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Uncertain Together: A Dyadic Exploration of Social Support During Uncertain Waiting Periods

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DEDICATION

To my wife, Laura, who is my greatest role model of support.

ABSTRACT OF THE DISSERTATION

Uncertain Together: A Dyadic Exploration of Social Support During Uncertain Waiting Periods

by

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Waiting for uncertain news can be a source of anxiety and worry for individuals most directly affected by the potential news; however, socially supportive others who are highly connected to the individual, such as romantic partners, also have their own experience. In the current studies, I investigated how romantic couples jointly experience uncertain waiting periods, with a particular focus on the perception of various types of support and links between support, strategy use, and waiting experiences. Using dyadic data from two samples of couples experiencing distinct periods of uncertainty, results revealed that partners reported distinct experiences based on their roles, perceived rather than enacted support played the largest role in participants' experience, and individual differences seem to affect perceptions and provision of support. Together, these studies provide a first step toward understanding the interaction between supportive dyads during the stressful experience of awaiting uncertain news.

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Chapter 1: Introduction

George's company is currently going through a reorganization, and rumors have spread that some jobs might be cut. All positions are potentially on the chopping block, but no one can offer George information about his chances of remaining employed. George is forced to cope with uncertainty regarding his future. At home, George confides in his wife, Martha, regarding his distress over not knowing what will happen or what he should do. They discuss beginning the hunt for a new job, putting in time to impress the boss, or simply trying to stay upbeat and optimistic, but nothing seems to keep the distress at bay. As the days progress, George continues to feel stress about the potential lay-offs. Meanwhile, Martha begins to worry not only about how to help George handle the situation, but how to help herself as well.

As the preceding scenario illustrates, uncertainty over what the future holds can be a source of anxiety and worry (Dugas, Schwartz, & Francis, 2004; Sweeny et al., 2016; Sweeny & Cavanaugh, 2012; Sweeny & Dooley, 2017; Poole, 1997). Often people must wait for important information to alleviate uncertainty, such as medical test results, professional evaluations, or the outcome of company reorganizations. A growing body of research focuses on how individuals most directly affected by the potential news experience waiting periods (e.g., Boivin & Lancastle, 2010; Howell & Sweeny, 2016; Sweeny & Andrews, 2014; Sweeny & Falkenstein, 2015; Sweeny et al., 2016); however, these individuals are not necessarily the only ones affected by the uncertainty. Socially supportive others who are highly connected to the individual, such as romantic partners, also have their own experience, but no studies have directly examined the experience of close

others during stressful waiting periods. In other words, although uncertainty researchers are gaining a clearer understanding of George's experience, little is known about Martha's experience. In the current studies, I investigated how romantic couples jointly experience these stressful, uncertain waiting periods and how supportive behaviors affect not only the recipient, but the provider as well.

Waiting for Uncertain News

With many of life's stressors, people are able to prepare for the future by making plans for next steps. For example, if George gets fired from his job, he will likely experience high levels of stress, but the appropriate course of action (e.g., search job postings, apply for new jobs) is relatively clear. In contrast, when people are awaiting uncertain news (e.g., employees learn of impending lay-offs but do not yet know who the targets will be), the appropriate course of action is less certain. Is George better off spending effort getting a jump on the job search or continuing his work with high hopes that his position is safe?

This type of uncertainty regarding how one should prepare for future potentialities is highly anxiety-provoking (Boivin & Lancastle, 2010; Sweeny & Andrews, 2014). In fact, anxiety during an uncertain waiting period tends to surpass the anxiety experienced upon facing an undesirable outcome (Sweeny & Falkenstein, 2015) and can even rival levels of anxiety associated with general anxiety disorder (Scott, 1983). This anxiety can lead to greater risk-taking (Porcelli & Delgado, 2009) and interferes with people's ability to simultaneously handle other stressors (Monat, Averill, & Lazarus, 1972). Additionally, both physical health and sleep quality suffer as people attempt to cope with not knowing how to prepare for the future (Howell & Sweeny, 2016). Because these uncertain waiting periods are

so ubiquitous, understanding how people can effectively improve their response to this uncertainty can greatly improve multiple dimensions of well-being.

A growing body of research identifies cognitive and behavioral strategies that individuals use to navigate the stress of uncertainty, as well as how the use of these strategies shifts across a waiting period (Sweeny & Cavanaugh, 2012; Sweeny et al., 2016). These *waiting strategies,* illustrated in the Uncertainty Navigation Model (Figure 1), can mitigate anxiety by providing a sense of certainty or control over uncertain and uncontrollable situations, and they may influence psychological responses to the eventual news. Included among these waiting strategies are *reappraisal* (bracing for the worst, maintaining hope and optimism, focusing on silver linings of undesirable outcomes, and diminishing the importance of the outcome); *direct emotion management* (suppressing or distracting oneself from thoughts and feelings about the outcome); and *consequence mitigation* (e.g., mentally preparing for how to cope with an undesirable outcome, taking action to reduce the detrimental effects of an undesirable outcome). People awaiting uncertain news often shift between strategies, and people's use of certain strategies are more prevalent at predictable times during the waiting period (Boivin & Lancastle, 2010; Sweeny & Cavanaugh, 2012). For example, people tend to become more pessimistic (i.e., bracing for the worst) as the moment of truth arrives (Carroll, Sweeny, & Shepperd, 2006). However, despite documenting the use of these strategies, evidence is mixed regarding which strategies are the most effective tools to increase well-being during waiting periods (Sweeny et al., 2016).

Research continues to explore the strategies and resources that people use to cope with uncertainty, but it focuses on intrapersonal approaches to emotion regulation. That is, research has primarily examined how individuals manage their own experience. For many stressful events, though, people do not function in isolation; instead, they continue to interact with friends and loved ones in ways that may influence their experience. In particular, interaction with close others during these stressful experiences can generate perceptions of love, caring, esteem, and mutual assistance – that is, social support.

Turning to Others

Perceiving a strong social support network is a critical resource for managing stressful life events and plays a considerable role in both mental and physical health (Taylor, 2011). Perceptions of support relate to positive health behaviors, recovery, longevity, and psychological adjustment to life events (e.g., Rutledge et al., 2004; Turner-Cobb et al, 2002; Uchino, Cacioppo, & Keiecolt-Glaser, 1996; Wills & Vaughan, 1989). Additionally, support may reduce distress (Fleming, Baum, Gisriel, & Gatchel, 1982; Sarason, Levine, Basham, & Sarason, 1983) and help people move past traumatic events (Mehnert et al., 2010). Perhaps, then, people's propensity to turn to their support networks during stressful life events (Bolger & Eckenrode, 1991; Cohen & Wills, 1985; Wethington & Kessler, 1986) is unsurprising. Although people may seek this support from relatives, friends, or other members of their support network, the most common source of support for many people is their romantic partner (Zimet et al., 1998). Uncertain waiting periods are no exception. While awaiting bar exam results, 93% of law graduates who were in a romantic relationship talked to their partner about the exam

immediately after the exam, and 96% talked with their partner about the exam immediately before receiving their results (Dooley, Sweeny, Howell, & Reynolds, 2018). Of those who talked to their partners, law graduates who felt understood, cared for, and valued by their partner (i.e., those who perceived high partner responsiveness; Reis, Clark, & Holmes, 2004) also reported better health and sleep quality. In the current studies, I further investigated how and when interactions with supportive partners are beneficial.

Unfortunately, despite people's propensity to interact with supportive others during stressful moments, the benefits from the support one actually receives, termed *enacted support*, are not always as pronounced as the benefits of perceived support (Bolger & Aramel 2007; Gleason, Iida, Shrout, & Bolger, 2014; Wethington & Kessler, 1986). In fact, enacted support can sometimes be more detrimental than receiving no support at all (Shrout, Herman, & Bolger, 2006). This surprising effect of enacted support may stem from a mismatch between the support given and the support required (Cutrona & Russell, 1990), a failure to effectively communicate the intended support message (Coyne, Wortman, & Lehman, 1988), or unintended negative consequences of the support provided (McClure et al., 2014; Gleason et al., 2014). For example, providing support at the wrong time might cause the recipient to feel ineffective at handling the stressor or generate a sense of inequity in the relationship that the support recipient now has to accommodate. Considerable research has focused on how, when, and why support fails (Maisel & Gable, 2009), and the current studies seek to add to that literature.

Though these issues can arise in any support context, uncertain waiting periods may create additional hurdles to effective support. Just as the support recipient is uncertain regarding how to prepare for the future, supportive partners may be unable to decipher how to help the recipient prepare. For instance, Martha could attempt to help George stay optimistic or she could help him prepare for a job loss. In this regard, partners have a relatively unclear sense of which social scripts to follow when trying to provide support (see Schank & Abelson, 1977; Thoits, 2013). The coping strategies people use throughout an uncertain waiting period also shift over time (Boivin & Lancastle, 2010), so the support needed to match the current strategy use of the recipient may differ from one moment to the next, leaving the supportive partner in a quandary. Thus, one goal of the current studies is to examine the benefits of support behaviors during waiting periods.

Looking Beyond the Support Recipient

Taking on the role of a supportive partner is difficult, particularly when the outcome is uncertain. Moreover, beyond the uncertainty of how to provide support, romantic partners are often facing their own challenges during waiting periods which may influence their experience and supportiveness (Goldsmith, 2015; Segrin, Badger, Sieger, Meek, & Lopez, 2006; Ybema, Kuijer, Hagedoorn, & Phunk, 2002). Martha must deal not only with her stress over how to support her husband, but also with any worries about how their lifestyle will change if George is laid off, how the loss might affect their finances, and whether she needs to begin looking for more lucrative employment. With the focus placed more on the recipient, supportive partners may report inequity between support given and support received (Barbee, Rowatt, & Cunningham, 1998) or that their own

stressors are being ignored. Supporters may also feel resentful of the lack of control they have, given the expectation that they support their partner despite their own needs.

In a study using a dictator-style game, researchers instructed some participants on how to distribute money to other players and found that participants who were told to donate more money experienced lower affect, vitality, and self-esteem (Weinstein & Ryan, 2010). Interestingly, however, in the same study, participants who were instead given the choice of how much money they wanted to distribute (rather than direct instruction) experienced *more* positive affect, better vitality, and higher self-esteem when they gave more money to other participants (Weinstein & Ryan, 2010). These findings suggest that helping under certain circumstances (e.g., when it is one's choice) can benefit the provider, and contribute to a growing literature suggesting that despite the difficulties of support provision, providers may experience physiological and psychological benefits from supporting others (Brown, Nesse, Vinokur, & Smith, 2003; Inagaki & Orehek, 2017). For instance, writing supportive notes to others caused reductions in stress (Inagaki & Eisenberger, 2016), spending money on others versus the self resulted in lower resting blood pressure (Whillans, Dunn, Sandstrom, Dickerson, & Madden, 2016), and providing tangible support to friends and family members is associated with decreased mortality (Poulin, Brown, Dillard, & Smith, 2013).

Given the prevalence and difficulties of supportiveness during uncertain waiting periods, understanding the support provider's experience may be particularly important. Does Martha feel better if she is focused on helping George, or does her supportiveness result in better feelings for him but worse for her? Unfortunately, studies of supportive

others during waiting periods have been viewed through the lens of participants' self-reports about their partner, rather than directly assessing the partner's experience (Dooley et al., 2018). Thus, the current studies seek to understand the benefits of social support on the recipient, as well as the simultaneous experience of the support provider. By examining both the support recipient's and the supportive partner's experiences, researchers can begin to understand where relationship partners match and differ in how they experience the waiting period, as well as the mutual interactive effects of these two experiences.

Overview of Proposed Studies

In the current studies, I examined the experience of romantic partners during uncertain waiting periods, with a particular focus on the perception of various types of support and links between support, strategy use, and waiting experiences. My study addresses four primary questions: (1) How does the experience of awaiting news differ between recipient and provider? (2) How does strategy use relate to how recipient and providers experience the waiting period? (3) How does support provision/perception relate to the waiting experience both participants? and (4) How do trait-like individual difference play a role in support provision/perception?

Question 1: How do experiences differ across participants? My first question investigated general differences in how people experience uncertain waiting periods depending on their supportive role. For example, does Martha experience the same degree of anxiety about the potential job loss as George? Presumably the person awaiting the news will report greater distress than the romantic partner, but in some cases support providers suffer as much or more than the person directly affected by the stressor (e.g.,

Northouse et al., 1995), particularly with empathic people who tend to share their partners' emotional state (Devoldre, Davis, Verhofstadt, & Busse, 2015). Past research on partners dealing with chronic stressors, such as cancer, has demonstrated that partners' distress fluctuates in tandem, and partners frequently experience comparable distress (Hagedoorn, Sanderman, Bolks, Tuinstra, & Coyne, 2008; Segrin, Badger, Sieger, Meek, & Lopez, 2006). However, given the inherent uncertainty when awaiting news of results, partners may have more flexibility regarding their appraisal of whether an undesirable outcome will even occur, let alone how to respond. Similarly, partners may utilize different waiting strategies to deal with the lack of certainty. For example, George might put more effort into bracing for worst-case scenarios than Martha, or vice versa. Thus, to answer my first question, I examined the experiences and strategy use of support recipients (the person awaiting news) compared to their romantic partners during a stressful uncertain waiting period.

Question 2: How does strategy use relate to waiting experiences? My second question explored how recipient's and provider's use of certain strategies relates to their experience while awaiting uncertain news. As part of this question, I am not only interested in how one individual's strategy use relates to his or her experience, but also how one's partner's strategy use relates to one's own experience. That is, George's maintenance of positive expectation may help him feel good, but Martha's positivity might also play a role. The recipient's (e.g., George) strategy use may also relate to the provider's (e.g., Martha) experience. To answer this question, I will focus on four aspects of the dyadic interaction between support recipients and their romantic partners using an

Actor-Partner Interaction Model (APIM; Kenny, Kashy, & Cook, 2006). This model highlights the mutual influence that dyad members may have on their own outcomes as well as their partner's.

As part of this model, I generated an estimate of similarity in strategy use between partners (Figure 2a, *r*). That is, if George is focused on trying to distract himself, is Martha also trying to distract herself from thinking about the stressor? Although past research has examined the emotional experience of partners during stressful experiences, and past research has explored waiting strategy use by the individual most directly affected by the uncertain news, no research has specifically explored the partner's use of waiting strategies. Thus, this study gives a first step in understanding whether partners are navigating uncertain waiting periods in similar ways.

The model also includes an estimate of how support recipients' strategy use relates to their waiting experience (Figure 2a, a_1). For example, if George is using more positive expectation management, does George also feel more positive emotions? Similarly, this model examines the effect of the provider's strategy use on their waiting experience (Figure 2a, p_1). That is, does Martha also feel more positive emotions if she is maintaining positive expectations? Because providers are often indirectly affected by the impending news, their coping strategies may differ.

In addition to identifying how individual's own strategy use predicts their experience, APIMs also examine the effects of one partner's strategy use on the other partner's experience. That is, how does Martha's personal bracing for worst-case news influence George's experience, and vice versa? By simultaneously examining recipient's

and provider's variables, I can estimate an effect for recipient strategy use affecting provider experience (Figure 2a, p_2), and an effect for provider strategy use affecting recipient experience (Figure 2a, p_1). Research shows that other people's emotions often provide a source of emotional regulation (Butler, Scheier, & Carver, 2002; Niven, Totterdell, Stride, & Holman, 2011; Zaki & Williams 2013). In the context of uncertain waiting periods, one partner's choice of how to respond to uncertainty may have a direct effect on how the other partner appraises the situation and emotionally responds. By using APIMs to study the association between waiting strategy use and waiting experience, the current study explores all of these potential effects.

Question 3: How does support perception relate to waiting experience and strategy use? For my third question, I began exploring the role of social support during the waiting period by examining the relationship between social support and participant. To accomplish this goal, I again used an Actor-Partner Interaction Model (APIM; see Figure 2b) to highlight the mutual influence that dyad members may have on their own outcomes as well as their partner's.

Similar to the Question 2 APIM, the model includes an estimate of how partners agree on the support that is present during the waiting period (Figure 2b, *r*). That is, if George thinks that Martha is negatively validating his feelings, does Martha also report trying to validate George? Research on support perceptions has demonstrated inconsistencies in agreement between partners regarding supportiveness in a relationship, potentially due to differences between recipient and provider attentional focus (Gable, Reis, & Downey, 2003). That is, providers may focus on positive support behaviors,

whereas recipients recall the negative or failed support attempts. Given the potentially greater challenge to support providers during uncertain waiting periods, support agreement may be particularly lacking in these situations.

Beyond partner agreement regarding support, these APIMs explore how support recipients' perceptions of support relate to their own waiting experience (Figure 2b, a_1). That is, if George is noticing more of Martha's positive, upbeat support behaviors, does George feel more positive as well? Previous research has demonstrated links between greater participant perceptions of partner responsiveness and better health, coping, and sleep quality during uncertain waiting periods (Dooley et al., 2018). The current study seeks to build on this research by examining a greater variety of support behaviors and their relation to waiting experience, as well as the effect of support on waiting strategy use.

Unfortunately, George may not always notice Martha's upbeat support, though her behaviors may still result in George feeling more positive. That is, Martha's behaviors may influence George's waiting experience irrespective of what George perceives. Fortunately, by simultaneously examining provider and recipient variables, APIMs allow the examination of how providers' reported use of support strategies relates to recipients' waiting experience (Figure 2b, p_2). This relationship captures the beneficial (or harmful) effects of social support, responsiveness, positive reframing, and negative validation (Marigold et al., 2014) on the recipient from the perspective of the individual giving the support.

