you and why?
- 6. Can you tell me about a time when someone provided you with tangible, physical support that you found helpful?
 - a. Probe: What specifically did they do?
 - b. Probe: What happened first?
 - c. Probe: What happened next?

- d. Probe: How did you respond?
 - e. Probe: Did this person offer to provide you this support? Or did you ask for this type of support?
 - f. Probe: How was this helpful to you and why?
7. Can you tell me a story of a time when someone tried to support you before you asked for support or advice or before they understood your problem?
 - a. Probe: How did you react?
 - b. Probe: How did this make you feel?
 - c. Probe: Did you find this support or advice helpful? Why?
 - d. Probe: Did you find this support or advice unhelpful? Why?
 8. Can you tell me about a time when you explicitly asked someone for help?
 - a. Probe: How did the person react?
 - b. Probe: How did their reaction make you feel?
 - c. Probe: Did you find this support or advice helpful? Why?
 - d. Probe: Did you find this support or advice unhelpful? Why?
 9. Can you describe a time when someone offered support or advice that made it seem like they were talking down to you?
 - a. Probe: What specifically did they say or do?
 - b. Probe: How did you react?
 - c. Probe: How did this make you feel?
 - d. Probe: Did you find this support or advice helpful? Why?
 - e. Probe: Did you find this support or advice unhelpful? Why?
 - f. Probe: Did your opinion of this person change after they were insensitive? Why or why not?
 10. Can you tell me about a time when someone offered support that seemed insensitive?
 - a. Probe: What specifically did they say or do?
 - b. Probe: What happened first in the conversation?
 - c. Probe: What happened next?
 - d. Probe: How did this make you feel?
 - e. Probe: How did you respond?
 - f. Probe: Did your opinion of this person change after they were insensitive? Why or why not?
 11. Can you tell me about a time someone expressed concern or empathy, or showed they cared about you?
 - a. Probe: What specifically did they say or do?
 - b. Probe: What happened first?
 - c. Probe: What happened next?
 - d. Probe: How did the conversation end?
 - e. Probe: How did this make you feel and why?

- f. Probe: How did you respond?

Member Checking

1. In the other interviews I've done, some participants have said that they sometimes feel annoyed but also grateful when someone helps them. Can you tell me about a time when someone helped you and you felt annoyed in the moment, but were also grateful?
 - a. Probe: What specifically did they say or do?
 - b. Probe: Did you ask for this support?
 - c. Probe: How did you react?
 - d. Probe: Did you feel anything besides annoyed and grateful? If yes, what did you feel?

Final Questions

1. Is there anything else you'd like to share or add? Is there anything we've missed that would be important for me to know about seeking and/or receiving support if you are diagnosed with MDD?
2. Do you have any questions for me?

APPENDIX 2. CODEBOOK

Primary-cycle codes (First-level codes)

Code	Definition/Explanation	Examples
Helpful		
Platitudes	Short statements, cliches, overused remarks	It's okay to not be okay. (Ann) Be true to yourself. (Sara)
Advice to manage	Advice that helps one manage symptoms and does not aim to "fix" or advice that helps challenge thought patterns	Break things up into small tasks. (Esther) It's okay to wallow for a little bit, just don't stay stuck there. (Melissa)
Advice from media	Helpful advice seen in media or online	Seeing a TikTok about breaking things up into small tasks. (Esther) Psychology today article (Rock)
Validation	Support provider affirms participant	I think they've validated by saying this is not your fault . . . that it's actually a disease. (Catherine)
Characteristics	Characteristics of support provider that are helpful	Similar experiences, understanding, kind, nonjudgmental, consistent
Listen	Support provider listens to participant (i.e., emotional support)	They're there to just listen to anything that I need to get off my chest. (Rock) He's always willing to listen to me when I need to process, um, issues. He doesn't try to fix it. (Melissa) The biggest thing that is nice to have is just somebody to talk with . . . and talk about how I'm feeling. (Ben)
Life maintenance	Offers of goods or services that help participant live in a functional household	Cleaning, paying bills, laundry, grocery shopping
Dark humor	Making a joke about MDD as a way of coping	Joking about being "broken" or "mentally screwed up"
Blunt	Frank advice or accountability	We're still very blunt with each other and we're very

