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ADAPTIVE COMMUNICATIVE BEHAVIOR OF MOTHERS AND THEIR ADULT DAUGHTERS AFTER A BREAST CANCER DIAGNOSIS

A Dissertation in

Communication Arts and Sciences

by

Carla L. Fisher

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The dissertation of Carla L. Fisher has been reviewed and approved* by the following:

Jon F. Nussbaum  
Professor of Communication Arts and Sciences and Human Development and Family Studies  
Dissertation Advisor  
Chair of Committee

Dennis S. Gouran  
Professor of Communication Arts and Sciences and Labor Studies and Employment Relations  
Graduate Director of Department of Communication Arts and Sciences

Michelle A. Miller-Day  
Associate Professor of Communication Arts and Sciences

Melissa A. Hardy  
Distinguished Professor of Human Development and Family Studies, Sociology, and Demography  
Director of Gerontology Center

James P. Dillard  
Professor of Communication Arts and Sciences  
Head of Department of Communication Arts and Sciences

*Signatures on file in the Graduate School.
ABSTRACT

A diagnosis of breast cancer is life altering. Diagnosed women do not cope with this transition alone. A patient’s family interactions are critical to her well-being and adjustment. In particular, diagnosed women’s mother-daughter bond is a significant part of their experience. Although kin communication can function both adaptively and maladaptively in women’s adjustment to cancer, health professionals do not provide families guidance in how to communicatively adjust in a healthy manner. The research report in this dissertation had two purposes: 1) to investigate the significance of family communication in adjusting to breast cancer by using Carstensen’s (1991, 1992) socioemotional selectivity theory (SST) and 2) to explore how diagnosed women communicatively adjust to the disease in their mother-adult daughter bond through openness, avoidance, and emotional support.

The study incorporated a multiple methods design and involved the collection of both cross-sectional and longitudinal data. A single phase quantitative design served the first purpose, and a multimethods qualitative design the second purpose. For the first purpose, women in three age groups (young, middle, and later adulthood) representing the following two conditions were recruited to participate in a survey: 1) 301 healthy women and 2) 39 women diagnosed with breast cancer. Chi-Square tests of associations were run to examine associations between a limited time perspective (due to age or diagnosis of breast cancer) with social partner preference. Women in Condition 2 (representing each age group) also participated in the qualitative phase. A total of 40 diagnosed women participated and recruited their mothers or adult daughters. A total of 78 women (35 dyads) participated in an individual in-depth interview. Subsamples (N = 10) participated in longitudinal diaries and diary-interviews (N = 8). Women shared how they communicatively adjusted to cancer in their mother-daughter bond through open communication, avoidance, and enacted emotional support. Grounded theory was used to examine all transcripts and diaries. The diary-interview method was employed to permit triangulation with findings from the interviews. Findings from the diary-interview method were analyzed as illustrative and descriptive case studies (a case study representing the experiences of each age group of dyads) and compared with the analyses of the interviews. The case studies deepened the credibility of the findings from the interviews and illustrated each communicative phenomenon on a deeper level.

The quantitative results extend the utility of SST. Using SST as a framework, Hypothesis 1 and Research Question 1 focused on whether a limited time perspective, due to being closer to the end of life because of age or a breast cancer diagnosis, leads women to prefer kin communication partners. The results revealed that both time factors led women to prioritize communication in family bonds. The qualitative findings showed how women communicatively adapted to breast cancer in their mother-daughter bond. Research Questions 2-5 related to what cancer-related topics diagnosed women openly share or avoid in this bond as well as their motives. Across ages, women openly disclosed physical aspects of the disease (e.g., treatment side effects) but often avoided talking about emotional or distressful topics (e.g., mortality). Diagnosed women often displayed openness and avoidance to protect the mother/daughter from distress. Developmental diversity influenced women’s open and avoidant communication. Research Questions 6-7 asked how mothers and daughters of diagnosed women enact emotional support. Across age groups, women had similar experiences particularly in regard to support that
always functioned adaptively (e.g., using humor and listening). Age appeared to influence
women’s conceptualization of emotional support, their communication preferences, and their
evaluations of support. The context in which support was enacted affected whether women
perceived other behaviors as helpful or unhelpful in their adjustment to cancer. The diary
findings primarily matched the interview results. Those findings also furthered our understanding
of openness, avoidance, and emotional support within the context of mothers and daughters
coping with breast cancer treatment.