Just as the APIMs assess how both recipient and provider perceptions of support affect the recipient's outcomes, they simultaneously explore the effect of both sets of perceptions on the provider's waiting experience. For one, the current study examines the effect of provider support provisions on their own waiting experience (Figure 2b, a_2). Does Martha's efforts to be an upbeat supporter lead to her own positive mentality, or does it take a toll on her? As mentioned earlier, growing evidence suggests that support provision can be a beneficial behavior, but the boundary conditions of this effect are still unclear (Inagaki & Orehek, 2017). Additionally, I examined how the recipient's perceptions of support relate to the partner's waiting experience (Figure 2b, p_1). For example, George may feel Martha has given upbeat support and respond in ways that lead Martha to feel positive herself. On the other hand, support recipients who feel that their partners are not adequately providing support may interact with their partners in ways that increase their partners' distress. By using APIMs to study the association between support perceptions and waiting experience, the current study will explore all of these potential effects.

Question 4: How do individual differences influence support perceptions?

Given the subjective nature of both recipient and provider support perceptions, the current study also explores how trait-like individual differences relate to how partners perceive support during uncertain waiting periods. If George is a more optimistic individual, does he also perceive more support from Martha? Recent research suggests that people who have a more pessimistic outlook perceive less support from supportive others than do people who maintain a more optimistic mindset (Dooley et al., 2018).

However, existing findings are inconclusive as to whether this link between an optimistic mindset and support perception is a result of trait-like individual differences that influence perception of support, or if people who engage in particular waiting strategies (in this case, bracing for the worst vs. maintaining hope and optimism) are easier or more difficult to support. To answer this question, I once again used APIMs that explore both actor and partner effects of individual differences related to support perceptions (Figure 2c).

To examine these dyadic interactions during the waiting period, I will analyze data from two studies of support recipients undergoing an uncertain waiting period. In Study 1, participants interacted with their romantic partner while awaiting feedback on a speech given in the lab for an unfriendly audience. This study presents a situation in which the outcomes of potentially negative feedback are primarily relevant to only one member of the dyad. In Study 2, law graduates awaiting bar exam results and their romantic partners completed surveys across the 4-month waiting period. In this study, the outcome has the potential to directly affect both the primary participant and the partner, given the implications of the bar exam for employment options. Additionally, Study 2 assessed partners' perceptions of the participant's experience, which provide insight into how and when partners choose certain supportive strategies in relation to the participant's needs. Together, these studies provide a first step toward understanding the interaction between supportive dyads during the stressful experience of awaiting uncertain news.

Chapter 2: Study 1

Study 1 examines how participants and partners await uncertain outcomes when the feedback directly affects only one member of the dyad. In these situations that are skewed toward the needs of the participant, partners may take on supportive roles without the strain and distraction of their own distress. On the other hand, partners may feel disconnected from the experience of the participant, resulting in a greater struggle to decipher the needs of the participant and appropriate supportive responses. One member of each romantic dyad underwent a task designed to induce performance stress, while the other member of the dyad was present in a supportive capacity. During the study, partners had the opportunity to interact for 5 minutes while awaiting uncertain feedback regarding the performance.

Method

Participants. Romantic dyads (N = 134 dyads, 268 individuals; M_{age} = 19.58, SD_{age} = 1.67) enrolled in the study in order to gain psychology course credit. Eligibility for the study required being in a relationship for more than 3 months and fluency in English. Partners of enrolled participants also received course credit if applicable. Participating couples were also entered into a raffle for an Amazon gift card. Participants were predominantly Latino (43.3%), followed by Asian (27.2%), White (11.9%), Pacific Islander (1.2%), Black (0.4%), Mixed (11.1%), and Other (5.0%). The sample consisted of primarily heterosexual couples (94%) with 3 homosexual male couples (2.2%) and 5 homosexual female couples (3.8%). Of the heterosexual couples, 66% (81 dyads) had the

female performing the stressful task and 34% (42 dyads) had the male performing the task.

Design. During the study, one member of each romantic dyad underwent a task designed to induce social stress and anxiety while the other member of the dyad was present in a supportive capacity. The partner who originally enrolled in the study was assigned the role of *recipient*, whereas the other individual joining the participant was assigned the role of *provider*. (These labels were for experimenter use only, not told directly to the participants.) From this point on, I will refer to each individual participant using these labels, while reserving the term *participants* to refer to both individuals.

Experimenters gave recipients time to prepare for a performance task, time to perform the task, and then time to wait for feedback regarding the performance. Thus, the study primarily consisted of three phases: preparation phase, task phase, and waiting phase. During the waiting phase, experimenters brought the couple together while awaiting the uncertain feedback.[1] In between each phase, participants completed questionnaires assessing variables of interest to the current study. I describe those variables, along with further details regarding the procedure, below.

Procedures and measures.

[1] The current sample is a subset of a larger sample that consisted on 4 distinct conditions: (1) a *preparation condition*, in which the couple was together during the preparation phase, but separate during the waiting phase (59 dyads, 118 individuals); (2) a *waiting condition*, in which the couple was separate during the preparation phase, but together during the waiting phase (74 dyads, 138 individuals); (3) a *both-phases condition*, in which the couple was together during both the preparation and waiting phase (60 dyads, 120 individuals); and a *no partner condition*, in which the couple was separate during both the preparation and waiting phase (110 individuals). For the current study, I exclusively use participants from the *waiting* and *both-phases* conditions, given these conditions both have partners present to provider support during the uncertain waiting period of interest.

Introduction and informed consent. Upon arrival to the study, experimenters greeted and seated both participants. After signing in, participants underwent a simultaneous informed consent process, informing the participants that the study would include a stressful task and video recording. Participants then indicated their willingness to participate. If either partner was unwilling to participate, the couple was removed from the study.

Baseline survey. Following consent, providers were taken to a separate room to complete questionnaires assessing individual difference measures of interest to our study. Note that both participants filled out this questionnaire regarding their own individual differences. I assessed defensive pessimism (Norem & Cantor, 1986), dispositional optimism (Scheier & Carver, 1985), intolerance of uncertainty (Carleton, Norton, & Amundson, 2007), adult attachment style (Simpson, Rholes, & Phillips, 1996), empathy (Spreng, McKinnon, Mar, & Levine, 2009), and relationship satisfaction (Hendrick, 1988).

I used the Life-Orientation Test-Revised (LOT-R; Scheier & Carver, 1985) to assess dispositional optimism. Dispositional optimism refers to the tendency of individuals to generally expect good things, rather than bad things, to happen (6 items minus the filler items; e.g., “In uncertain times, I expect the best,” “I rarely count on good things to happen to me”; 1 = *strongly disagree*, 5 = *strongly agree; M* = 4.06, *SD* = .91, α = .77).

I used the 5-item version of the Defensive Pessimism Questionnaire (DPQ; Norem & Cantor, 1986) to assess defensive pessimism. This scale refers to people’s

tendency to maintain generally negative predictions of future outcomes as a way of increasing motivation (e.g., “I usually prepare for the worst,” “Considering what can go wrong helps me prepare”; 1 = *not at all true of me,* 7 = *very true of me; M* = 5.26, *SD* = .98, α = .77).

I assessed intolerance of uncertainty using the 12-item short form of the Intolerance of Uncertainty Scale (Carleton, Norton, & Amundson, 2007). Intolerance of uncertainty refers to dispositional characteristics associated with negative beliefs about uncertainty and its implications. Those who are intolerant of uncertainty tend to react negatively to uncertain situations and events (e.g., “Unforeseen events upset me greatly,” “I always want to know what the future has in store for me”; 1 = *not at all characteristic of me,* 5 = *extremely characteristic of me*; *M* = 2.83, *SD* = .71, α = .86).

To assess adult attachment, I used the Adult Attachment Questionnaire (AAQ; Simpson, Rholes, & Phillips, 1996). This measure consists of 2 subscales for anxious attachment (9 items; e.g., “I rarely worry about being abandoned by others,” “I often worry that my partners don't really love me”; *M* = 3.33, *SD* = 1.13, α = .66) and avoidant attachment (8 items; e.g., “I find it relatively easy to get close to others,” “I'm not very comfortable having to depend on other people.”; *M* = 3.54, *SD* = 1.01, α = .77). All items were answered on a 7-point scale (1 = *strongly disagree*, 7 = *strongly agree*).

I assessed participants’ empathy using the Toronto Empathy Scale (TES; Spreng, McKinnon, Mar, & Levine, 2009). This scale measures the tendency for individuals to experience similar emotions as those around them. Participants indicate the frequency in which they feel or act in a described manner (16 items; e.g., “When someone else is

feeling excited, I tend to get excited too," "Other people's misfortunes do not disturb me a great deal"; 0 = *never*, 4 = *always; M* = 3.34, *SD* = .34, α = .81).

Finally, I assessed the general relationship satisfaction of each partner using the Relationship Assessment Scale (RAS; Hendrick, 1988). This 7-items scale measures participants' feelings about their current relationship partner using a 7-point scale specific to each item (e.g., "In general, how satisfied are you with your relationship?" 1 = *low satisfaction*, 7 = *high satisfaction*; *M* = 6.04, *SD* = .79, α = .82). Following the individual difference measure, participants completed demographic questions.

Task description. Following the baseline survey, experimenters retrieved the provider, bringing the couple back together. The experimenter then read through a description of the task to both participants, first indicating that the recipient would be the one to undergo the task. For this study, recipients underwent the Trier Social Stress Task (TSST; Kirschbaum, Pirke, & Hellhammer, 1993). The TSST is a task designed to induce moderate psychological and physiological stress in a laboratory setting. The original protocol consists of a preparation period and task period in which participants have time to prepare and deliver a speech about a hypothetical perfect job. For the purpose of this study, I also included a waiting period following the task, during which recipients had time to anticipate feedback on their performance. The full task description is included in Appendix A.

Following the description, participants had the opportunity to ask questions. However, experimenters were instructed to only reiterate information already included in the description. Researchers then left the room and gave recipients 5 minutes to prepare

for the upcoming presentation (note that this timing is reduced from 10 minutes in the original TSST protocol). After 5 minutes, researchers returned to the room and instructed both participants to complete a pre-task survey. These data are not used in the current analyses and are not discussed further.

Trier Social Stress Task (TSST). After completing the survey, the researcher led the recipient into a separate room to perform the Trier Social Stress Task (the provider was asked to remain apart for the duration of this phase). Recipients stood opposite two trained experimenters across a long table (about 10 feet), and any notes receivers brought with them were taken away. As soon as both experimenters were seated, one experimenter started a stopwatch timer (set for 5 minutes) and instructed the recipient to "please begin." The recipient then had the full 5 minutes to present the prepared speech. As part of the task protocol, experimenters did not provide positive verbal or nonverbal feedback (e.g., smiling, nodding, "mmhmm"-ing). If recipients stopped talking before their 5 minutes ended, experimenters told them to continue talking (e.g., "Please use all the available time," "Continue however you think is best").

After 5 minutes, experimenters instructed the recipient to "subtract the number 13 from 1022, and continue subtracting 13 until I tell you to stop." Experimenters had a sheet with correct answers (e.g., 1022, 1009, 996) and interrupted receivers if they made any errors, telling the receiver to start again from the number 1022. Receivers received 60 seconds to subtract as many times as possible (note that this time is shorter than the time allowed in the original TSST protocol). After 60 seconds, researchers instructed the receiver to stop.

If at any time during the TSST recipients became visibly distraught, researchers gave them the opportunity to end the study. Recipients who elected to end the study were immediately debriefed and given credit for participation.[2]

Waiting phase. Following completion of the TSST, experimenters informed the recipient that time was required for deliberation regarding the performance and left the room. Depending on the session condition, the experimenter either brought the provider to join the recipient during this period (*waiting*/*both condition*) or left the provider in a separate room, thus leaving the recipient isolated during this period (*preparation/none condition*). My analyses focus on the data from conditions in which participants interacted. Experimenters left the recipient in the room for 5 minutes, though neither participant was informed of how long the experimenter would be gone.

Post-task survey. After 5 minutes of interacting with their partner, both participants completed an 8-item anxiety measure used in previous research on anxiety during uncertain waiting periods (e.g., Sweeny & Cavanaugh, 2012; Dooley et al., 2018; Sweeny & Dillard, 2014; 8 items; e.g., "I feel anxious," "I feel at ease"; 1 = *strongly disagree*, 5 = *strongly agree; M* = 2.28, *SD* = .91, α = .91),

Participants also reported their use of five waiting strategies relevant to waiting performance feedback based on the Uncertainty Navigation Model (see Sweeny & Andrews, 2014; Sweeny et al., 2016): positive expectation management (2 items; e.g., "I'm hoping for the best when it comes to [my/my partner's] evaluation on the speech

[2] Two recipients elected to end the study during the Trier task. Their data were not used in my analyses. A third participant elected to end the Trier task after 3 minutes, but continued participation in the study (i.e., entered the waiting phase with provider and completed all further study materials). The data for this couple were used in my analyses.

task"; *M* = 2.28, *SD* = .91, α = .76); bracing (2 items; e.g., "I want to make sure I keep my expectations low when it comes to [my/my partner's] evaluation on the speech task"; *M* = 2.28, *SD* = .91, α = .82); benefit-finding (3 items; e.g., "I feel like I would grow as a person if [I do/my partner does] poorly on the speech task"; *M* = 2.28, *SD* = .91, α = .72); distancing (3 items; e.g., "The speech task doesn't really measure anything important"; *M* = 2.28, *SD* = .91, α = .65); distraction (1 item; "I have been trying to distract myself from thinking about [my/my partner's] evaluation on the speech task"; *M* = 2.28, *SD* = .91), and suppression (2 items; e.g., "I have been trying to hide my feelings about [my/my partner's] evaluation on the speech task"; *M* = 2.28, *SD* = .91, α = .78).

Finally, each participant completed a series of questions regarding their interactions with their partner during the study (23 items adapted from the Support Strategies Scale; Marigold et al., 2014). That is, providers indicated the degree to which they had enacted specific support strategies, whereas recipients indicated the degree to which they had received specific support strategies. The scale includes six subscales assessing the degree of perceived responsiveness (3 items; e.g., "[My partner/I] understood [me/my partner]"; *M* = 5.84, *SD* = 1.35, α = .80), negative validation (7 items; e.g., "[My partner/I] allowed [me/my partner] to be negative"; *M* = 4.13, *SD* = 1.31, α = .76), positive reframing (6 items; e.g., "[My partner/I] tried to cheer [me/my partner] up"; *M* = 4.24, *SD* = 1.54, α = .84), and informational support (2 items; e.g., "[My partner/I] provided [me/my partner] with advice on how to deal with the task"; *M* = 4.39, *SD* = 2.05; α = .91), emotional support (3 items; e.g., "[My partner/I] comforted [me/my partner]"; *M* = 4.98, *SD* = 1.76; α = .86) and efforts to distract (1 item; e.g., "[My

partner/I] tried to distract [me/my partner] from the task"; $M = 4.21$, $SD = 2.20$). All items were rated on a 7-point scale (1 = *never occurred/not true of me*, 7 = *occurred all of the time/very true of me*). Finally, I assessed demographic questions about each participant, include age, gender, and ethnicity.

***Debriefing*.** Following completion of the post-task survey, both participants were brought together to receive a full debriefing with both experimenters. In particular, experimenters informed the participants that they would not be receiving any feedback; however, experimenters offered blanket statements suggesting that the performance was above average, considering the intentionally stressful nature of the task. Before leaving, participants reported any suspicions and indicated their willingness to have their data used in future analyses.

Results

The analyses for this project addresses four questions: (1) How does anxiety and strategy use of support providers differ from those of the person awaiting news? (2) How does use of strategy relate to experienced anxiety? (3) How does support provision/perception relate to the waiting experience of both participants? and (4) How do trait-like individual difference relate to support provision/perception?

Overview of dyadic analyses. Due to the hypothesized interdependent nature of partners' experiences during uncertain waiting periods, I primarily used dyadic analyses to test my questions of interest (except Question 1, see below). Specifically, I used Actor-Partner Interdependence Models (APIMs). These models simultaneously examine relationships between each member of a dyad's score on a predictor variable and their

score on an outcome variable (termed *actor effects*), as well as relationships between each dyad member's score on the predictor variable and the other dyad member's score on the outcome variable (termed *partner effects*). Thus, the predictor score for each member of a dyad will have both an actor effect (the relationship to their own outcome) and partner effect (the relationship to their partner's outcome).

I used Multilevel Modeling (MLM) as my method of parameter estimation, using the dyad as a Level 2 predictor. In this study, the dyad members are distinguishable as either support provider or recipient; thus, I used a two-intercept model to predict differences in actor/partner effects between roles. In order to run this model, the dataset must include two dummy-coded variables to denote role (e.g., in a "PartnerDummy" variable, partners would be coded 1, whereas recipients would be coded 0). This method has the advantage of easier interpretation of role-based actor/partner effects (for detailed explanation, see Kenny, Kashy, & Cook, 2006). However, in order to test whether actor and partner effects differ significantly from each other, I also ran a similar Interaction Model using single effects-coded variables to distinguish dyad members rather than two dummy-coded variables. For each parameter, I report the parameter estimate, its standard error, and the *p*-value for a *t*-test indicating parameter estimate difference from zero. I also z-scored all variables prior to analysis in order to facilitate easier comparability of effect sizes.