		much like, “What the hell are you doing right now?” (Esther) She ended up like forcing me to get up and get out of bed. (Samantha) My friends are more like, “No this is what we’re doing.” (Sara)
Emotions	Feelings participants expressed when support is helpful	Supported, loved, cared for, seen
Unhelpful		
Platitudes	Short statements, cliches, overused remarks	Suck it up, get over it, you’ll be okay, others have it worse
Instructions	Instructions on what participant should do to fix or cure MDD	You should do . . . If you pray hard enough . . . Have you tried . . .? Recommendations to health care providers (e.g., psychiatrist, therapist)
Characteristics	Characteristics of support provider that are unhelpful	Lack of understanding, dismissive, unrelatable
Pestering	Support provider annoys participant with frequent or persistent requests	The fact that like my mom just kept pushing [her advice] and pushing and pushing it. (Esther) People pestering me about what’s bothering me because that disrupts my thinking and coping process in my mind. And that becomes the thing that I’m now frustrated at. (Rock)
Emotions	Feelings participants expressed when support is unhelpful	Babied, misunderstood, invalidated, unsupported, shame, disrespected
Primary-cycle codes not related to helpful/unhelpful support		
Stigma	Prejudice or judgment participant feels about having MDD	Support providers calling participant “crazy” or other epithets. I don’t want to be somebody who’s stigmatized by a mental illness. (Samantha)

Secondary-cycle codes (Second-level codes)

Code	Definition/Explanation	Examples
Sequential Patterns		
Support recipient explicitly asks for support	Participant explicitly requests support	After the second time I was hospitalized, [I] met with her and I said, “You know, I really need somebody who’s going to be help me be accountable.” (Melissa) Reaching out to someone and asking if they could spend time together or talk on the phone. (Rachel)
Support recipient discloses problem	Participant tells someone they have a problem or are experiencing symptoms of MDD	I think there was a coworker who I had just told her, like out of the blue that I was taking medication, and she said, “Oh yeah, for what?” I told her, and she said, “Oh, I’m taking those, too and for the same condition.” (Eva) I told her all my problems, and then she gave me solutions, and I was pissed off. (Jeremy)
Support provider reaches out	Support provider offers support by asking how a participant is doing	If . . . a friend called me [it would be helpful], but it has to be the right friend. I’m very picky about who calls me and asks me how I’m doing. (Catherine) Like another person will reach out and just be like, “How are you?” And I was like,

		“Fine. Don’t really want to talk right now.” (Rachel)
Unsolicited support	Support provider recognizes the participant is struggling and gives unprompted support	Support provider taking initiative and doing laundry for the participant. (Rock) Support provider unsolicited recommends professional support. (Samantha)
Forced support	Support provider makes or requires participant to do something against their will	Forcing participant to get out of bed and go grocery shopping together. (Esther) Involuntary hospitalization. (Judy, TJ)
Secondary-cycle codes not related to sequence		
Metaphors	Metaphors about MDD	Dark cloud over head (Catherine) There’s no light switch [for depression]. (Esther) I always describe it as like a fight with your brain. (Sara)

APPENDIX 3. DISTRESSED INTERVIEWEE PROTOCOL

If an interviewee shows signs of emotional distress including but not limited to extreme anxiety/nervousness, crying, or angry outbursts, the interviewer will follow this procedure:

1. Ask the interviewee if they are feeling OK. If yes, reassure interviewee that the interview can be stopped at any point without forfeiting incentive or jeopardizing status at the university. Tell interviewee to let you know if the interview needs to be stopped.
2. If interviewee not feeling OK, ask the interviewee if they would like to stop the interview, or tell the interviewee you think that the interview needs to be stopped. Reassure the interviewee that is OK to stop the interview and that stopping the interview has no bearing on him/her getting the incentive or his/her status at the university.
3. If the interview is stopped, reassure the interviewee that they will get the help they need to feel better. Give the interviewee the resources sheet to show them the various places that could offer help. Encourage the interviewee to use the resources, not try to handle the situation alone.

If the interviewee continues to show signs of emotional distress more than ten minutes after interview has stopped, suggest that you call someone to get help. The NAMI crisis hotline number, which provides 24/7 support from trained counselors is: 1-800-950-6264.

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VITA

Degrees Awarded

Bachelor of Arts, Communication, 2018, Anderson University (SC)

Professional Positions

Graduate Teaching Assistant, University of Kentucky
Admissions Counselor, Montreat College

Scholastic Honors

Dean's List, Anderson University (SC), 2014-2018 (awarded each semester)

Professional Publications

Scarduzio, J. A., & Adams, M. F. (2021). From spillover to reporting decisions: exploring how ambiguity and uncertainty in online sexual harassment creates risk for employees. In K. N. Engemann, K. J. Engemann, & C. W. Scott (Eds.), *Organizational risk management: Managing for uncertainty and ambiguity*. DeGruyter.

Conference Presentations

Adams, M. F., Scarduzio, J. A., Malvini Redden, S. (2021). *"It shouldn't have been me getting punished": The Role of Sensegiving and Sensebreaking in Reporting Sexual Harassment* [Accepted paper presentation]. To be presented at the annual meeting of the National Communication Association, Seattle.

Adams, M. F., Scarduzio, J. A., Limperos, A. M., & Fletcher, J. (2021). Workplace sexual harassment on Facebook: The impact of the online setting on uncertainty and coping. Presented at the annual meeting of the International Communication Association, Virtual.

Madison Adams