The major implications of this dissertation extend theoretical and practical knowledge of
family communication, cancer, aging, and health. First, the findings extend SST. Later life
women appear to prefer kin communication partners more so than younger generations. In
addition, when women are diagnosed with breast cancer in stages 3 or 4, regardless of age, they
prefer kin communication partners more than women diagnosed in earlier stages. These findings
enhance existing literature in health communication by expanding our theoretical understanding
of the role of family communication in a cancer context. Second, the qualitative findings
demonstrate that human development affects women’s open, avoidant, and support
communicative needs when adjusting to breast cancer. These findings also highlight the need for
scholars to appreciate context to capture whether kin communication functions adaptively or not
when adjusting to this health transition.
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Chapter One

REVIEW OF LITERATURE

Introduction

“The interpersonal communication that fuels our social world is as essential to our survival as any biological or physical process that keeps us alive” (Hummert, Nussbaum, & Wiemann, 1994, p. 3). Communication is a fundamental part of being—the core of family. It builds kin relationships, maintains family networks, and enables individuals to achieve life satisfaction. Communication is one key to a high quality of life.

Family communication is especially important when encountering traumatic changes. During such transitions, people often call on family members for support. Family, stress, and adaptation research indicates that “the way people cope is largely a function of their interaction with others” (Afifi & Nussbaum, 2006, p. 282). Communication can function both adaptively and maladaptively for families facing strenuous circumstances. Thus, communication is a major factor in a family’s ability to maintain well-being while adjusting to the transition (Groth, Fehm-Wolfsdorf, & Hahlweg, 2000; Pennebaker, Kiecolt-Glaser, & Glaser, 1988). Capturing families’ communicative adjustment to transitions can be vital in understanding how families cope, adapt, and prosper across the life span.

A frequently experienced stressful transition families encounter today is the diagnosis and treatment of cancer. Cancer is the second leading cause of death after heart disease in the United States (Hoyert, Kung, & Smith, 2003). The diagnosis of cancer is one of the most difficult challenges a family will face. Family plays a critical role in patients’ coping as diagnosed individuals seek support in familial bonds (Mallinger, Griggs, & Shields, 2006; Manne, 1998). Research demonstrates that a patient’s family interactions are critical to his/her
well-being and adjustment to cancer (Goldsmith, Miller, & Caughlin, in press; Hagedoorn et al., 2000; Pistrang, Barker, & Rutter, 1997). Scholars often focus on the presence or absence of open communication or social support in relation to patients’ adjustment to the disease. Cancer patients and spouses who openly communicate cancer-related concerns, feelings, and problems in their relationship exhibit better psychological adjustment (Lichtman, Taylor, & Wood, 1987), social adjustment, emotional adjustment, and self-esteem (Zemore & Shepel, 1989). Also, in comparison to patients with positive levels of family support, individuals without these positive levels of family support often have more depressive symptoms, troubled relationships, and cancer-related symptoms that manifest physiologically and, ultimately, can negatively affect health (Helgeson & Cohen, 1999). Hence, a strong family support network enhances patients’ quality of life (Suinn & VandenBos, 1999).