Using MLM to estimate the APIM parameters, each model generates two actor effects: the degree to which recipients' predictor variable predicts their own outcome (*recipient-actor*) and the degree to which providers' predictor variable predicts their own

outcome (*provider-actor*). I also generated two partner effects: the degree to which providers' predictor variable predicts the recipient's outcome (*provider-partner*) and the degree to which recipients' predictor variable predicts the provider's outcome (*recipient-partner*). The parameters for each APIM are presented in Tables 4-8.

Question 1: Anxiety and strategy use related to participant role. Before delving into the role of social support, I first examined differences in how dyad members' experience during uncertain waiting periods. First, I ran paired-samples *t*-tests between dyad members for anxiety and all six waiting strategies (Table 2). Recipients reported experiencing more anxiety than providers, $t(132)=7.34$, $p < .001$, as well as more efforts at bracing, benefit-finding, distraction, and suppression. Recipients also reported significantly less efforts to maintain positive expectations and to distance themselves from feedback than did providers.

Question 2: Strategy use related to anxiety. Next, I examined the relationship between strategy use and anxiety using multiple APIMs. Bivariate correlations ignoring role (participant or partner) are presented in Table 3. For the APIMs, I first ran bivariate correlations between recipient and provider reports of strategy use and found positive relationships between partners' use of bracing, $r(63) = .18$, $CI = [.01,.34]$, $p = .04$, and distraction, $r(63) = .21$, $CI = [.03, .37]$, $p = .02$. However, partners' use of positive expectation management, $r(130) = .14$, CI = [-.03, .3], $p = .11$, benefit-finding, $r(130) = .01$, $CI = [-.16, .18]$, $p = .91$, distraction, $r(129) = .03$, $CI = [-.15, .2]$, $p = .76$, and suppression, $r(130) = .07$, $CI = [-.11, .24]$, $p = .46$, were not significant associated.

I also generated estimates for each actor and provider effect, displayed in Table 4. Regarding actor effects, recipients' use of greater bracing, distraction, and suppression predicted greater anxiety among recipients. Similarly, providers' use of distraction and suppression predicted greater anxiety among providers. Regarding partner effects, providers' use of positive expectation management predicted less anxiety among recipients. There were no significant partner effects from recipients' strategy use to partners' anxiety.

Given the correlational nature of the data, I also considered the inverse predictive relationships, from anxiety to strategy use. Regarding actor effects, more anxious recipients used more bracing, distraction, and suppression, and less positive expectation management. Similarly, more anxious providers used more distraction and suppression. These findings were largely consistent with the previous, inverse version of the models. In contrast, regarding partner effects, greater anxiety among providers predicted greater use of positive expectation management among recipients, whereas greater anxiety among recipients predicted less use of positive expectation management among providers.

Question 3: Support perception related to waiting experiences and strategy use. I next ran further APIMs for each pairwise grouping of support measures (responsiveness, positive reframing, negative validation, informational support, emotional support, distraction support) with anxiety and each waiting strategy (positive expectation management, bracing, benefit-finding, distancing, distraction, and suppression). Bivariate correlations ignoring role are presented in Table 5. As with the

previous set of analyses, I ran each pairwise model twice: once using support provision/perception to predict anxiety/strategy use, and once using anxiety/strategy use to predict support provision/perception.

First, the bivariate correlations between partners for each measure of support demonstrated significant agreement in partners' perceptions of positive reframing, $r(63) = .45$, $CI = [.23, .63]$, $p < .001$, negative validation, $r(63) = .41$, $CI = [.18, .60]$, $p < .001$, and informational support, $r(63) = .56$, $CI = [.36, .71]$, $p < .001$. Correlations were only marginally significant for perceptions of responsiveness, $r(63) = .21$, $CI = [-.04, .43]$, $p = .10$, emotional support, $r(63) = .23$, $CI = [-.01, .46]$, $p = .06$, and distraction support, $r(63) = .22$, $CI = [-.03, .44]$, $p = .09$.

The models with support perception/provision predicting anxiety/strategy use (see Table 6) demonstrated significant actor effects. Specifically, recipients who perceived greater responsiveness engaged in more positive expectation management and distancing, and less distraction. Recipients who perceived more positive reframing and negative validation engaged in more distancing, and recipients who perceived more negative validation engaged in more benefit finding. Finally, recipients who perceived more informational support engaged in less distraction. Turning to providers, providers who reported giving more emotional support engaged in more distancing, and providers who reported giving more distraction support engaged in more suppression. These models also demonstrated a single significant partner effect, such that when recipient perceived more suppression support, providers engaged in less suppression. There were no significant provider-partner effects.

Next, I ran APIMs using anxiety and waiting strategy use to predict support perception/provision (see Table 6). Regarding actor effects, more anxious recipients perceived greater distraction support from their partner. In addition, recipients who engaged in more bracing, distraction, and suppression perceived greater distraction support from their partner. Recipients' attempts to brace for the worst were predictive of other support perceptions, including perceptions of more positive reframing, negative validation, and emotional support from their partner. Finally, recipients who engaged in more benefit-finding and distancing strategies reported significantly more negative validation from their partner. Provider-actor effects were more limited. Providers who engaged in more positive expectation management reported giving more informational support; providers who engaged in more distancing reported being more responsive and giving more emotional support; and providers who engaged in more suppression reported giving more distraction support.

Turning to partner effects, when recipients engaged in more bracing and suppression, their partners reported being more responsive. When providers engaged in more bracing and suppression, recipients perceived less positive reframing from them, and when providers engaged in more positive expectation management, recipients perceived more negatively validation from them. Finally, when providers engaged in more benefit-finding, recipients perceived more informational support from them.

Question 4: Individual differences related to support perception/provision. To examine the role of individual differences in support provision and perceptions, I ran APIMs for each pairwise grouping of individual difference measures (dispositional

optimism, defensive pessimism, intolerance of uncertainty, anxious attachment, avoidant attachment, and empathy) and each support measure (responsiveness, positive reframing, negative validation, informational support, emotional support, distraction support). Bivariate correlations ignoring role are presented in Table 7. Regarding actor effects, more defensively pessimistic recipients perceived greater responsiveness and more emotional support from their partner; however, no other recipient-actor effects were significant. I also found no recipient-partner effects, indicating that recipients' individual differences did not significantly predict providers' reported support behaviors.

These analyses also revealed few significant provider effects, whether actor or partner. However, providers who were more empathic reported giving more positive reframing support, informational support, and emotional support. Providers' empathy also had significant provider-partner effects, such that when providers were more empathic, recipients perceived greater responsiveness and more negative validation and emotional support from their partner. Further details regarding parameters for each of the APIMs are presented in Table 8.

Discussion

In the current study, I examined how support recipients and providers experience an uncertain waiting period when the feedback directly affects only one member of the dyad. My goal was to explore four primary questions: (1) How does role influence waiting experiences? (2) How does strategy use relate to anxiety? (3) How does support provision/perception relate to waiting experiences? and (4) How do trait-like individual difference play a role in support provision/perception? Given the multitude of analyses in

the current study, the ability to draw conclusions from individual analyses is limited. Therefore, my discussion attempts to highlight patterns that help to illuminate the role of support during uncertain waiting periods.

Partners differ in their waiting experiences. My first question explored differences in waiting experiences between participants based on their social support role, either recipient or provider. Because the feedback in the current paradigm was primarily relevant to only the recipient, I expected to find significant differences between recipients' and providers' anxiety and use of waiting strategies.

My findings confirmed that recipients reported greater anxiety than providers. Past research has demonstrated that couples can experience strong mood contagion (Butler & Randall, 2013; Neumann & Strack, 2000), but in the case of my study, this contagion seemed to be limited. Additionally, role influenced use of all waiting strategies. Compared to support providers, recipients spent more effort bracing for worst-case outcomes, trying to find benefit in failure, attempting to distract themselves, and trying to suppress thoughts about their performance. These findings are consistent with previous research demonstrating that others are unlikely to brace for non-self-relevant feedback (Sweeny, Shepperd, & Carroll, 2009) and expand these findings to other coping strategies people use while they wait for uncertain news. Conceptually consistent with these previous findings, providers were more likely to try to maintain positive expectations or downplay the importance of the feedback. Because the feedback was not self-relevant, providers may have an easier time making light of both the likelihood and impact of worst-case possibilities.

Interpersonal dynamics of waiting strategies are complex. My next question focused on the association between strategy use and anxiety and found that for both recipients and providers, greater use of distraction and suppression techniques was bidirectionally related to greater anxiety. That is, use of these strategies may provoke anxiety, and greater anxiety about the impending news may motivate greater attempts to distract oneself from and suppress thoughts about the stressor. For recipients but not providers, anxiety was also related to greater bracing and distancing, and less positive expectation management. Again, the causal order of these relationships was unclear, though the negative relationship between anxiety and positive expectation management was significant only when anxiety was the predictor in the model. Thus, more anxious recipients may find positive expectations more challenging to uphold.

Positive expectation management also showed interesting dynamics between partners when it came to anxiety were also significant. When providers engaged in positive expectation management, recipients were less anxious; in contrast, when providers were more anxious, recipients engaged in more positive expectation management. Combined with the lack of significant provider-actor effects for positive expectation management, these findings suggest that providers who maintain more positive expectations may not feel less anxious themselves, but their efforts toward personal positivity translate into lower anxiety for their partner. However, more anxious providers hurt the recipient's, but not their own, ability to remain optimistic. Recipients also seemed to influence providers, such that providers with less anxious partners were better able to maintain positive expectations. This finding suggests that positive

expectations are more sensitive to external cues from one's partner than other strategies. Thus, although there is growing debate regarding the best method of waiting well (Sweeny et al., 2016), benefits of an optimistic mindset may be more interpersonally dependent.

Perceptions are key when it comes to support and waiting experiences. My next question addressed perceptions of support behaviors and their links to anxiety and strategy use during the waiting period. In this study, recipients and providers were in general agreement regarding the supportive behaviors in which providers engaged. Although past research demonstrated discrepancies in perceptions versus provision of support (Gable, Reis, & Downey, 2003), the short 5-minute interaction, along with a relatively obvious opportunity for a supportive interaction in a contrived situation, might have led to both greater self- and other-monitoring. In a longer, less contrived scenario, however, partners may exhibit less agreement.

Regarding the apparent effects of support, I found little evidence for links between support behaviors and anxiety, in either recipients or providers. This finding adds to a growing literature suggesting that anxiety experienced during uncertain waiting periods may be particularly resistant to the effects of social support (Dooley et al., 2018). Past research has been unable to test whether this non-effect was due to recipients' perceptual limitations during a stressful event (i.e., George might be too caught up in his worries to notice Martha's supportive behaviors) or providers' inability to provide support that effectively reduces anxiety. The current study allowed for an initial test of

these pathways, and the findings suggest that anxiety was unmoved by both enacted support and perceptions of support.

Turning to the effects of support on strategy use, my findings revealed broad effects of perceived support (including responsiveness, positive reframing, and negative validation efforts, as well as other weaker relationships) on recipients' use of positive expectation management. The joint positive relationship with both positive reframing and negative validation is surprising, given that these supportive behaviors are conceptually opposite. However, perceptions of either type of support may indicate that providers are active in the support process (additionally generating more perceived responsiveness). This perception of involvement from one's partner may then facilitate one's ability to maintain positive expectations. That is, if George feels that Martha is there for him, he may be better able to stay in an optimistic state of mind. Further supporting this interpretation were weak but consistent relationships between perceptions of support and recipients' use of benefit-finding. Although these findings were non-significant, the pattern suggests that recipients' ability to see light at the end of the tunnel of uncertainty may be influenced by their perception of their partner's level of engagement. On the other hand, recipients were less likely to engage in distraction efforts and distancing if they perceived various types of support from their partner. Thus, recipients who feel that their partners are there for them may feel less of a need to mentally retreat from the stressor.

Although perceptions of support did not predict recipients' efforts to brace, recipients who engaged in this pessimistic strategy tended to perceive more support from

their partner. A possible explanation for this effect is that recipients who are fearing the worst may more clearly communicate their support needs. However, these findings emerged as recipient-actor effects, not as recipient-partner effects. Thus, providers themselves did not report giving more support in response to recipients' bracing, yet pessimistically-minded recipients are perceiving more support nonetheless.

An alternative explanation is that recipients who perceive impending failure may place greater focus on positivity in other areas of their lives. That is, if George believes he is going to lose his job, he might perceive other aspects of his life more positively, such as the supportiveness of his wife. However, this explanation is tentative and requires further testing to confirm whether bracing prompts people to seek other forms of self-validation, such as relational supportiveness. This effect is also contrary to past research finding a negative relationship between bracing and perceptions of responsiveness (Dooley et al., 2018), and thus further replication attempts are needed to explore the reliability of this finding.

With the exception of some weak and inconsistent effects, I found few effects of providers' reports of their support behaviors on either providers' or recipients' strategy use. The lack of significant partner effects may be evidence that the recipient is more engaged and mentally invested in the supportive interaction, given that the stressor primarily affects the recipient. Thus, the recipient's perceptions are the best predictor of the recipient's psychological state.

A final interesting finding was that recipients who perceived that their partner was helping them to engage in distraction also reported that they themselves were engaging in

distraction, although the causal relationship was stronger from recipients' strategy use to perceptions of support. However, recipients' use of distraction was unrelated to providers' reports of providing distraction support, suggesting that perception is a key aspect of this relationship. That is, recipients were either using a strategy that matched the support they felt they received, or they were perceiving support that was consistent with the strategies they were using.

Together, these findings suggest that recipients are engaging in waiting strategies related to support they think they are receiving, rather than what providers thinks they are giving. In the current study, unfortunately, distraction was the only supportive behavior with a corresponding waiting strategy, but future studies should explore relationship between waiting strategies and more strategy-relevant support behaviors.

Pessimism is important to recipients' perceptions, whereas empathy is key trait in support providers. My fourth question sought to investigate how individual differences among participants influence how they provide or perceive support while awaiting uncertain feedback for themselves or their partner. Past research has highlighted the value of explanatory styles (i.e., optimism and pessimism) in the context of social support, such that optimistic outlooks relate to greater perceptions of support (Brissette, Scheier, & Carver, 2002). However, the relationship between optimistic mindset and perceptions of responsiveness was not significant in the current study. A growing body of research suggests that although optimists may perceive more global support, there is little evidence that optimists actually receive more support in the moment (Vollman & Renner, 2010; Vollman & Renner, 2007).

Perhaps surprisingly, more defensively pessimistic recipients perceived greater support from their providers, particularly responsiveness and emotional support. Partners of defensively pessimistic recipients also reported feeling more responsive and giving greater support. Research suggests that people like others who are optimistic (Helweg-Larsen, Sadeghain, & Webb, 2002), so perhaps support providers felt uncomfortable with their partners' pessimistic attitude and thus greater motivation to provide support to alleviate their pessimism. Because the situation in the current study presents an acute moment of distress, providers may feel capable and willing to give support to their pessimistic partners. However, more chronic distress presentations have been shown to have the inverse effect on support giving (Forest, Kille, Wood, & Holmes, 2014; Revenson, 2009), and further research should explore these seemingly contradictory findings in a longer-term waiting period.

The current study also found non-significant actor and partner effects of attachment style on support perceptions. These findings somewhat contradict past research suggesting that anxiously attached individuals receive less support and interpret supportive attempts as less effective (Collins & Feeney, 2004; Collins & Feeney, 2000; Simpson, Rholes, & Nelligan, 2004). Methodologically, however, the current study differs from past research in important ways that may have curtailed the influence of attachment styles. People with anxious or avoidant attachment styles have greater difficulty making their support needs apparent. Because our paradigm created an obvious opportunity for a supportive interaction regarding a clear and specific stressor, anxious or

avoidant participants may have been able to receive support without specifically seeking it.

Despite past research showing the benefits of relational health to support giving (Gleason & Iida, 2015; Maisel, Gable, & Strachman, 2008; Talley, Mollix, & Shlegel, 2010), relationship satisfaction was surprisingly unrelated to support perceptions, though more satisfied partners reported giving more emotional support. Given the current methodology, however, partners may have felt a social requirement to provide support for the short period of time regardless of their satisfaction. Follow-up tests also demonstrated a slight ceiling effect for relationship satisfaction (*M*s > 5.5 out of 7), which may be due to a selection bias of studying recipients who had providers willing to join them for an hour-long psychological study with no compensation.

Empathy, however, stood out as a significant individual difference, with providers' empathy predicting both their own reported support behaviors and the recipient's perceptions of support. That is, both partners agreed that more empathetic providers were more supportive. This finding supports past research on empathy as an important element of social support provision, whether through increased ability to perceive the recipient's needs or motivation to alleviate the vicarious feelings of distress (Devoldre, Davis, Verhofstadt, & Buysse, 2015; Trobst, Collins, & Embree, 1994).

Conclusion. Overall, the findings from Study 1 highlight the value of examining both the support recipient and support provider simultaneously to understand how partners experience the stress of uncertain waiting periods. The uncertainty of awaiting uncertain performance feedback was stressful for recipients, and recipients' perceptions

of support were associated with how they experienced the wait. Although providers' individual differences influenced their support-giving, particularly when it came to empathy, I found little evidence for provider effects across analyses. That is, recipients' anxiety and coping strategies seemed to reflect their perceptions of support rather than providers' reports of support behaviors. However, because the feedback in the current study was largely irrelevant to the provider, these non-effects may be due to a lack of personal engagement by support providers. Thus, in the next study I sought to replicate and extend the Study 1 findings by examining support during a uncertain waiting period in which the outcome had the potential to affect both partners.