The bulk of scholarship investigating family communication following a cancer diagnosis is based on married couples’ “self” reports (see Goldsmith, 2004; Goldsmith et al., in press). Rarely is communication in other kin bonds even considered. Yet, another kin bond, the mother-daughter relationship, has emerged in a select few studies as an important factor in women’s adjustment to breast cancer (Burles, 2006; Oktay & Walter, 1991; Spira & Kenemore, 2000). Breast cancer afflicts more than 200,000 women each year, adding to more than 2 million women already living with the disease (Jemel et al., 2003). Even though women seek support from various loved ones, regardless of age at diagnosis, they describe their mother-daughter bond as an important part of their cancer coping experience. The significance of this kin bond is not entirely surprising given that the mother-daughter relationship is often the longest, most emotionally connected bond a woman will experience in her lifetime (Fischer, 1986). Mothers and daughters are often described as “linked lives” (Fischer). Their bond evolves across the life
span, frequently becoming closer with increasing age. They adjust to each other’s shifting needs as they age and encounter various life events (Fingerman, 2003; Fischer, 1986). Although research on the mother-daughter bond in a cancer context is scarce, scholars have found that mothers and daughters do share the breast cancer transition psychologically, physically, and socially (Burles, 2006; Cohen et al., 2002; Cohen & Pollack, 2005; Oktay, 2005; Oktay & Walter, 1991; Spira & Kenemore, 2000). They experience similar psychological and physiological distress (e.g., uncertainty, fear regarding the future, elevated stress hormones) (Cohen et al., 2002; Cohen & Pollack, 2005). Mothers and daughters also socially share aspects of the cancer experience (e.g., medical decision-making) (Burles, 2006; Kenen, Arderon-Jones, & Eeles, 2003; Spira & Kenemore, 2000; Oktay & Walter, 1991). Unfortunately, little is known about how mothers and daughters communicatively adjust to this transition or how their interactions are tied to patients’ well-being. This knowledge is critical in fully understanding women’s breast cancer experiences and is the focus of this dissertation.

By capturing how women communicatively adjust to cancer in their family bonds, health professionals may be able to develop interventions and social services that can aid families coping with cancer. Family communication and health are clearly connected. This link suggests that competent communication is necessary for survival and that health professionals are beginning to appreciate how important cancer patients’ family interactions are in their ability to adjust in a healthy manner. Surprisingly, families are not given much guidance to psychosocially or communicatively adjust to the disease and its associated changes in individual and relational life (Ostroff, Ross, & Steinglass, 2000). This lack of guidance is of concern because not all families communicate support in healthy ways. Individuals are not necessarily born with the ability to communicate competently (Pecchioni, Wright, & Nussbaum, 2005). In addition,
families admit not knowing how to be supportive. It is not unexpected then that those diagnosed with cancer sometimes report that kin are unhelpful or upsetting. In fact, while women diagnosed with breast cancer do characterize their mother-daughter bond as supportive, they also describe the relationship as distressful (Oktay & Walter, 1991). These divergent experiences are, no doubt, tied to variance in their communicative abilities to adjust to the disease in a manner that maximizes their wellness.

Families are in need of assistance that maximizes the communicative competencies related to successful coping and surviving with a diagnosis of cancer. Studies are needed to create interventions to help health professionals guide families’ adjustment to this disease. Such scholarship must, however, represent the nature of family interactions in a manner that accurately addresses patients’ needs. The literature to date is not entirely successful in doing so. As mentioned, scholars have narrowly focused on one family bond (marital couples) (Goldsmith et al., in press). Doing so assumes all kin relationships experience the same communicative adjustment to cancer even though research suggests that the relationship itself is an influential factor in how individuals adjust to the disease (Albrecht & Goldsmith, 2003; Goldsmith, 2004; Pecchioni et al., 2005; Primomo, Yates, & Woods, 1990). Moreover, scholars often only examine the presence or absence of open communication or social support when examining how families communicatively adjust to cancer (Goldsmith, 2004). This narrowed focus ignores the importance of how families enact support or engage in communicative adjustment. As communication can be both helpful and not helpful in patients’ adjustment, it is important to capture competent communicative adjustment to cancer. Finally, the method utilized to capture communication places limits upon the utility of much of this research. Scholars primarily use quantitative survey methodology to attain married couples’ self-reports. Often, the measures in
these investigations were originally created based on behaviors enacted to adjust to other transitions, in other relationships (including non-kin bonds), and in other contexts (e.g., college) (Barrera, 1981; Barrera, Sandler, & Ramsay, 1983). In using such measures, scholars minimize the diversity of the communication context by assuming communication adjustment is the same in all bonds and transitions. This approach is problematic, as context does influence family behavior and the adaptive potential of their communication (Albrecht & Goldsmith, 2003). Even the type of bond (e.g., friend, family, or professional) in which communication is enacted affects whether communication is perceived to be helpful (Primomo et al., 1990).

To enhance our understanding of family communication after a diagnosis of cancer and, ultimately, cancer care, new scholarship is needed. Scholars must engage in methodological and theoretical approaches that allow patients’ and other family members’ voices to be heard. Moreover, research must investigate how family communication is central to quality of life (Segrin, 2006). Senior communication scholars in aging, health, and family communication have recently called for this type of socially relevant applied scholarship—research that serves as a catalyst for social change (Goldsmith et al., in press; Kelley, 2008; Nussbaum, 2007).

Specifically, this dissertation enhances scientific understanding of family communication and cancer and produces knowledge that can help families cope with this transition. First, the health industry needs to expand its conceptualization of “quality” care by appreciating the importance of kin communication in patients’ adjustment to cancer. Thus, the first purpose of this study was to investigate the significance of family communication in breast cancer patients’ adjustment. Second, the health industry needs to expand its approach to care. To do so, it must have the means to do so. The health community needs information about how families communicatively adjust to the disease and how this behavior is tied to well-being. The second
purpose of this dissertation is to explore the adaptive communication of mothers and daughters after a breast cancer diagnosis.

Following is a review of relevant literature. This review begins with an examination of how women’s mother-daughter bond is part of their transition to breast cancer. This section is followed by an overview of communicative behavior families enact to adjust to the disease. The review concludes with a consideration of theoretical perspectives that are helpful in understanding the importance of family communication in adapting to cancer. A research hypothesis and inquiries follow this review.

Review of Previous Research

_Mothers, Daughters, and Breast Cancer_

Women with breast cancer characterize the mother-daughter relationship as significant in their transitional experience (Burles, 2006; Oktay & Walter, 1991). Mothers and daughters’ unified presence in the face of breast cancer is not entirely unexpected. As noted, mothers and daughters are often “linked lives” across the life span (Fischer, 1986). They are each other’s confidant, advisor, friend, and nurturer. They often become closer and more emotionally connected as their bond evolves. Even though mothers and daughters struggle with understanding one another and maintaining their complex dynamic (Tannen, 2006), they often experience a special closeness that persists across social classes and generational differences (Fischer, 1986). Their closeness is naturally tied to their shared roles as women in family. It has long been argued that, in comparison to other kin bonds, the mother-daughter relationship has the highest potential for emotional bonding and connectedness (Fischer, 1986, 1991). Their enduring connection, especially during adulthood, undoubtedly aids them in adjusting to and emerging from strenuous transitions like a breast cancer diagnosis.
Transitions, or turning points, are important focal points in understanding human behavior across the life span (Baxter & Bullis, 1986). They are sometimes narrowly described as life-changing events that affect a family’s environment or an individual alone. In actuality, turning points are long-term or multiple processes of change that transform a family and its individual members (Cowan, 1991). Hence, they may lead to both individual and relational changes. Transitions alter individuals’ sense of self, assumptive world, and behavior. These events also lead to relational adjustments and are moments that eventually redefine family bonds (Baxter & Bullis, 1986). The communicative behavior individuals enact to adjust to these changes affects the nature of their transitional experiences. In light of this, turning points are exemplars of family change that scholars can focus on to better appreciate the importance of interpersonal communication in human survival.

Turning points are especially helpful in understanding mothers and daughters’ unique connection and the importance of their bond as women encounter stressful changes like breast cancer. Turning points shape mothers and daughters’ linked lives. They lead to relational changes in boundaries, roles, behavior, and intimacy. Moreover, mothers and daughters often jointly take on the challenges of transitions. Thus, their communication shapes their transitional experiences. Although the turning point of breast cancer has yet to be explored communicatively, the transitional nature of this diagnosis has been examined from other perspectives. This research demonstrates that the diagnosis of breast cancer is both a poignant turning point in the lives of women and their kin relationships, particularly the mother-daughter bond. Furthermore, these studies illuminate the transitional nature of breast cancer and are helpful in understanding the numerous changes mothers and daughters must communicatively adapt to.
Once women are diagnosed with breast cancer, they experience drastic individual changes. Among other things, they must learn to manage intense and complex emotional, psychological changes. Typical experienced emotions include increased anger or sadness, loss of control, feelings of helplessness, increased anxiety and depression, struggles with self-esteem and identity, as well as feelings of betrayal (see Spira & Kenemore, 2000, for a review). Although women of different ages share some of the same psychological manifestations, their age at diagnosis also influences their emotional concerns. For example, Oktay and Walter (1991) reported that women diagnosed in their twenties struggle more with anxiety about their future, particularly their ability to have children and form intimate relationships. In contrast, women diagnosed in midlife are concerned with self-reliance and their adolescent children’s well-being. Finally, women diagnosed in later life tend to struggle more with depression and despair in comparison to women in other age groups. Oktay and Walter’s research demonstrates that age partly determines the individual emotional challenges diagnosed women face. In light of this, it is possible that age is an influential factor in how women communicatively cope with these varying emotional concerns as they adjust to breast cancer.