Chapter 3: Study 2

Study 2 builds on the results from Study 1 by examining the interaction between recipients' and providers' experiences when the outcome has the potential to negatively influence both members of the dyad. Additionally, to improve the validity and generalizability of our findings, Study 2 examines an uncertain waiting period, namely the California bar exam, that was more significant than the contrived presentation task (albeit a well-validated stressful task) used in Study 1, and Study 2 included a broader set of well-being measures. The exam that is the focus of Study 2 took place in July 2016, and law graduates taking the exam waited four months for their results. This study builds upon previous research using similar samples and contexts (e.g., Dooley et al., 2018; Sweeny & Andrews, 2014; Sweeny et al., 2016; Howell & Sweeny, 2016).

Method

Participants. As part of a larger study of the wait for bar exam results, law graduates taking the July 2016 California bar exam were recruited from law schools across the United States. As part of the recruitment process, we also offered romantic partners of participants the chance to enroll in the study. In order for partners to be eligible, the couple must have been in the relationship for at least 3 months. The current study exclusively utilizes this subsample of the larger study. The final sample examined results from 132 participants (66 couples; 49% female; Mage = 28.17, SDage = 4.96). Participants were predominantly White (57.6%), followed by Asian (19.7%), Latino (6.1%), Black (2.3%), Mixed (12.9%), and Other (1.5%). All of the couples were heterosexual (98.5%) except for 1 homosexual dyad. Of the heterosexual dyads, 56% (36

dyads) had the female awaiting bar exam results and 44% (28 dyads) had the male awaiting results. For consistency of terminology, from this point forward I will refer to the law graduates enrolled in our study as *recipients* and the partners of these law graduates as *providers*. The term *participants* will refer to both parties simultaneously. All participants received $10 for each completed survey.

Procedures. All participants provided consent after the initial recruitment period and prior to completing the baseline survey. Participants received Amazon gift cards at the completion of the study commensurate with the number of surveys each individual completed. A researcher distributed the first set of surveys to recipients two weeks prior to the start of the bar exam and to providers within 3 days following the exam, and all participants completed their participation within 2 weeks after results became available in November 2016.

To be more specific, recipients completed a baseline survey two weeks prior to the start of the exam, and then they completed the first waiting survey 3 days following the completion of the exam and the final waiting survey within 24 hours before learning whether they passed the exam. I distributed the three additional waiting surveys to recipients at scheduled intervals across the 4-month waiting period, the timing of which depended on random assignment to one of five arbitrary groups that completed the remaining three waiting surveys at staggered intervals (see Table 1). In the end, all

recipients completed five waiting surveys spaced approximately five weeks apart, and a group of participants completed waiting surveys every week during the waiting period.[3]

Providers completed their first survey (including baseline measures) 3 days after recipients completed the bar exam, a second waiting survey halfway through the 4-month wait, and a final waiting survey within 24 of results becoming available.[4] Note that all study participants (recipients and providers) completed surveys at two overlapping time points: shortly after the exam (66 dyads) and within 24 hours prior to learning exam results (56 dyads). In the current study, I average participant experiences across all waiting period time points.

Measures.

Baseline questionnaire. The first questionnaire included measures of trait-like individual differences and baseline assessments of several key waiting variables. Both participants completed measures of dispositional optimism (Life Orientation Task-Revised; Carver & Scheier, 2014), defensive pessimism (Defensive Pessimism Questionnaire; Norem & Cantor, 1986), intolerance of uncertainty (Carleton, Norton, & Amundson, 2007), and attachment (Experiences in Close Relationships-Revised; Fraley, Waller, & Brennan, 2000). Participants also reported demographic information at this initial time point.

[3] Recipients also completed two surveys after they learned their bar exam result, one within 24 hours after learning their result and the final survey either one or two weeks following results (again randomly assigned). The post-news surveys are not pertinent to the current endeavor.
[4] Providers also completed a final survey within 24 hours after recipients learned their exam results, but post-news measures are not relevant to the current study.

As in Study 1, I assessed dispositional optimism using the Life-Orientation Test-Revised (LOT-R; Scheier & Carver, 1985; *M* = 4.77, *SD* = 1.09, α = .85), defensive pessimism using the 5-item version of the Defensive Pessimism Questionnaire (DPQ; Norem & Cantor, 1986; *M* = 5.16, *SD* = 1.14, α = .84), and intolerance of uncertainty using the Intolerance of Uncertainty Scale (IUS; Carleton, Norton, & Amundson, 2007; *M* = 3.29, *SD* = 1.03, α = .93).

To assess attachment-related anxiety and avoidance, I used the 36-item Experiences in Close Relationship-Revised scale (ECR-R; Fraley, Waller, & Brennan, 2000). This measure consists of 2 subscales: one for attachment-related anxiety (18 items; e.g., "I'm afraid that I will lose my partner's love," "I rarely worry about my partner leaving me"; *M* = 2.01, *SD* = 1.05, α = .92) and one for attachment-related avoidance (18 items; e.g., "I prefer not to show a partner how I feel deep down," "I tell my partner just about everything"; *M* = 1.23, *SD* = 1.30, α = .91). All items were answered on a 7-point scale (1 = *strongly disagree*, 7 = *strongly agree*). This measure was not used in Study 1, but measured similar attachment-related constructs as the Adult Attachment Scale (AAQ; Simpson, Rholes, & Phillips, 1996) in Study 1. However, research suggests the ECR-R provides more precise estimates of latent attachment (Sibley, Fischer, & Liu, 2005).

Waiting period questionnaires. Participants completed similar questionnaires at each of the relevant waiting time points, which I hereafter refer to as Waiting 1 through Waiting 3. These questionnaires assessed key variables in the uncertainty navigation model (Sweeny & Cavanaugh, 2012). Receivers and providers both completed similar

measures. For each measure, responses at distinct time points across the waiting period were averaged to create a single score for that waiting period variable for that participant.

Distress. Participants indicated the extent to which they felt worried in the past week by responding to three items adapted from previous research on waiting experience distress (Howell & Sweeny, 2016; e.g., "I feel anxious every time I think about [the/my partner's] bar exam," "I am worried about [my/my partner's] bar exam result," "I can't seem to stop thinking about [the/my partner's] bar exam"; 1 = *strongly disagree*, 7 = *strongly agree; M* = 3.66, *SD* = 1.45, αs > .82).

Rumination about the bar exam was measured at each point using one item asking how often in the past week participants had "thought about the bar exam prior to starting this survey" and three items assessing the frequency of bringing up the bar exam in conversation "…with other people," "…with friends who did not take the bar exam," and "…with family members" (1 = *not at all*, 5 = *almost constantly; M* = 5.52, *SD* = 1.15, αs > .67).

Emotions. I assessed current participant emotions using the Affect Adjective Scale (AAS; Diener & Emmons, 1985). This measure assessed the frequency of feeling specific emotions in the previous week. The emotions include four positively-valenced adjectives (happy, pleased, joyful, enjoyment/fun*; M* = 5.45, *SD* = .87, αs > .84) and five negatively-valenced adjectives (worried/anxious, angry/hostile, frustrated, depressed/blue, unhappy*; M* = 3.45, *SD* = 1.22, αs > .83). All items were assessed on a 7-point scale (1 = *strongly disagree*, 7 = *strongly agree*).

Subjective coping. Participants responded to a single item assessing how well they felt they were coping with the wait for the bar exam results (1 = *not well at all*, 7 = *very well; M* = 5.52, *SD* = 1.15).

Subjective physical health. In order to assess self-reported physical health, participants first self-reported their overall health during the past week ("During the past week, would you say your health has been…"; 1 = *poor*, 5 = *excellent; M* = 2.79, *SD* = .85).

Physical health interference. Participants also responded to four items taken from the Medical Outcomes Study (MOS; Stewart, Hays, & Ware, 1988) assessing whether physical health had interfered with regular activities during the past week (e.g., "cut down on the amount of time you spent on work or other activities," "accomplished less than you would like"; 1 = *not at all*, 7 = *very much; M* = 1.79, *SD* = .77, αs > .90), one item assessing the extent to which physical health interfered with normal social activities with family, friends, and neighbors (1 = *not at all*, 5 = *extremely; M* = 1.45, *SD* = .57), and 4 items assessing participant vigor (e.g., "How often during the past week…did you feel worn out?"; 1 = *all the time*, 7 = *none of the time; M* = 3.52, *SD* = .86, αs > .86). I standardized and averaged these nine items together to get a single physical health interference composite score (αs > .86).

Mental health interference. To assess mental health, participants completed the 4-item Patient Health Questionnaire (PHQ-4; Kroenke, Spitzer, Williams, & Lowe, 2009). In this measure, participants indicated how often they had been bothered by mental health-related problems in the previous week (e.g., "Feeling nervous, anxious, or on

edge", "Not being able to stop or control worrying"; 1 = *not at all*; 4 = *nearly every day; M* = 1.64, *SD* = .61, αs > .85). Additionally, participants responded to four items taken from the Medical Outcomes Study (MOS; Stewart, Hays, & Ware, 1988) assessing whether emotional problems (such as feeling depressed or anxious) had interfered with regular activities during the past week (e.g., "cut down on the amount of time you spent on work or other activities," "accomplished less than you would like"; 1 = *not at all,* 7 = *very much; M* = 2.23, *SD* = 1.15, αs > .89) and the extent to which emotional problems interfered with normal social activities with family, friends, and neighbors (1 = *not at all*, 5 = *extremely; M* = 1.75, *SD* = .82). I standardized and averaged these eight items together to get a single mental health interference composite score (αs > .88).

Sleep disturbance. Sleep disturbance and characteristics were assessed using the Pittsburgh Sleep Quality Index (PSQI; Buysse, Reynolds, Monk, Berman, & Kupfer, 1989). This index measures self-reported quality and patterns of sleep in adults, differentiating "poor" from "good" sleep quality by measuring seven areas (components): subjective sleep quality, sleep latency, sleep duration, habitual sleep efficiency, sleep disturbances, use of sleeping medications, and daytime dysfunction over the last week. Scoring for the PSQI utilizes a non-traditional scoring mechanic with higher results indicating greater sleep disturbances (for details, see Buysee et al., 1989; *M* = 5.39, *SD* = 2.60).

Expectation management. Participants indicated the extent to which they were trying to maintain a positive outlook with two items: "I'm hoping for the best when it comes to [my/my partner's] bar exam results," and "I'm trying to be optimistic about

[my/my partner's] bar exam results" (hereafter referred to as positive expectation management; 1 = *strongly disagree*, 7 = *strongly agree; M* = 6.32, *SD* = .72, αs > .56). Participants also indicated the extent to which they were bracing for the possibility of failure with two items: "I'm bracing for the worst when it comes to [my/my partner's] bar exam results," and "I want to make sure I keep my expectations low when it comes to [my/my partner's] bar exam results" (1 = *strongly disagree*, 7 = *strongly agree; M* = 3.57, *SD* = 1.45, αs > .78).

We assessed two forms of reappraisal: preemptive benefit-finding and distancing. Participants indicated their efforts to preemptively identify benefits of failure on three items (e.g., "I feel like I'll learn from the experience if [I fail/my partner fails] the bar exam"; 1 = *strongly disagree*, 7 = *strongly agree; M* = 3.40, *SD* = 1.32, αs > .76) and indicated their efforts to downplay the importance of the exam on 5 items (e.g., "The bar exam is a valid measure of the skills and abilities required to practice law," "The bar exam is not a good indicator of one's ability to practice law"; 1 = *strongly disagree*, 7 = *strongly agree; M* = 4.21, *SD* = 1.16, αs > .72).

Support strategies and responsiveness. Finally, participants completed a series of items regarding their interactions with their partner over the past week. First, participants indicated whether they had talked to their partner about the exam in the past week (*yes* / *no*). Participants who indicated that they had talked to their partner about the exam then responded to a set of items assessing perceptions of the provider's behaviors (24 items adapted from the Support Strategies Scale; Marigold et al., 2014; 1 = *strongly disagree*, 7 = *strongly agree*). As in Study 1, this measure assessed responsiveness (3 items; *M* =

6.05, *SD* = .75, αs > .64), negative validation (7 items; *M* = 5.27, *SD* = .72, αs > .61), positive reframing (6 items; *M* = 4.40, *SD* = 1.01, αs > .65), informational support (3 items; *M* = 4.27, *SD* = 1.34, αs > .70), emotional support (3 items; *M* = 5.84, *SD* = .88, αs > .58), and efforts to help distract (3 items; *M* = 5.10, *SD* = 1.10, αs > .50).

Additionally, I created an additional 6 items for the purposes of this study to assess behaviors intended to facilitate the use of specific waiting strategies. These included positive expectation management ("I helped my partner be optimistic"; *M* = 5.81, *SD* = 1.00), bracing ("My partner helped me to brace for the worst"; *M* = 3.89, *SD* = 1.56), preemptive benefit-finding ("My partner helped me to focus on good things that might come from failing the bar exam"; *M* = 3.32, *SD* = 1.64); distancing ("My partner helped me remember that failing the bar exam would not mean that I am incompetent or unqualified to practice law"; *M* = 4.37, *SD* = 1.63), suppression ("My partner helped me suppress my feelings about the bar exam"; *M* = 3.47, *SD* = 1.42), and proactive coping ("My partner helped me think about how I would cope if I fail the bar exam"; *M* = 4.55, *SD* = 1.42).

Results

As in Study 1, my analyses were intended to explore four questions: (1) How does the experience of awaiting news differ between recipient and provider? (2) How does strategy use relate to how recipient and providers experience the waiting period? (3) How does support provision/perception relate to the waiting experience both participants? and (4) How do trait-like individual difference play a role in support provision/perception? Similarly, I primarily utilized Actor-Partner Interdependence Models (APIMs) with

multilevel modeling (MLM) as my method of parameter estimation for the distinguishable dyad. Each model generated four effects: the degree to which recipients' predictor variable predicts their own outcome (recipient actor effect; a_{recip}), the degree to which providers' predictor variable predicts their own outcome (provider actor effect; a_{provid}), the degree to which providers' predictor variable predicts the recipient's outcome (provider partner effect; p_{provid}) and the degree to which recipients' predictor variable predicts the provider's outcome (recipient partner effect; p_{recip}). Due to the number of analyses, unless otherwise noted I only highlight significant results at $\alpha = .05$ in the text below. Full details for parameters for each APIM are presented in Tables 9-12.

Question 1: Waiting experience and strategy use related to participant role. Prior to examining dyadic models of social support during this uncertain waiting period, I examined differences in how participants experienced the uncertain waiting period depending on their role. I ran paired-samples t-tests between dyad members for each of the measures of participant waiting experience and waiting strategy use (Table 2). Similar to Study 1, recipients reported greater worry, negative emotions, and mental health issues, as well as worse subjective health and subjective coping than providers. Recipients and providers did not differ in positive emotions, rumination, physical health issues, or sleep disruption. Regarding strategy use, recipients engaged in more bracing and less positive expectation management and benefit finding than providers. Dyad members did not differ in distancing.

Question 2: Strategy use related to well-being. Next, I explored the relationship between strategy use and well-being using multiple APIMs. The correlations between

study variables ignoring role and dyadic effects are presented in Table 3. The bivariate correlations between partners' and recipients' strategy use showed significant positive relationships for bracing, $r(63) = .33$, $CI = [.09, .53]$, $p = .009$, and benefit-finding, $r(65) = .41$, $CI = [.19, .6]$, $p < .001$, but not for positive expectation management, $r(63) = .19$, $CI = [-.06, .42]$, $p = .14$, or distancing, $r(65) = .22$, $CI = [-.02, .44]$, $p = .08$.

Next, I generated estimates of actor and partner effects (see Table 9). For recipient actor effects, recipient who engaged in more positive expectation management reported greater positive emotion, better subjective coping and health, and less physical health interference, and recipients who engaged in more benefit finding reported less worry. In contrast, recipients who engaged in more distancing reported more worry, and recipients who engaged in more bracing reported less positive emotion, more worry, worse subjective coping and health, more physical and mental health interference, and more sleep disruption.

Recipients also demonstrated partner effects of bracing and distancing, such that providers reported less positive emotion when recipients engaged in more bracing and distancing, and providers also reported worse subjective health and greater sleep disruption when recipients engaged in more distancing.

For providers, greater use of positive expectations management strategies was predictive of less physical and health interference, and providers who engaged in more bracing and distancing also reported significantly more worry. Turning to partner effects, recipients reported less worry when providers engaged in less distancing.

Question 3: Support perception related to well-being and strategy use. To explore the effects of support on waiting experience and waiting strategy use, I ran multiple APIMs for each pairwise grouping of support behaviors (e.g., responsiveness, informational support, bracing support) with each measure of well-being (e.g., positive emotions, worry) and waiting strategies (e.g., bracing, distraction). Bivariate correlations ignoring role are presented in Table 5.

First, bivariate correlations showed significant agreement between recipients and providers on perceptions of responsiveness, $r(59) = .47$, $CI = [.24, .65]$, $p < .001$, as well as support targeted towards positive expectation management, $r(58) = .40$, $CI = [.16, .59]$, $p = .002$, distancing, $r(59) = .31$, $CI = [.06, .52]$, $p = .02$, and proactive coping, $r(59) = .32$, $CI = [.07, .54]$, $p = .01$. Correlations between perceptions and provision of other support behaviors were non-significant or only marginally significant.