Women’s personal lives are transformed by cancer. Yet, their interpersonal lives are as well. Spira and Kenemore (2000) have observed that, “the closer others are to the patient, the more likely they are to feel that their life is changed” (p. 174). This effect seems to apply to women’s mothers and daughters. Mothers and daughters share and are affected by the breast cancer transition relationally, psychologically, and physiologically. Research shows that after a woman is diagnosed, her mother-daughter relational bond is altered (Burles, 2006). Burles determined that at times mothers and daughters experience a role reversal. This change occurs as
daughters and mothers take on new roles and responsibilities. For instance, daughters sometimes assume maternal responsibilities like childcare and housework. Some daughters even take on a more leadership role in the family by becoming the acting parent to younger siblings. Daughters may also provide social support to their mothers and “mother” them for the first time in their relationship. Oktay and Walter (1991) noted that this relational change can be difficult, particularly for aging mothers and adult daughters. Aging mothers sometimes feel daughters try to take over control, which can result in a power struggle. It is likely that their communicative behavior affects whether this outcome occurs, as mothers and daughters interactively negotiate these changes in their bond. Therefore, their communication influences whether they adjust in positive or negative ways.

Kenen et al. (2003) assert that like their diagnosed mothers, daughters ultimately live with a psychological “chronic risk” (a distress due to a fear of future disease reoccurrence for their mother as well as a risk for themselves in developing the disease). A few select studies have indicated that this shared experience of chronic risk can lead to negative psychological and physiological health outcomes. For instance, Boyer et al. (2002) examined the psychological states of 133 women diagnosed with breast cancer and 64 of their daughters (aged 15-71, average age 40). They reported that breast cancer patients at times experience posttraumatic stress disorder (PTSD) symptoms because of their diagnosis and treatment. In such cases, their daughters also exhibit the same psychological symptoms. Cohen et al. (2002) and Cohen and Pollack (2005) demonstrated that these psychological effects can extend further. They found that adult daughters (aged 20-45) of diagnosed mothers exhibit the same psychological and physiological effects their mothers incur. They collected psychological and biological data from 80 daughters of diagnosed mothers, 80 diagnosed mothers, and a control group of 47 healthy
daughters (whose mothers were not diagnosed). Like Kenen et al. (2003), Cohen et al. (2002) found that mothers’ and daughters’ shared experience appears to be most saliently linked with their shared psychological “chronic risk” distress. When daughters were aware of their increased risk of developing cancer, they displayed higher emotional distress and elevated levels of stress hormones. Moreover, these daughters had higher psychological distress in comparison to daughters of healthy (nondiagnosed) mothers of comparable age and education level. Cohen and Pollack (2005) extended these findings by showing that diagnosed mothers’ psychological distress is highly correlated with daughters’ psychological distress, particularly when the mother has an advanced stage of the disease. They also determined that these daughters have impaired immune functions and higher levels of stress hormones. Daughters’ biological effects were associated with their mother’s psychological distress. Collectively, these studies demonstrate that diagnosed women’s daughters share with their mothers some of the same psychological effects of the disease and that daughters may even exhibit signs of negative health outcomes.