Associations between support and well-being. Next, I generated actor and partner effect parameters using support perception/provision as predictors and well-being measures as outcomes (Table 10). For recipient-actor effects, recipients who perceived greater responsiveness also reported more positive emotion, less negative emotion, less physical and mental health interference, and less sleep disruption. Recipients who perceived more informational support from their partner also reported more positive emotion. Surprisingly, recipients who perceived more emotional support and positive reframing from their partner, as well as support efforts toward bracing, distancing, distraction, suppression, and proactive coping, reported greater worry. Recipients who perceived more emotional support, positive reframing, distraction support, and

suppression support—but not bracing, distancing, or proactive coping support—reported poorer subjective coping, and recipients who perceived more emotional support, distraction support, and negative validation reported more rumination. Finally, recipients who perceived more distraction support and suppression support reported greater mental health interference.

For provider-actor effects, providers who gave more emotional support, positive expectation management support, and proactive coping support also reported more positive emotion. Providers who engaged in more positive reframing support reported better subjective health, whereas providers who engaged in more negative validation support reported less physical health interference.

For partner effects, recipients reported experiencing more worry when providers reported greater efforts to help the recipient brace; however, recipients experienced less worry when the provider reported giving more positive reframing support. When recipients perceived more positive reframing support, however, providers reported worse subjective coping.

Next, I explored the potential for reverse causation by running APIMs using waiting experiences as predictors and support perceptions/provision as outcomes (Table 10). For recipient-actor effects, recipients who reported experiencing more positive emotion, less negative emotion, better subjective health, less physical health interference, and less sleep disruption also perceived greater responsiveness from their partner. Recipients who reported more positive emotion, less sleep disruption, less physical health interference, and better subjective health also perceived more positive expectation

management support from their partner. Recipients who worried more perceived more positive reframing and emotional support, as well as bracing support, distraction support, suppression support, and proactive coping support. Recipients who reported poorer subjective coping and greater mental health interference perceived more distraction support from their partner. Finally, recipients who experienced more positive emotion and rumination perceived more negative validation and emotional support from their partner, and recipients with better subjective health perceived more positive reframing.

For provider-actor effects, providers who experienced more positive emotion reported giving more emotional support, bracing support, and proactive coping support, and providers who experienced more worry reported giving more benefit-finding support. Similarly, there were few significant provider-partner effects, except that recipients perceived greater responsiveness and negative validation support when the provider reported better subjective coping.

For recipient-partner effects, providers reported giving more positive reframing support when recipients experienced greater worry and worse subjective coping. In addition, providers reported giving more distancing support when recipients experienced more positive emotion; providers reported giving more emotional support when recipients had better subjective health; and providers reported giving more positive expectation management support when recipients experienced less physical health interference.

***Associations between support and strategy use*.** Next, I explored the relationship between support perception/provision and strategy use by running multiple APIMs with

support perceptions/provision as predictors and strategy use as outcomes (Table 11). For recipient-actor effects, recipients who perceived more positive reframing support, informational support, and positive expectation management support from their partner reported using more positive expectation management. Recipients who perceived more positive reframing support, bracing support, distancing support, and proactive coping support engaged in more bracing. Recipients who perceived more positive expectation management support, benefit-finding support, and proactive coping support engaged in more benefit finding. Finally, recipients who perceived more bracing support, distancing support, and proactive coping support engaged in more distancing.

For provider-actor effects, no provider reports of support provision significantly predicted providers' use of positive expectation management or distancing strategies. However, providers who reported giving more positive reframing support, emotional support, positive expectation management support, bracing support, benefit-finding support, distancing support, distraction support, and proactive coping support engaged in more benefit finding. Providers who reported giving more bracing support and benefit finding support engaged in more bracing.

The only significant partner effects were for providers' reports of support predicting recipients' strategy use (i.e., provider-partner effects). Specifically, recipients reported using more positive expectation management and less distancing when the provider reported being more responsive, and recipients used more benefit-finding when providers reported giving more suppression support. No recipient-partner effects were significant.

Finally, I explored the potential for reverse causality by running APIMs using waiting strategies as predictors and support perceptions/prevision as outcomes (Table 11). For recipient-actor effects, recipients who used more positive expectation management, more benefit-finding, and less bracing perceived more positive expectation management support from their partner. Recipient who used positive expectation management also perceived greater responsiveness and informational support. Recipients who used more benefit-finding perceived more informational support, negative validation, benefit-finding support and proactive coping support. Recipients who engaged in more bracing perceived more positive reframing and bracing support, and recipients who engaged in more distancing strategies perceived more distancing support from their partner.

For provider-actor effects, providers who engaged in more benefit finding reported giving more positive reframing support and emotional support, as well as bracing support, benefit-finding support, distancing support, distraction support, and proactive coping support. Providers who engaged in more bracing also reported giving more bracing support, benefit-finding support, and proactive coping support. Providers who used more positive expectation management also reported giving more positive expectation management support and less bracing support.

For partner effects, only providers' use of positive expectation management negatively predicted recipients' perceptions of distancing support. No other partner effects were significant.

Question 4: Individual differences related to support perception/provision.

Next, I examined how individual differences predicted support perceptions and provision. I ran multiple APIMs for each pairwise grouping of my individual difference measures (dispositional optimism, defensive pessimism, intolerance of uncertainty, anxious attachment, and avoidant attachment) with each support measure. Bivariate correlations ignoring role are presented in Table 7, and the parameters for each APIM are displayed in Table 12.

For recipient actor effects, greater dispositional optimism predicted perceptions of greater responsiveness and less suppression support from their partner. Recipients who were more intolerant of uncertainty perceived less suppression support and distraction support from their partner. No other actor or partner effects for dispositional optimism or intolerance of uncertainty were significant. Recipients who were higher in anxious or avoidant attachment perceived less responsiveness from their partner. Additionally, recipients who were more avoidantly attached perceived less of all supportive behaviors other than positive reframing, benefit-finding support, and suppression support.

There were no significant actor effects for defensive pessimism, but several partner effects emerged. Recipients of more defensively pessimistic providers perceived more responsiveness and less positive reframing from their partner. Recipients of providers who were higher in anxious attachment perceived less positive reframing and emotional support, whereas recipients of providers who were higher in avoidant attachment perceived more positive reframing and greater emotional support from their partner.

Discussion

In the current study, I built on the design of Study 1 to examine how both support recipients and providers experience an uncertain waiting period when the outcome has the potential to negatively influence both members of the dyad. In this study, I also used data from the California bar exam to create a less contrived waiting paradigm. Once again, I explored four primary questions: (1) How does the experience of awaiting news differ between recipient and provider? (2) How does strategy use relate to how recipient and providers experience the waiting period? (3) How does support provision/perception relate to the waiting experience both participants? and (4) How do trait-like individual difference play a role in support provision/perception?

The current study also expanded upon Study 1 by integrating more measures of well-being. Following the Study 1 finding of a relationship between perceptions of distraction support and recipients' use of distraction waiting strategies (Question 3), I further expanded the list of supportive behaviors to encompass support behaviors directly related to attempts to help the recipient engage in specific waiting strategies. Once again, given the multitude of analyses and inherent potential for Type I errors, instead of interpreting specific significant or non-significant results I primarily looked for patterns of results with flexibility regarding interpretation of "significance."

Partners again differ in their waiting experiences. My first question explored differences in experiences between participants based on their social support role. Because the current paradigm entailed uncertainty about feedback that could negatively affect both participants in both direct and indirect ways, I expected to find greater

similarity between experiences than in Study 1. Similar to Study 1, I explored well-being as well as use of waiting strategies.

Regarding well-being, Study 2 included several measures of both mental and physical health. Despite the outcome potentially affecting both partners, I found evidence for role differences for many of these metrics, including negative emotions, worry, subjective coping, subjective health, and mental health, with recipients reporting less desirable experiences for each variable. Partners demonstrated equivalent experience for positive emotions, rumination, physical health, and sleep quality. Thus, the most stress-related variables were heightened for the focal member of the couple.

For use of specific waiting strategies, my hypothesis that partners would have similar experiences was also not supported, such that role influenced participants' reports of positive expectation management, bracing for worst-case outcomes, and benefit-finding. However, members of the couples reported equal efforts to downplay the importance of the stressor (distancing). Despite my assumption that bar exam results would be more self-relevant to providers, at least compared to the contrived lab experience in Study 1, these findings are more consistent with research on non-self-relevant feedback (Sweeny, Shepperd, & Carroll, 2009). In the future, studies should address this potential issue by assessing providers' perception of outcome self-relevance as a moderator.

Expectation management is consistently associated with couples' health and well-being while waiting. My second question investigated the relationship between participants' strategy use and well-being. Of the strategies, bracing seemed to be most

consistently related to recipients' well-being by various metrics. This finding is consistent with Study 1's finding that greater bracing was related to greater anxiety in recipients. As in Study 1, however, the causal direction of this relationship is unclear. That is, George expecting to lose his job may lead him to feel worse, and feeling worse may cue George to believe that losing his job is more likely. Thus, bracing may create a negative feedback loop for recipients of support. I found similar effects for providers' bracing and providers' well-being, suggesting that bracing may be a key target for interventions designed to improve well-being in couples awaiting news.

On the other hand, positive expectation management was associated with better health and well-being in recipients. Similar to bracing, the effects were significant regardless of their order in the model. This pattern may suggest that positive expectations create a positive feedback loop in which more positive recipients feel better, and these better feelings cue the recipient to anticipate more positive outcomes (Carver, 2006). Other strategies seemed to more clearly emerge from participants' worry rather than the other way around. Specifically, recipients and providers who were more worried also reported more distancing and less benefit-finding.

As in Study 1, I found few partner effects, though providers' worry predicted recipients' distancing (if Martha was more worried, George was more likely to think about how his life is more than just his career), and providers' worry was predicted by recipients' benefit-finding (if George was thinking about the positives of losing his job, Martha experienced more worry). Most notably, recipients' distancing predicted less positive emotion, poorer subjective coping, and greater sleep disruption in their partners.

These findings suggest that providers may find the wait challenging when recipients discount the stressor. Further research is necessary to explore the mechanisms of these interpersonal effects.

Support has complex associations with well-being. My third question sought to examine role of support perceptions in couples' well-being and strategy use. In contrast to Study 1, participants demonstrated low agreement regarding the supportive behaviors partners offered during the waiting period. Due to the much greater length of this study compared to Study 1, this discrepancy may reflect greater subjectivity as partners remember and report only the support behaviors (or lack thereof) that are salient to them, rather than a comprehensive report of support. Additionally, Study 2 was designed in a way that assessed providers' reports of support at different times than recipients' perceptions of support. Interestingly, however, participants did strongly agree on their perceptions of responsiveness. That is, although participants were perceiving or remembering different support behaviors during the waiting period, their gestalt perceptions of care, understanding, and value were more consistent. This finding supports the idea that perceptions of responsiveness are less a function of specific support behaviors and more a product of relationship qualities and satisfaction as a whole (Lemay, Clark, & Feeney, 2007; Rafaeli & Gleason, 2009).

Turning to actor and partner effects, recipients' perceptions of responsiveness predicted their well-being on several measures, although the reverse direction showed even stronger and more consistent effects. That is, although George's perception that

Martha is responsive may make him feel good, George's is also likely to see Martha as responsive when he feels good.

Greater worry and rumination, and to some degree poorer subjective coping, were related to greater perceptions of support among recipients in both predictive directions. That is, worried, ruminative recipients perceive more support from their partners, and surprisingly, recipients who perceive more support are also more worried and ruminative. Note that the rumination variable consisted of items asking about the frequency of participants talking to others about the stressor, which may prompt more opportunities to perceive support. This finding may suggest that more distressed participants are engaging in more supportive interactions; however, providers did not report giving more support when recipients were more distressed, suggesting that distress affects perceptions rather than objective behaviors. This finding may also further support past research regarding the immutability of distress during uncertain waiting periods (Dooley et al., 2018), even extending the findings to suggest that supportive attempts may exacerbate distress. Certainly, ample research on enacted support demonstrates that support can have a detrimental effect on well-being (Gleason, Iida, Shrout, & Bolger, 2014; Shrout, Herman, & Bolger, 2006; Wethington & Kessler, 1986). Interestingly, some well-being measures in my study, such as positive emotions and subjective health, were positively predictive of support perceptions. Thus, both greater distress and greater well-being, by different measures, potentially led to greater perceptions of support by recipients. This finding deserves greater attention and replication in future studies to identify potential mechanisms and moderators.

Significant provider-actor effects were sparser, suggesting that the provision of support during these waiting periods did not take a significant toll on providers, nor did support provision incur particular benefits. That said, providers who reported giving more informational support and positive reframing also reported marginally more rumination—that is, they dwelled more on the stressor when they gave more support. Thus, providers who are engaged in supportive efforts may find themselves mentally enwrapped in the stressor as well.

As in Study 1, I also found few partner effects, with several exceptions. Recipients perceived greater responsiveness and negative validation when providers reported better subjective coping; however, recipients also perceived less positive reframing support when providers were coping better. Interestingly, providers' coping was not related to their own perceptions of their support provision, which may suggest that better copers are more effective at communicating certain support behaviors (and less effective at others), even if they do not themselves realize it.

Turning to strategy-specific support strategies, participants demonstrated some agreement in their perceptions of support, though once again agreement was greater for some strategies than others. Partners particularly agreed on whether providers were helping the recipient to be optimistic and hopeful. As described above, positive reframing support did not demonstrate significant agreement, suggesting that efforts at optimism and efforts to reorient the situation are recalled or perceived differently. Bivariate correlations between perceptions of positive expectation management support and positive reframing support showed that although recipients view these behaviors similarly

(r = .29, p = .02), providers did not (r = .13, p = .33). Thus, efforts to promote optimism may be easier to notice or remember than more general efforts at cheering up and downplaying negative feelings.

For the APIM effects, recipients who felt they were receiving more strategy-specific support tended to worry and ruminate more and cope more poorly. Similar to the findings for general support behaviors, more distressed individuals may create more opportunities for supportive interactions, though once again I found no partner effects of recipients' worry predicting providers' reports of support provision. However, worry and coping were unrelated to support targeted at maintaining optimism and finding benefit in an undesirable outcome, perhaps because they tend to be more positive strategies–-somewhat less defensive and linked to more positive emotions. For instance, if George is distressed about the potential job loss, he may not process "everything will be fine" as well as he may process behaviors that match his pessimism.

Finally, recipients' who experienced more positive emotions and better health perceived more positive expectation management support from their partner. Thus, recipients who are feeling more positive about the experience may project these feelings onto their interpretations of providers' behaviors. Although non-significant, greater positivity in recipients demonstrated trending positive relationships with providers' reports of giving positive expectation management support as well. It seems that both partners agree that providers help healthier and more positive recipients to embrace hope and optimism.

Support has complex associations with strategy use. In addition to exploring the role of support in couples' well-being while they wait, I also explored how support perceptions related to participants' use of specific waiting strategies. In contrast to Study 1, I found fewer associations between general support perceptions and strategy use. Recipients' perceptions of positive reframing attempts predicted greater use of both positive expectation management and bracing strategies, but not others. These strategies are conceptually contradictory, thus making this finding challenging to interpret and deserving of further research to replicate this finding.

In addition, recipients who used more benefit-finding perceived more informational support and negative validation. That is, if George is trying to see the silver lining in losing his job, he is also more likely to notice and recall times when Martha gave advice or allowed him to vent about the stressor. On the other hand, providers who engaged in more benefit finding reported giving more emotional support and positive reframing.

Once again, I found few partner effects linking support and strategy use across members of the couple. The only significant effects were for responsiveness, such that recipients engaged in more positive expectation management and distraction efforts when providers viewed themselves as more responsive. Interestingly, this effect arose for providers' perceptions, not recipients' perceptions. Because this finding did not emerge in from Study 1, further research is necessary to replicate this finding.

Next, I explored the role of support behaviors targeted at specific waiting strategies to determine whether these specific forms of support facilitated use of

particular strategies. Here, a pattern emerged in which recipients who reported getting a particular type of support also reported using more of the associated strategy. For example, recipients who perceived that their partner was trying to help them brace also reported engaging in more bracing during the waiting period. This pattern also appeared for positive expectation management, benefit-finding, and distancing. Unfortunately, due to data collection error, I was unable to assess distraction and suppression strategy use. However, these findings mirror the findings for distraction related to distraction support provision in Study 1.

For providers, I also found a similar pattern of positive relations between the support the provider reported giving and the strategies the provider reported using during the waiting period, though the effects were weaker. Interestingly, however, relationships between providers' reports of strategy-specific support and recipients' reports of their use of those strategies did not follow this pattern. In fact, specific to distancing support, the relationship with recipients' distancing was negative, albeit non-significant. This finding provides further evidence that recipients' memory for and attention to providers' support attempts are more predictive of their waiting experience than is providers' intent and highlights the importance of studying both members of a couple during stressful life events.

Optimism and attachment styles are important to recipients' support perceptions. My fourth question sought to investigate links between individual differences and support perceptions and provision. As mentioned earlier, past research has highlighted the value of explanatory styles on support perceptions (Brissette et al.,

2002; Vollman & Renner, 2007, 2010). In the current study, I found more pronounced evidence for benefits of dispositional optimism on recipients' perceptions of their partner's responsiveness. Contrary to study 1, however, recipients' level of defensive pessimism was unrelated to their perceptions of responsiveness. As mentioned, past research demonstrates an bias in which people are uncomfortable with pessimistic self-presentations. In Study 1, this bias might have been a motivating factor for the provider to alleviate the recipient's distress. In Study 2, which covers a much longer period of time, trait-like defensive pessimism may present more of a chronic issue, resulting in providers pulling away or offering less support. In fact, research on pessimistic self-presentations demonstrates that support-givers are more likely to discount and disengage from pessimists, particularly if they feel that their support is ineffective (Forest, Kille, Wood & Holmes, 2014).

Interestingly, recipients perceived their partner as more responsive when the partner was more of a pessimist. One interpretation of this finding is that more pessimistic partners are more stressed about and engaged in the waiting experience, and thus they might be better able to place themselves in the shoes of their partner. On the other hand, providers' optimistic outlooks may be less appreciated if they convey support but not validation of the recipient's distress. In fact, recipients' perceptions of responsiveness were related to reports of negative validation, but not positive reframing. Thus, defensively pessimistic mindsets may provide an advantage when conveying understanding, care, and value for what the recipient is experiencing.

I also examined the role of attachment styles on support perceptions and provision. In contrast to Study 1, the current study showed effects of recipients' attachment styles on support perceptions. Consistent with past research (e.g., Simpson, Rholes, & Nelligan, 2004), recipients who were anxiously attached perceived significantly less responsiveness and emotional support from their partners. Recipients also perceived less support from anxiously-attached partners, particularly with regard to emotional support and positive reframing, and anxiously-attached partners trended towards considering themselves less responsive as well. Thus, anxious attachment style in either partner presents challenges to support during these waiting periods.

The degree to which recipients were avoidantly attached had even more consistent relationships with support perceptions. In fact, the negative relationship between recipients' avoidant attachment and their perceptions of partners' responsiveness was the strongest association in the study. More avoidantly attached recipients perceived less of nearly every support behavior, albeit non-significantly in some cases (reframing, benefit-finding, and suppression). However, providers of avoidantly attached recipients did not believe they provided less support. Thus, this finding suggests that people who are avoidantly attached may not communicate their support needs effectively or have difficulty perceiving supportive attempts from their partners.

Chapter 4: General Conclusion

In the current studies, I examined the experience of romantic partners during uncertain waiting periods, with a particular focus on the perception of various types of support and links between support, strategy use, and well-being broadly defined. Using dyadic data from two samples of couples experiencing distinct periods of uncertainty, my study addressed four primary questions: (1) How does the experience of awaiting news differ between recipients and providers of support? (2) How does strategy use relate to how recipients' and providers' well-being? (3) How does support provision/perception relate to the well-being and strategy use? and (4) How do trait-like individual difference play a role in support provision/perception? Although the two samples and contexts and the respective findings differed in many ways, some findings deserve further discussion.

First, in both samples, partners reported distinct experiences based on their roles, even when the focal stressor had clear relevance to the provider. Although past research has documented comparable levels of distress between partners who are experiencing a stressful event (e.g., cancer diagnosis; Hagedoorn, Sanderman, Bolks, Tuinstra, & Coyne, 2008; Segrin, Badger, Sieger, Meek, & Lopez, 2006), this shared experience may be partly a product of the degree of certainty and clarity regarding the stressor. If George loses his job, both he and Martha will have to respond to the financial hit. However, uncertain waiting periods leave greater opportunity for variability in expectations and appraisals of the stressor. That is, until George actually loses his job, Martha can maintain her belief that everything will turn out okay or distract herself with her own concerns and activities. Past research shows that friends fail to brace for others unless the

stressor is made personally relevant (Sweeny, Shepperd, & Carroll, 2009), so the stressors in the current studies may not have been sufficiently relevant to support providers to invoke this level of engagement. Future studies can extend this work to contexts in which the outcome of the wait has a clear and direct effect on providers.

Second, the relationships between strategy use and well-being were largely bidirectional, and the majority of these effects were restricted to recipients. Past research on uncertainty navigation has highlighted the challenges of awaiting uncertain news, and evidence is mixed regarding which strategies are effective for reducing stress, if any (Sweeny et al., 2016). In the current studies, specific strategies such as bracing for the worst were related to recipients' well-being experiences, although it remains unclear whether well-being was the cause or result of that strategy. For bracing specifically, findings from both studies suggested that bracing led to more negative experiences, and negative experiences led to more bracing. Findings for other waiting strategies were inconsistent across studies, but the bidirectionality with well-being was relatively consistent. Thus, future studies should implement experimental procedures to determine causal links.

Third, perceived rather than enacted support played the largest role in participants' experience, particularly for recipients. Although some partner effects stood out in each study, most significant effects were recipient-actor effects, suggesting that the way recipients experience uncertain waiting periods is dependent on the support they are noticing and/or remembering rather than the support their partner reports providing. Moreover, recipients are more likely to perceive support associated with their own

behaviors. That is, recipients who are bracing for the worst are more likely to perceive behaviors targeted at helping them brace for the worst, though the provider may not report giving more of that type of support. Except for distancing, providers also report giving support in line with the strategies they were using, suggesting that both participants use their own strategies as a filter by which to interpret supportive interactions. Future studies should further investigate this perceptual phenomenon by exploring the extent to which recipients and providers alike are attentionally blind to other support behaviors. For instance, if Martha is bracing for the job loss, does she notice the times she casually mentions that everything will be okay? The role of perception was also highlighted by the fact that partner effects were largely non-significant. That is, the support that providers report giving was unrelated to the recipient's experience, nor did the recipient's perceptions of support influence the provider's experience.

Fourth, individual differences seem to affect perceptions and provision of support. Although the findings across studies were somewhat inconsistent and likely a function of individual differences interacting with the specific stressor and procedures, explanatory style and attachment style were important traits that deserve further attention. For instance, the current study contributes to the growing literature demonstrating the benefits of constructive pessimistic approaches to uncertain waiting periods (Sweeny & Dooley, 2017; Sweeny et al., 2016), but pessimism can also backfire, particularly in supportive contexts (Forest, Kille, Wood, & Holmes, 2014). Thus, research needs to examine the line between constructive and non-constructive pessimism. Avoidantly attached

recipients may experience additional struggles during uncertain waiting periods, particularly if the stress of uncertainty contributes to decreases in support-seeking behaviors or distancing during supportive interactions.

Fifth, the comparison of similar variables across two distinct waiting periods highlights the fact that all waiting periods are not created equal. The current studies differed in a number of ways that may have influenced strategy effectiveness, support recognition, and individual difference dynamics. Previous research has highlighted situational moderators of the waiting experience (e.g., Sweeny & Cavanaugh, 2012), but future research should focus more on the characteristics of specific waiting periods that could generate variability in both intra- and interpersonal experiences.

In addition to the studies described above, future research should also focus on the role of recipients in providing support to their partners. That is, how does George attempt to support Martha while he is awaiting news about potential layoffs? Given the growing literature on the benefits of support-giving (e.g., Brown et al., 2003; Inagaki & Eisenberger, 2016; Inagaki & Orehek, 2017; Whillans et al., 2016), recipients might reduce their own distress by focusing on the support needs of others. Exercises that enable people to focus on their relationships, such as gratitude journal writing, also have a profound effect on well-being (Lyubomirsky & Layous, 2013; Lyubomirsky, Dickerhoff, Boehm, & Sheldon, 2011) that may translate to the waiting experience.

Of course, notable limitations influence the interpretability of the current findings. For instance, the correlational nature of the findings makes causal conclusions about the relationship between support, strategy use, well-being, and individual differences are

tentative at best. Although I attempted to investigate all models through a bidirectional lens, further research is necessary to explore causal patterns as well as the possibility of unaccounted third variable explanations. Despite these limitations, the current findings provide a strong starting point for future studies of dyadic support during uncertain waiting periods.

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Table 1

Schedule and Sample Sizes for Staggered Study 2 Design

Week:	Pre exam		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	MoT	
Group 1	X		X	X					X					X					X	
Group 2	X		X		X					X					X				X	
Group 3	X	Exam	X			X					X					X			X	Feedback
Group 4	X		X				X					X					X		X	
Group 5	X		X					X					X					X	X	
Partners			X								X								X	

Table 2

Comparisons Between Recipients and Providers in Strategy Use and Well-Being

		Study 1			Study 2		
	Role	***M* (*SD*)**	***t***	***df***	***M* (*SD*)**	***t***	***df***
Waiting Strategies							
Positive Expectation Management	Recipient Provider	3.44 (1.04) 4.46 (0.62)	-10.36***	132	6.04 (0.84) 6.60 (0.43)	-5.08***	62
Bracing	Recipient Provider	3.66 (1.05) 2.23 (1.10)	11.90***	132	4.03 (1.51) 3.13 (1.25)	4.18***	62
Benefit-Finding	Recipient Provider	3.11 (1.00) 2.74 (1.05)	2.97**	132	3.17 (1.27) 3.62 (1.34)	-2.48*	64
Distancing	Recipient Provider	3.10 (0.62) 3.23 (0.58)	-2.03*	132	4.27 (1.20) 4.15 (1.12)	0.70	64
Distraction	Recipient Provider	2.60 (1.21) 1.89 (1.07)	5.14***	131	4.16 (2.16) -	-	-
Suppression	Recipient Provider	2.49 (0.99) 1.97 (1.03)	4.31***	132	4.05 (1.13) -	-	-
Well-being							
Anxiety	Recipient Provider	2.67 (0.95) 1.92 (0.73)	7.34***	132	- -	-	-
Worry	Recipient Provider	- -	-	-	4.33 (1.32) 2.94 (1.16)	7.07***	64
Rumination	Recipient Provider	- -	-	-	3.79 (1.27) 3.54 (1.27)	1.06	63

Negative Emotions	Recipient Provider	- -	-	-	3.70 (1.24) 3.17 (1.15)	3.24**	63
Positive Emotions	Recipient Provider	- -	-	-	5.47 (0.89) 5.46 (0.84)	0.05	63
Subjective Coping	Recipient Provider	- -	-	-	5.27 (1.19) 5.81 (1.01)	-3.31**	62
Subjective Health	Recipient Provider	- -	-	-	3.04 (0.70) 3.39 (0.95)	-2.60*	63
Physical Health	Recipient Provider	- -	-	-	0.00 (0.77) -0.08 (0.84)	0.89	63
Mental Health	Recipient Provider	- -	-	-	0.13 (0.93) -0.15 (0.84)	2.05*	63
Sleep Quality	Recipient Provider	- -	-	-	5.19 (2.50) 5.42 (2.61)	-0.42	64

Note. † $p < .10$; * $p < .05$; ** $p < .01$; *** $p < .001$.

Table 3

Bivariate Correlations of Waiting Strategy Use with Waiting Experience by Study

	Pos. Exp. Management	Bracing	Benefit-finding	Distancing	Distraction	Suppression
Study 1						
Anxiety	-.27***	.38***	.17**	-.10	.50***	.51***
Study 2						
Worry	-.20*	.52***	-.06	.30**	-	-
Rumination	-.02	.17	-.06	.17	-	-
Negative Emotions	-.15	.20*	-.16	.07	-	-
Positive Emotions	.26**	-.18*	.17	-.03	-	-
Subjective Coping	.25**	-.34***	.11	-.26**	-	-
Subjective Health	.29**	-.22*	.16	-.12	-	-
Phys Health Interference	-.24**	.20*	-.04	.09	-	-
Mental Health Interference	-.21*	.26**	-.05	.09	-	-
Sleep Disruption	.00	.15	-.10	.22*	-	-

Note. Table values represent bivariate correlations between study variables
† $p < .10$; * $p < .05$; ** $p < .01$; *** $p < .001$.

Table 4

Model Parameters for Waiting Strategy Use Predicting and Predicted by Anxiety (Study 1)

	Strategy *predicting* anxiety				**Strategy *predicted by* anxiety**			
	Actor Effects		Partner Effects		Actor Effects		Partner Effects	
	Rec	*Prov*	*Rec*	*Prov*	*Rec*	*Prov*	*Rec*	*Prov*
Positive Expectation Management	-.11	.00	.11	-.32*	-.16*	.02	-.14*	.21*
Bracing	.33**	.12	.09	.16†	.22**	.14	.13†	.09
Benefit-Finding	.15†	.08	.09	.02	.13	.12	.01	.13
Distancing	-.14†	-.05	.02	.07	-.13	-.07	.03	-.02
Distraction	.40***	.43***	-.01	.03	.39***	.53***	.03	-.04
Suppression	.47***	.42***	.00	-.04	.41***	.62***	-.03	.00

Note. Table values represent parameter estimates for each actor and partner effect
† $p < .10$; * $p < .05$; ** $p < .01$; *** $p < .001$.

Table 5

Bivariate Correlations of Strategy Use and Well-Being with Support Perceptions by Study

	Responsiveness	Positive Reframing	Negative Validation	Informational Support	Emotional Support	PEM Support	Bracing Support	Benefit-Finding Support	Distancing Support	Distraction Support	Suppression Support	Proactive Coping Support
Study 1												
Waiting Strategy Use												
Pos. Exp. Management	.09	.11	.09	.11	.07	-	-	-	-	.05	-	-
Bracing	.07	.16*	.16*	.05	.12	-	-	-	-	.19**	-	-
Benefit-Finding	.10	.21**	.16*	.10	.14	-	-	-	-	.04	-	-
Distancing	-.13	-.16*	-.03	.04	-.09	-	-	-	-	-.08	-	-
Distraction	-.10	.01	.05	-.08	-.01	-	-	-	-	.24**	-	-
Suppression	-.01	.08	.13	.01	.05	-	-	-	-	.23**	-	-
Waiting Experience												
Anxiety	-.01	.00	.12	-.03	.08	-	-	-	-	.12	-	-
Study 2												
Waiting Strategy Use												
Pos. Exp. Management	.29**	.28**	.22*	.10	.22*	.44***	.04	.08	.00	.04	.04	.08
Bracing	-.26**	-.13	.10	.14	-.10	-.28**	.36***	.15	.18*	.12	.09	.17

Benefit-Finding	.14	.19	.26**	.16	.17	.35***	.30**	.47***	.33**	.20*	.15	.41***
Distancing	.05	.03	.20*	.03	.12	.04	.16	.07	.27**	.11	-.05	.18*
Waiting Experience												
Worry	-.23*	-.13	.11	.13	-.11	-.08	.19*	.08	.11	.17	.22*	.11
Rumination	.02	.06	.23**	.16	.12	.18*	.04	.11	.12	.12	.07	.12
Negative Emotions	-.30**	-.18*	-.12	-.06	-.15	-.17	-.08	-.15	-.09	-.03	.10	-.13
Positive Emotions	.40***	.15	.24**	.05	.17	.23**	.12	.09	.12	.13	-.06	.19*
Subjective Coping	.25**	.01	-.12	-.07	.16	.10	-.15	-.06	-.11	-.12	-.14	-.11
Subjective Health	.32**	.13	.10	.18*	.09	.22*	.06	.06	.06	.10	-.01	.15
Physical Interference	-.19*	-.08	-.06	-.10	-.07	-.13	-.03	-.02	-.03	-.03	.08	.00
Mental Interference	-.20*	-.04	.03	.03	-.04	-.04	.09	.02	.04	.08	.23**	.05
Sleep Disruption	-.13	-.04	.04	-.05	-.01	-.06	-.06	-.02	-.02	-.07	.04	-.13

Note. Table values represent bivariate correlations between study variables
† $p < .10$; * $p < .05$; ** $p < .01$; *** $p < .001$.

Table 6

Model Parameters for Support Perceptions Predicting and Predicted by Anxiety and Waiting Experience (Study 1)

	Support *predicting* experience				**Support *predicted by* experience**			
	Actor Effects		Partner Effects		Actor Effects		Partner Effects	
	Rec	*Prov*	*Rec*	*Prov*	*Rec*	*Prov*	*Rec*	*Prov*
Responsiveness								
Anxiety	-.03	.12	.07	-.12	-.10	.17	-.10	.16
Pos. Exp. Management	.23*****	.06	.10	-.20†	.13	.23	-.11	.23
Bracing	.00	.03	-.04	.15	.13	-.03	.21	-.14
Benefit-Finding	.21†	.08	.05	-.09	.12	.05	-.07	.05
Distancing	-.15	-.12	-.12	.00	-.10	-.13	.02	-.08
Distraction	-.32*****	-.04	-.03	-.03	-.13	-.05	-.04	-.07
Suppression	-.02	-.05	-.03	-.13	.02	-.03	-.12	-.04
Positive Reframing								
Anxiety	.11	.11	-.06	.19	.16†	.13	.16	.07
Pos. Exp. Management	.30*****	.04	.00	-.12	.09	.15	-.03	.21
Benefit-Finding	.03	.23	-.02	.10	.30******	.06	.17	-.24*****
Bracing	.18	.10	.10	-.08	.18†	.08	.01	.07
Distancing	-.23†	.11	-.13	.13	-.05	.06	.08	-.03
Distraction	-.05	.12	-.18	.28†	.08	-.02	.15	-.19†
Suppression	.13	.17	-.28*****	.22	.23*****	.02	.21†	-.19*****
Negative Validation								
Anxiety	.05	-.03	.10	.01	-.04	.01	-.01	.14
Pos. Exp. Management	.28*****	.00	.05	-.10	.17†	.10	.02	.33*****
Benefit-Finding	.17	.10	.01	.08	.28*****	.02	.17	-.13
Bracing	.43******	.23	-.11	-.16	.25******	.13	-.03	.03
Distancing	-.20	.13	-.25†	.00	-.19*****	.06	-.10	-.13
Distraction	-.28*****	.00	-.09	.11	.03	-.04	.08	-.04
Suppression	-.04	.11	-.15	.09	.11	.04	.10	-.04
Informational Support								
Anxiety	-.11	.04	.07	.05	-.07	.10	-.01	.13

Pos. Exp. Management	.21	.16	-.04	-.22	.08	.45*	-.09	.21
Benefit-Finding	.01	.08	-.06	-.02	.13	-.03	.03	-.15
Bracing	.14	-.01	.16	-.20	.12	.08	-.08	.21*
Distancing	.00	-.02	-.06	.02	.12	-.08	.08	-.13
Distraction	-.31*	.02	-.11	.10	-.09	-.05	.01	-.14
Suppression	-.04	.09	-.20	.04	.05	-.02	.05	-.12
Emotional Support								
Anxiety	.12	.17	.04	-.07	.03	.22	-.03	.15
Pos. Exp. Management	.16	.06	.05	-.16	.07	.20	-.10	.22
Benefit-Finding	.04	.07	.03	.15	.23*	.00	.21	-.18†
Bracing	.10	.16	-.03	.06	.14	.14	.10	.06
Distancing	-.10	-.16	-.06	-.06	-.03	-.15	-.03	-.06
Distraction	-.14	.08	-.17	.02	-.02	.02	.02	-.17
Suppression	.05	.07	-.18	-.07	.09	.02	-.05	-.10
Distraction Support								
Anxiety	.16	.07	-.18	.01	.18*	.12	.05	.05
Pos. Exp. Management	-.17	.03	-.05	.10	.01	.11	.07	.10
Benefit-Finding	.16	.15	-.01	-.03	.40**	.14	.00	-.12
Bracing	.00	.05	.06	.16	.03	.11	.17	.06
Distancing	-.13	-.19	.14	-.03	-.06	-.20	.01	.05
Distraction	.29*	.16	-.05	.08	.31**	.14	.12	-.06
Suppression	.14	.34**	-.17	.17	.25**	.26*	.20	-.05

Note. Values represent parameter estimates for each actor and partner effect; †$p<.10$; *$p<.05$; **$p<.01$; ***$p<.001$.