The preceding studies confirm that breast cancer is a shared mother-daughter transition on multiple levels. Still, the current research does not account for how mothers and daughters communicatively adjust to this turning point. Their communication is important as the reviewed literature demonstrates that, because of this transition, women must adjust to many changes. Cowen (1991) states that when encountering transitions, “The individual, couple, or family must adopt new strategies, skills, and patterns of behavior to solve new problems” (p. 17). Hence, their communication is key to their ability to adjust to cancer competently.

**Mother-Daughter Communication and Turning Points**

A plethora of research concerning the mother-daughter bond suggests that mothers and daughters communicatively shape the nature of their transitional experiences (Fischer, 1986,
For instance, a commonly studied turning point, the daughter’s transition to adolescence, is a time period fraught with issues of autonomy (La Sorsa & Fodor, 1990). Daughters encounter a dialectical struggle between wanting their mother’s nurturing presence and needing independence and a separate sense of self (Hershberg, 2006; Kaufman, 1999). The mother must grapple with her daughter’s desire for separation from her and may even feel threatened as she sees her daughter becoming independent and needing her less (Hershberg, 2006). This transitional period is typically characterized by negative communication, including tense interactions, frequent conflict, and even emotional distance (La Sorsa & Fodor, 1990). It is likely that these features of mother-daughter communication enhance the difficulty of this transition.

A similar struggle with autonomy returns late in the bond’s relational life span when a daughter assumes caretaking responsibilities for her aging mother. However, in this case, communication often functions positively. Sheehan and Donorfio (2002) discovered that women alter their communication in ways to maintain acceptance and tolerance. This communicative adjustment ultimately enhances their relational closeness (Fischer, 1986). Similarly, when daughters marry or become mothers, their communication can enhance their connection with their mother. During these transitions, daughters often experience a relational change called “seeing the woman behind the role” (Miller-Day, 2004) or “filial comprehending” (Nydegger, 1991). In essence, daughters begin to view their mothers as women—individuals. At the same time, mothers reassess their daughters’ maturity. As their understanding of one another increases, they change their communication by becoming more open. This communicative behavior allows mothers and daughters to play a more intimate role in each other’s lives. Thus, their open behavior enhances their linked lives.
Communication is an integral part of mothers’ and daughters’ transitional experiences. Undoubtedly, their communicative adjustment is especially critical in the face of traumatic health changes, like a cancer diagnosis. It is important to understand the adaptive functioning of their communication to create interventions that guide mothers and daughters in how to adjust communicatively to the disease in healthy ways. Although mother-daughter communicative adjustment to breast cancer has not yet been explored, the adaptive functioning of family communication in other bonds, namely married couples, has been studied (Goldsmith, 2004; Goldsmith et al., in press; Manne, 1998). This research illuminates features of family communicative adjustment that warrant attention to better understand the adaptive functioning of mothers’ and daughters’ behavior after a breast cancer diagnosis.

*Adaptive Family Communication Behavior after a Cancer Diagnosis*

Communication is critical to understanding how families respond to strenuous turning points, how they take on these transitions together, and how they ultimately may emerge strengthened and resilient. Recently, scholars have become more concerned with how family communication can affect socioemotional well-being when coping with cancer. Thus, they have begun investigating how kin interactions can function adaptively in patients’ adjustment to the disease (Manne et al., 2005). Although most of this scholarship centers on one kin bond (married couples), the research to date suggests that family interactions are key in adapting to this type of health crisis (Edwards & Clark, 2004; Manne, Dougherty, Veach, & Kless, 1999). This scholarship typically focus on three types of communicative behavior families enact: open communication, avoidance, and social support. Across disciplines, scholars have produced knowledge showing how these types of behavior can both positively enhance and impair individuals’ adjustment to cancer.
Open Communication and Avoidance

Open communication and avoidance affect individuals’ adjustment to cancer in both helpful and unhelpful ways. This form of communicative adjustment concerns how openly individuals communicate about their experience with cancer or, in contrast, how they may avoid interactions to adjust. As noted, most studies only capture marital couples’ open and avoidant behavior. However, this body of research does provide insight on communication phenomena worthy of closer examination.