Table 7

Bivariate Correlations Between Individual Differences and Support Perceptions by Study

	Responsiveness	Positive Reframing	Negative Validation	Informational Support	Emotional Support	PEM Support	Bracing Support	Benefit-Finding Support	Distancing Support	Distraction Support	Suppression Support	Proactive Coping Support
Study 1												
Dispositional Optimism	.09	.05	.09	.07	.06	-	-	-	-	.07	-	-
Defensive Pessimism	.19**	.13	.06	.06	.13	-	-	-	-	.01	-	-
Intolerance of Uncertainty	.00	-.03	.08	-.05	.07	-	-	-	-	.08	-	-
Anxious Attachment	-.01	.07	.00	-.02	.04	-	-	-	-	.04	-	-
Avoidant Attachment	-.01	-.12	-.02	-.10	.00	-	-	-	-	.00	-	-
Empathy	.08	.14*	-.01	.10	.10	-	-	-	-	.04	-	-
Satisfaction	.12	.03	.08	.08	.20**	-	-	-	-	.03	-	-
Study 2												
Dispositional Optimism	.24**	.00	-.06	-.11	.06	.11	-.07	-.02	-.08	-.15	-.16	-.03
Defensive Pessimism	.06	.09	.08	-.06	.12	.08	.03	-.06	.05	.17	.12	.06
Intolerance of Uncertainty	-.05	.08	.02	.03	.03	.02	<.001	.06	.08	.09	.23**	.05
Anxious Attachment	-.40***	-.13	-.10	-.05	-.06	-.13	-.11	-.09	-.12	-.07	.09	-.12
Avoidant Attachment	-.29**	-.05	-.16	.09	-.28**	-.10	-.19	-.01	-.14	-.12	-.06	-.16

Note. Table values represent bivariate correlations between study variables
† $p < .10$; * $p < .05$; ** $p < .01$; *** $p < .001$.

Table 8

Model Parameters for Individual Differences Predicting Support Perception/Provision (Study 1)

	Actor effects		Partner effects	
	Rec	*Prov*	*Rec*	*Prov*
Dispositional Optimism (LOT-R)				
Responsiveness	.14	.09	-.12	.18†
Positive Reframing	.09	.06	-.01	.13
Negative Validation	.07	.14	.00	.18
Informational Support	.08	.08	-.03	.11
Emotional Support	.10	.01	-.10	.14
Distraction	.06	.09	.10	.06
Defensive Pessimism (DPQ)				
Responsiveness	.23**	.11	.10	-.09
Positive Reframing	.12	-.04	.11	-.17†
Negative Validation	.16†	.00	.12	-.08
Informational Support	.12	-.07	-.02	-.14
Emotional Support	.20*	.00	.20†	-.07
Distraction	-.01	.08	.23†	-.02
Intolerance of Uncertainty (IU)				
Responsiveness	-.05	.16	.19†	.16
Positive Reframing	.13	-.06	.19†	-.12
Negative Validation	-.08	.05	.13	.01
Informational Support	-.09	.08	-.01	.02
Emotional Support	.05	.10	.03	.09
Distraction	.08	.09	.08	.09
Anxious Attachment (AAQ-Anx)				
Responsiveness	-.20†	.23†	-.09	.16
Positive Reframing	-.03	.12	-.20†	.03
Negative Validation	-.04	.15	.02	.14
Informational Support	-.05	.03	-.09	-.04
Emotional Support	-.04	.18	-.18	.12

Distraction	-.04	.18	-.15	.09
Avoidant Attachment (AAQ-Avoid)				
Responsiveness	-.04	.00	.18	-.05
Positive Reframing	.06	-.15	.05	.09
Negative Validation	-.19	-.11	.18	-.06
Informational Support	-.02	-.20†	.01	-.06
Emotional Support	.08	-.12	.16	.07
Distraction	-.13	.15	-.04	.21*
Empathy (TES)				
Responsiveness	-.02	.18†	-.09	.28**
Positive Reframing	-.09	.19*	-.16	.13
Negative Validation	.13	.17†	-.13	.22**
Informational Support	.00	.25*	-.06	.15†
Emotional Support	-.01	.26**	-.13	.20*
Distraction	.04	.09	.06	-.02
Relationship Satisfaction (RAS)				
Responsiveness	.11	-.02	.07	.19†
Positive Reframing	.02	.13	.02	.09
Negative Validation	-.02	.23†	-.16	.03
Informational Support	.08	.04	.05	.07
Emotional Support	.15	.29*	-.09	.10
Distraction	-.06	.12	-.01	.18†

Note. Values represent parameter estimates for each actor and partner effect. †$p<.10$; *$p<.05$; **$p<.01$; ***$p<.001$.

Table 9

Model Parameters for Strategy Use Predicting Well-Being (Study 2)

	Strategy use *predicting* experience				**Strategy use *predicted by* experience**			
	Actor Effects		Partner Effects		Actor Effects		Partner Effects	
	Rec	*Prov*	*Rec*	*Prov*	*Rec*	*Prov*	*Rec*	*Prov*
Pos. Exp. Management								
Worry	-.04	.06	-.02	-.12	-.06	.08	-.06	.00
Rumination	.11	-.29	.19†	.09	.12	-.13	.06	.22†
Negative Emotions	-.04	-.28	-.01	.10	-.02	-.16	.09	-.07
Positive Emotions	.38**	.22	.02	-.11	.52***	.05	-.03	-.14
Subjective Coping	.21*	-.03	-.04	.14	.39**	-.06	.08	-.20
Subjective Health	.23*	.21	-.01	.20	.47**	.04	.13	-.03
Physical Health Interference	-.21*	-.45*	.19†	.05	-.37**	-.13	.04	.23†
Mental Health Interference	-.08	-.48*	.05	.05	-.15	-.21	.06	.06
Sleep Disruption	-.05	.05	.12	-.09	-.09	.05	-.02	.17
Bracing								
Worry	.45***	.41**	.03	.01	.57***	.33*	.03	.04
Rumination	.17	.08	-.10	.01	.22†	.02	.07	-.15
Negative Emotions	.16	.25	-.18	.11	.31*	.11	.08	-.28*
Positive Emotions	-.41**	.23	-.26*	-.09	-.44**	.20	-.22†	-.08
Subjective Coping	-.37**	-.10	-.20	-.02	-.33**	-.14	-.06	-.19
Subjective Health	-.32*	.05	-.11	.12	-.40**	.00	.04	-.04
Physical Health Interference	.27*	.19	-.09	-.07	.29*	.10	-.08	-.07
Mental Health Interference	.25*	.22	-.03	.13	.29*	.15	.12	-.06
Sleep Disruption	.34**	.04	.14	-.19	.33**	.06	-.08	.13
Benefit-Finding								
Worry	-.25*	.18	.09	.16	-.26†	.31*	.00	.31*
Rumination	-.18	.08	-.10	.16	-.07	.01	.12	-.06
Negative Emotions	-.04	-.21	.12	-.05	-.07	-.27†	.02	.01
Positive Emotions	.17	.10	.07	.01	.17	.18	.10	.10

Subjective Coping	.26†	-.14	.23†	-.14	.11	-.04	-.03	.18
Subjective Health	.12	.24†	-.21	-.01	.16	.12	.05	-.10
Physical Health Interference	-.02	-.10	.03	-.01	.03	-.06	.02	-.01
Mental Health Interference	-.13	-.01	.10	.08	-.10	-.01	.04	.09
Sleep Disruption	-.27†	-.08	.16	.15	-.20	-.03	.05	.13
Distancing								
Worry	.29**	.26*	.04	.21*	.42**	.28†	.23†	-.03
Rumination	.10	.18	.02	.21†	.16	.15	.20	.02
Negative Emotions	.09	-.02	.08	.17	.13	-.09	.22	.04
Positive Emotions	-.10	.11	-.25*	-.09	-.06	.07	-.12	-.25†
Subjective Coping	-.19	-.21†	-.16	-.24†	-.18	-.24	-.19	-.19
Subjective Health	-.10	-.07	-.25*	-.04	-.12	-.09	-.05	-.22†
Physical Health Interference	.15	.00	.02	.04	.17	.00	.05	.01
Mental Health Interference	.10	.00	.05	.22	.14	-.02	.21†	.02
Sleep Disruption	.18	.19	.24*	.05	.19	.22†	.05	.28*

Note. Values represent parameter estimates for each actor and partner effect. †p<.10; *p<.05; **p<.01; ***p<.001.

Table 10

Model Parameters for Support Perceptions Predicting and Predicted by Well-Being (Study 2)

	Support *predicting* waiting experience				**Support *predicted by* waiting experience**			
	Actor Effects		Partner Effects		Actor Effects		Partner Effects	
	Rec	*Prov*	*Rec*	*Prov*	*Rec*	*Prov*	*Rec*	*Prov*
Traditional Support Behaviors								
Responsiveness								
Worry	-.11	-.23	.01	.01	-.16	-.21	-.01	.01
Rumination	-.04	.09	-.03	.14	-.01	.05	.05	.03
Negative Emotions	-.32**	-.07	-.04	-.08	-.42**	-.06	-.16	-.06
Positive Emotions	.37**	.20	.13	.05	.58***	.13	.16	.10
Subjective Coping	.17	.05	.18	-.06	.19	.18	.02	.37*
Subjective Health	.23†	.26	.12	-.04	.51**	.14	.15	.12
Physical Interference	-.24†	-.03	.10	-.02	-.44**	.03	-.16	.15
Mental Interference	-.24†	-.05	-.11	.16	-.23†	-.08	-.01	-.14
Sleep Disruption	-.24†	.19	-.04	-.10	-.40**	.08	-.20	.00
Positive Reframing								
Worry	.22*	.06	.03	.26*	.29*	.03	.27*	.11
Rumination	.12	.27†	.00	.24	.14	.13	.19	-.04
Negative Emotions	.07	-.17	-.06	.01	.12	-.24	.14	-.20
Positive Emotions	.06	-.08	-.02	-.01	.11	.00	.01	-.06
Subjective Coping	-.23*	.21	-.24*	-.22	-.19†	.22	-.27*	-.24†
Subjective Health	.13	.31*	-.05	-.04	.28*	.13	-.09	-.06
Physical Interference	-.16	-.01	-.01	.04	-.24†	.02	.08	-.01
Mental Interference	.04	.07	-.01	.21	.02	.02	.15	-.03
Sleep Disruption	-.06	-.02	-.02	.19	-.11	.01	.17	-.01
Negative Validation								
Worry	.14	-.08	-.02	-.24†	.15	-.06	-.13	-.07

Rumination	.30*	-.05	.09	-.31†	.28*	.01	-.07	.00
Negative Emotions	-.14	.05	.00	-.02	-.21	.05	-.05	.03
Positive Emotions	.14	.16	-.01	-.14	.27*	.12	-.06	-.14
Subjective Coping	.00	.13	.11	.28†	.01	.11	.12	.33*
Subjective Health	.04	-.03	.08	-.08	.10	.01	-.02	.05
Physical Interference	.06	-.35*	.12	.05	.07	-.19	.02	.09
Mental Interference	.06	-.11	.07	-.06	.02	-.06	.02	.06
Sleep Disruption	.05	-.15	.15	-.10	.02	-.08	-.06	.13
Informational Support								
Worry	.00	.09	-.04	.09	.02	.05	.10	-.08
Rumination	.01	.30†	.01	.11	-.03	.13	.10	.05
Negative Emotions	-.19	-.02	-.03	-.08	-.20	-.01	-.08	.06
Positive Emotions	.25*	.05	.08	-.16	.23†	.14	-.12	.03
Subjective Coping	.00	-.15	.07	-.04	-.08	-.09	-.03	.16
Subjective Health	.22†	-.14	.22†	.01	.25†	-.04	.04	.12
Physical Interference	-.21†	.06	.01	.07	-.23†	.06	.05	.04
Mental Interference	-.11	.15	-.07	.11	-.05	.05	.08	-.03
Sleep Disruption	-.19	.14	.09	-.02	-.20	.08	-.03	.08
Emotional Support								
Worry	.33**	.13	-.01	-.12	.33*	.22	-.10	-.01
Rumination	.37**	.23	.05	-.15	.30*	.20	-.08	-.02
Negative Emotions	-.02	-.16	.00	-.12	-.02	-.17	-.04	-.09
Positive Emotions	.09	.33*	-.10	-.01	.27*	.28*	-.02	-.11
Subjective Coping	-.27*	-.14	-.07	.00	-.21	-.14	-.04	.07
Subjective Health	.02	.07	-.09	.22	.16	.00	.33*	-.09
Physical Interference	-.01	-.08	.11	-.16	-.08	-.03	-.12	.14
Mental Interference	.18	-.03	.05	-.07	.10	.00	-.03	.02
Sleep Disruption	.04	.05	.14	-.10	-.01	.07	-.07	.10
Strategy-Specific Support								
PEM Support								
Worry	.06	-.01	.03	.05	.07	-.03	.03	.11
Rumination	.21	.21	.01	-.04	.20	.16	.02	.02
Negative Emotions	.05	-.23	.09	-.26	-.07	-.14	-.14	-.03
Positive Emotions	.10	.35*	-.10	.27†	.35**	.07	.20	-.12

Subjective Coping	.02	-.06	.05	-.04	.05	.00	.04	.06
Subjective Health	.18	.03	.13	.07	.43**	.03	.22	.07
Physical Interference	-.06	-.06	.14	-.26	-.27*	.01	-.27*	.18
Mental Interference	.10	-.09	.08	-.08	.01	-.06	-.03	.03
Sleep Disruption	-.10	.14	.08	-.23	-.29*	.10	-.25†	.14
Bracing Support								
Worry	.48***	.09	.06	-.21*	.38**	.32†	-.24†	.12
Rumination	.27†	-.06	.00	-.18	.16	-.07	-.11	-.08
Negative Emotions	.04	-.11	.03	-.10	-.02	-.12	-.09	-.04
Positive Emotions	-.08	.22†	-.25†	.07	.02	.29*	.09	-.09
Subjective Coping	-.24†	-.11	-.06	.03	-.13	-.22	.00	-.06
Subjective Health	.04	.02	-.09	.11	.16	-.02	.27	-.07
Physical Interference	.02	-.04	.11	-.12	-.08	.02	-.11	.12
Mental Interference	.25†	.01	.03	-.10	.11	.07	-.05	.01
Sleep Disruption	.16	-.16	.07	-.18	.04	-.16	-.15	.02
Benefit-Finding Support								
Worry	.05	.17†	.06	.12	.05	.43**	.10	.26†
Rumination	.11	.18	-.13	.07	.10	.14	.19	-.12
Negative Emotions	-.27†	-.08	-.17	.08	-.12	-.22	.17	-.09
Positive Emotions	.16	.09	-.09	-.03	.08	.16	-.01	.01
Subjective Coping	.08	-.12	.13	-.18	-.05	-.23	-.21	.01
Subjective Health	.31†	-.10	.11	.02	.25†	-.11	.11	-.02
Physical Interference	-.24	.08	.00	-.04	-.18	.18	-.04	.08
Mental Interference	-.13	.06	.01	.09	-.06	.17	.08	.05
Sleep Disruption	-.15	.00	-.01	.12	-.09	.02	.17	.02
Distancing Support								
Worry	.28*	.09	-.02	-.19	.23†	.25	-.15	-.03
Rumination	.14	.27†	-.13	-.18	.11	.24†	-.09	-.10
Negative Emotions	-.16	-.01	-.06	-.03	-.16	.00	-.07	.05
Positive Emotions	.03	.10	-.12	.22†	.22†	.09	.27*	-.10
Subjective Coping	-.23†	.02	-.12	.07	-.18	-.03	-.08	.00
Subjective Health	.06	.10	-.24†	.13	.12	.00	.18	-.17
Physical Interference	-.10	.06	.06	-.19	-.15	.10	-.11	.10
Mental Interference	.00	.12	-.03	-.09	-.02	.15	-.07	.05

Sleep Disruption	-.07	-.03	.15	.00	-.06	.03	.04	.10
Distraction Support								
Worry	.36**	.00	.08	-.06	.36*	-.05	.00	-.05
Rumination	.29*	.02	-.13	-.16	.25†	.03	-.06	-.16
Negative Emotions	.07	-.15	.01	-.01	.12	-.25	.11	-.10
Positive Emotions	-.07	.07	-.16	.13	.14	.10	.18	-.16
Subjective Coping	-.41**	.13	-.12	.01	-.32*	.20	-.07	.08
Subjective Health	.01	.23†	-.01	-.02	-.01	.20†	-.01	.01
Physical Interference	.10	-.16	.07	-.06	.10	-.15	-.07	.03
Mental Interference	.29*	-.12	.09	.03	.25*	-.15	.15	-.02
Sleep Disruption	.03	-.18	.02	.00	.04	-.19	-.02	-.06
Suppression Support								
Worry	.23*	.01	-.07	-.10	.30*	.19	-.11	-.09
Rumination	.16	-.01	-.09	-.03	.16	-.03	.01	-.14
Negative Emotions	.16	-.11	.02	-.13	.17	-.10	-.09	-.01
Positive Emotions	-.08	-.06	-.12	.10	-.03	-.06	.14	-.13
Subjective Coping	-.25*	.14	-.21†	.19	-.18	.02	.11	-.18
Subjective Health	-.04	.11	-.06	.05	-.06	.05	.03	-.06
Physical Interference	.12	-.01	.02	-.10	.15	.03	.02	.06
Mental Interference	.26*	.11	.16	-.07	.23†	.14	-.09	.13
Sleep Disruption	.07	-.04	-.09	.00	.08	.01	.05	-.07
Proactive Coping Support								
Worry	.34**	.05	.05	-.11	.33*	.21	-.08	.21
Rumination	.25†	.02	.07	-.04	.19	.02	.05	.00
Negative Emotions	-.04	-.15	.06	-.08	-.08	-.18	-.04	.00
Positive Emotions	-.02	.30*	-.18	.16	.13	.30*	.17	-.06
Subjective Coping	-.20	-.09	.04	-.06	-.20	-.09	-.12	.06
Subjective Health	.08	.17	-.14	.07	.23	.07	.15	-.11
Physical Interference	.03	.00	.19	-.18	-.05	.09	-.13	.22†
Mental Interference	.17	-.07	.11	-.01	.11	-.03	.04	.06
Sleep Disruption	-.11	-.23†	.20	.01	-.12	-.17	.02	.10

Note. Values represent parameter estimates for each actor and partner effect. †p<.10; *p<.05; **p<.01; ***p<.001.

Table 11

Model Parameters Support Perceptions Predicting and Predicted by Waiting Strategy Use (Study 2)

	Support *predicting* strategy use				**Support *predicted by* strategy use**			
	Actor Effects		Partner Effects		Actor Effects		Partner Effects	
	Rec	*Prov*	*Rec*	*Prov*	*Rec*	*Prov*	*Rec*	*Prov*
General Support								
Responsiveness								
Pos. Exp. Management	.02	.22	-.02	.35*****	.26*****	.27	.20†	.05
Bracing	-.18	-.08	-.11	.00	-.24†	-.13	-.09	-.23
Benefit-Finding	.11	-.07	.17	.08	.12	.02	.08	.14
Distancing	.25†	.11	-.08	-.40*****	.06	.14	-.21	-.03
Positive Reframing								
Pos. Exp. Management	.29******	-.10	.04	-.03	.12	-.25	.03	.00
Bracing	.30*****	.04	.05	.09	.29*****	.01	.13	-.02
Benefit-Finding	-.03	.36*****	-.03	-.05	-.01	.37******	-.17	.06
Distancing	.01	.13	.06	.08	.04	.11	.05	.07
Negative Validation								
Pos. Exp. Management	.16	.08	.10	-.17	.14	.15	-.09	.25
Bracing	.03	.00	-.12	-.02	.07	-.01	-.02	-.29†
Benefit-Finding	.13	.02	.00	.22	.30*****	-.02	.18	-.13
Distancing	.14	.25	-.02	-.21	.10	.23	-.16	-.02
Informational Support								
Pos. Exp. Management	.29*****	.02	-.01	.06	.26*****	-.01	.06	-.14
Bracing	-.04	.06	-.14	.20	-.02	-.01	.13	-.20
Benefit-Finding	.15	.03	-.09	.12	.35*****	.00	.20	-.18
Distancing	.10	.05	.02	-.14	.04	.09	-.08	.00
Emotional Support								
Pos. Exp. Management	.17	.14	-.03	.02	.19†	.27	.00	-.14
Bracing	.20†	.18	-.02	.10	.18	.21	.06	-.09
Benefit-Finding	.10	.36******	.11	.01	.11	.43******	-.16	.10
Distancing	.28*****	.26†	.03	-.08	.20	.26†	-.10	-.05

Strategy-Specific Support								
PEM Support								
Pos. Exp. Management	.42**	.20	.04	.12	.42***	.40*	.15	.18
Bracing	-.21†	-.19	.03	-.02	-.30*	-.17	-.06	.03
Benefit-Finding	.34**	.33*	-.01	-.09	.43**	.25†	-.06	-.03
Distancing	.01	.21	.01	-.02	-.10	.22	-.10	.14
Bracing Support								
Pos. Exp. Management	.15	-.11	-.09	-.11	.13	-.44*	-.02	-.28
Bracing	.49***	.35**	.07	.02	.31**	.72***	-.06	.07
Benefit-Finding	.04	.39**	-.04	.14	.10	.52**	.02	.07
Distancing	.42**	.06	.03	-.12	.24†	.11	-.10	.00
Benefit-Finding Support								
Pos. Exp. Management	.12	-.05	-.01	-.01	.08	-.24	.05	.00
Bracing	.17	.26*	.04	.12	.10	.50**	.10	.11
Benefit-Finding	.33*	.42***	.13	.06	.28*	.64***	-.05	.12
Distancing	.23	.13	-.14	-.05	.09	.16	-.05	-.06
Distancing Support								
Pos. Exp. Management	.06	-.11	-.14	-.03	.11	-.41†	.05	-.50*
Bracing	.41**	.12	.07	-.05	.25†	.24	-.05	.00
Benefit-Finding	.14	.38**	.10	.09	.19	.47**	-.03	.12
Distancing	.62***	.03	.11	-.12	.47**	.05	.03	-.06
Distraction Support								
Pos. Exp. Management	.25†	-.01	-.02	-.04	.17	-.11	.04	-.23
Bracing	.10	.10	.03	.08	.07	.17	.06	.00
Benefit-Finding	.13	.32*	-.16	.04	.22	.31*	-.07	-.21
Distancing	.24†	-.09	.20	-.08	.17	-.04	.00	.05
Suppression Support								
Pos. Exp. Management	.21†	-.06	-.03	.21†	.15	-.25	.21†	-.08
Bracing	.16	.04	.01	-.10	.13	.08	-.10	.01
Benefit-Finding	.01	.20	-.12	.26*	.16	.17	.27†	-.13
Distancing	.02	-.11	-.08	-.08	.06	-.12	-.02	-.13
Proactive Coping Support								
Pos. Exp. Management	.10	-.13	-.05	-.03	.15	-.37†	.06	-.21
Bracing	.33*	.24†	.07	-.01	.16	.41*	-.07	.12

Benefit-Finding	.27*	.42**	.02	.02	.31*	.53**	-.05	.09
Distancing	.45**	.06	.15	-.19	.23†	.15	-.13	.11

Note. Values represent parameter estimates for each actor and partner effect. †p<.10; *p<.05; **p<.01; ***p<.001.

Table 12

Model Parameters Individual Differences Predicting Support Perceptions (Study 2)

	Actor Effects		Partner Effects	
	Rec	*Prov*	*Rec*	*Prov*
Dispositional Optimism (LOTR)				
Responsiveness	.46**	-.04	.10	-.04
Positive Reframing	-.20†	-.08	-.01	.17
Negative Validation	.20	-.13	.08	-.14
Informational Support	.10	-.15	-.06	-.09
Emotional Support	.02	-.16	-.04	.06
PEM Support	-.03	-.05	.01	-.20
Bracing Support	-.09	-.04	-.03	-.16
Benefit-Finding Support	.22†	-.04	.06	-.13
Distancing Support	.01	-.11	.01	-.08
Distraction Support	-.02	-.14	.14	-.06
Suppression Support	-.12	-.07	-.02	-.01
Proactive Coping Support	-.24*	-.04	.04	.03
Defensive Pessimism (DPQ)				
Responsiveness	-.05	.19	.16	.26*
Positive Reframing	.06	-.11	.03	-.28*
Negative Validation	.11	.18	.09	.19
Informational Support	.02	.19†	.18	.13
Emotional Support	.09	.10	-.06	-.11
PEM Support	.14	.01	-.02	.09
Bracing Support	.14	-.05	.03	.10
Benefit-Finding Support	.16	.07	.17	.06
Distancing Support	.06	-.13	.06	.06
Distraction Support	.03	.06	.00	.02
Suppression Support	.18	.22†	.20	.04
Proactive Coping Support	.20	.01	.17	-.04
Intolerance of Uncertainty (IU)				

Responsiveness	-.09	.08	.13	.13
Positive Reframing	.08	.05	.03	-.16
Negative Validation	.08	.05	.15	.05
Informational Support	.21†	.07	.12	-.04
Emotional Support	.09	.05	-.11	-.07
PEM Support	.21†	-.05	-.11	.05
Bracing Support	.11	-.14	-.02	.18
Benefit-Finding Support	.05	.08	.04	.19
Distancing Support	.13	.09	-.25†	.12
Distraction Support	.15	.06	-.08	-.02
Suppression Support	.27*	-.04	.15	-.04
Proactive Coping Support	.34**	.04	-.01	-.05
Anxious Attachment (ECR-Anx)				
Responsiveness	-.33*	-.14	-.02	-.02
Positive Reframing	-.09	.06	.14	-.31*
Negative Validation	-.04	.06	-.06	-.14
Informational Support	.01	-.14	-.12	-.11
Emotional Support	-.28†	.04	-.17	-.40**
PEM Support	-.18	-.12	-.09	-.08
Bracing Support	-.19	-.13	-.21	.00
Benefit-Finding Support	-.21	.04	.02	.09
Distancing Support	-.07	-.11	-.01	.02
Distraction Support	-.21	-.10	.07	-.18
Suppression Support	.16	-.15	.03	-.07
Proactive Coping Support	.19	.04	-.20	-.16
Avoidant Attachment (ECR-Avoid)				
Responsiveness	-.77***	-.01	.03	-.05
Positive Reframing	-.16	.24†	-.12	.32**
Negative Validation	-.75***	-.17	.02	-.04
Informational Support	-.35*	.06	-.03	.05
Emotional Support	-.63**	.00	-.01	.33**
PEM Support	-.64**	.04	.01	.02
Bracing Support	-.55**	-.04	-.03	-.05
Benefit-Finding Support	-.46**	-.07	.12	-.09

Distancing Support	-.28	.13	.11	-.08
Distraction Support	-.60**	.10	-.01	.04
Suppression Support	-.63**	.10	-.26	.15
Proactive Coping Support	-.24	-.03	.12	-.02

Note. Table values represent parameter estimates for each actor and partner effect
† $p < .10$; * $p < .05$; ** $p < .01$; *** $p < .001$.

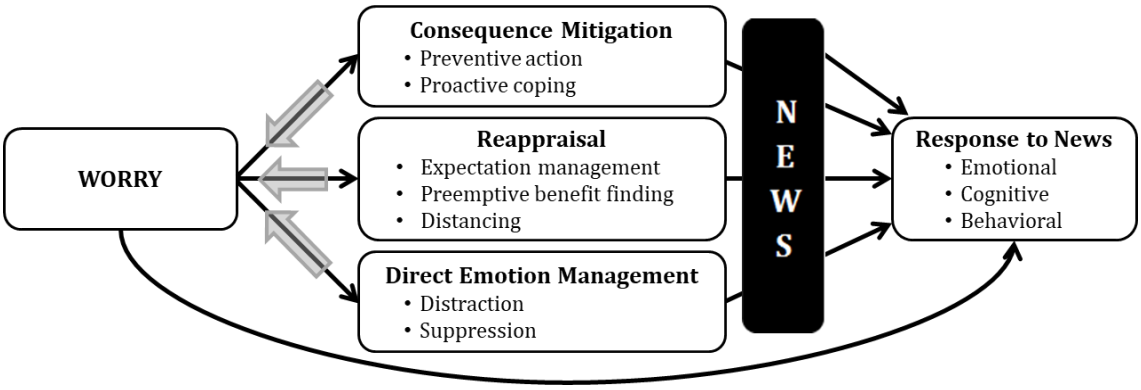
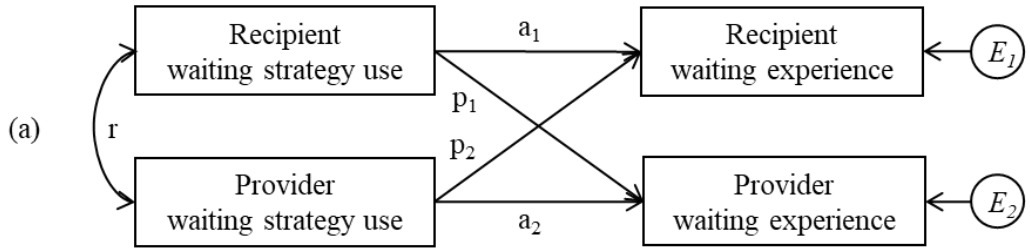
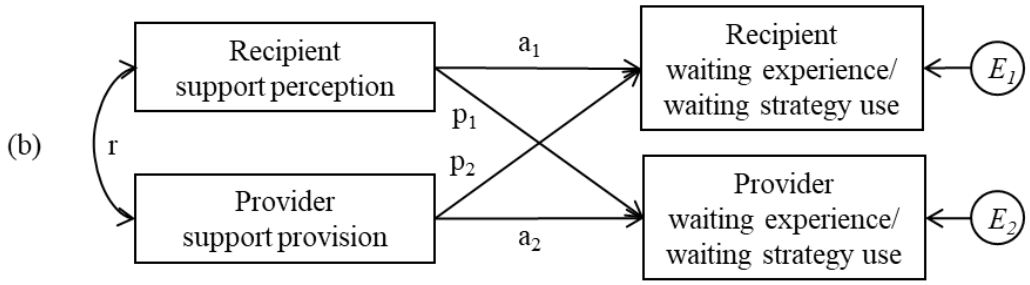


Figure 1. The Uncertainty Navigation Model (adapted from Sweeny & Cavanaugh, 2012)

Question 2: How does strategy use relate to waiting experiences?



Question 3: How does support perception predict waiting experiences and strategy use?



Question 4: How do individual differences influence support perceptions?

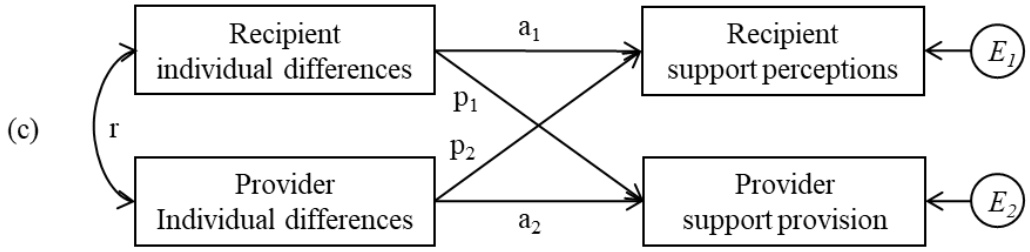


Figure 2. Actor-Partner Interaction Models. In each model, a_1 and a_2 indicate actor-effects. p_1 and p_2 indicate partner-effects. r indicates the relationship between partners' scores on the independent variable. E_1 and E_2 indicated residual error for each participants outcome.

Appendix A

Study 1 task description:

During this study, myself and a trained interviewer in the other room are here to assess how outgoing, gregarious, and comfortable you are in situations in which you must project yourself as an expert. This is a type of personality test for a trait called extraversion. You will be given a hypothetical situation in which you will be applying for your ideal job. You have dreamed about working in this job for as many years as you can remember. You have just seen an advertisement for this perfect job and decided to apply. After submitting your application, you have been invited for an interview. The job pays a very large salary. You are competing against a lot of other candidates, and the final selection will be made based on your ability to convince the interviewers of how your experiences, abilities, and education make you a better candidate than the others. In addition, you will be asked to perform a mental math test, which will give us additional information about your working memory capacity.

You will have 5 minutes to prepare a detailed speech. After the preparation time has elapsed, you will return and deliver your speech to these interviewers. Your speech should explain why you should get the job. Remember, you should try to perform better than all of the other participants.

These examiners are specially trained to monitor and rate your speech for its believability and convincingness, and they will compare your performance to that of the others who perform this task. Please let me know if you have any questions.