In general, open communication is the disclosure of feelings, thoughts, and information. Such interaction reflects the ability to talk openly about cancer with a loved one, as well as the patient’s partner’s willingness to engage in such a discussion. Hilton (1994), Figueiredo, Fries, and Ingram (2004) and Porter, Keefe, Hurwitz, and Faber (2005) classify open communication as patients’ and partners’ disclosures to each other concerning their fears, emotional issues, and doubts associated with cancer. Open communication is often juxtaposed to avoidant communication. Avoidance of communication refers to not discussing an issue or withholding information. Scholars use a variety of terms to represent such communication phenomena. For instance, Hagedoorn et al. (2000) compares “active engagement” (openly talking about concerns and feelings associated with cancer) with “protective buffering” (hiding feelings or concealing information). Depending upon the context, individuals are motivated to disclose or avoid communication for many reasons (e.g., to enhance relational closeness) (see Goldsmith et al., in press, for a review). Likewise, different factors predict individuals’ avoidance and openness (e.g., fear of stigma).

The potential outcomes of individuals’ open or avoidant communication are indicative of whether the behavior of interest functions in adaptive or maladaptive ways. A large amount of
scholarship indicates that open communication functions adaptively in couples’ adjustment to cancer (Boehmer & Clark, 2001; Hilton, 1994; Mallinger et al., 2006; Porter et al., 2005; Rosenberg et al., 2002). This behavior is reportedly the most satisfying form of communication in a marriage, even up to a year past diagnosis (Hilton, 1994). Research involving communication interventions shows similar findings. When men with prostate cancer receive a communication intervention that stimulates open communication in a supportive relationship, they have better pain control and care management over time in comparison to men who do not receive such an intervention (Rosenberg et al., 2002). These findings are also evident in general studies of disclosure, avoidance, and adjustment. Gross and Levenson (1997) noted that selective social interactions likely play a role in not only minimizing emotional distress but in diminishing psychophysiological arousal associated with negative affect. In addition, Pennebaker’s (1995, 1997, 2003) widely cited work reveals that disclosure is critical in healing and regulating emotion when coping with difficult experiences. He has shown that emotional expression, or disclosure, positively affects health by substantially improving psychosomatic conditions (Berry & Pennebaker, 1998; Davison & Pennebaker, 1996). In opposition to openness, avoidance is typically associated with negative outcomes. Individuals engaging in avoidant communication experience poorer relationship functioning, increased psychological distress, and poorer adjustment to cancer in comparison to patients communicating openly (Boehmer & Clark, 2001; Mallinger et al., 2006; Porter et al., 2005). Research relating to avoidance in personal relationships further suggests this behavior is maladaptive, in that avoidance is predictive of relational dissatisfaction (Caughlin & Golish, 2002).

It is not unreasonable to state that Western or North American research clearly favors open communication and its adaptive functioning. The research cited above provides a reason for
this bias. It also reflects a more general bias in scientific research to publish positive results (Goldsmith et al., in press). Although scholarship inconsistent with the bias for open communication does exist, it is much less abundant, particularly in the health-related research. Some research suggests that avoidant communication may function adaptively as well. Two ongoing programs of communication research (Baxter and Montgomery’s dialectics and Petronio’s communication privacy management) indicate that both open communication and avoidance can be beneficial to individuals’ relational well-being (see Baxter & Montgomery, 1996; Petronio, 2002). In this vein, Pederson and Valanis (1998) found that not all families benefit from open communication when adjusting to cancer.

Openness and avoidant communication are complex phenomena, and the research to date demonstrates that neither is all good or bad (Goldsmith et al., in press). Still, much remains unknown about how the forms of behavior influence families’ adjustments to cancer. Goldsmith et al. conclude that the outcomes of these behaviors depend upon the context of communication. According to Goldsmith (2004), “The notion that effective communication must be adapted to a situation to overcome constraints and obstacles is foundational to the study of communication (Clark & Delia, 1979)” (p. 23). The outcomes of avoidance and openness depend on contextual factors, such as features of the communication act, the individuals communicating, their relationship, and the socio-cultural context in which the communication is situated (Goldsmith et al.). Yet, context is surprisingly absent in research on open communication, avoidance, and cancer. Goldsmith et al. identify a variety of contextual factors that conceivably determine whether open communication and avoidance function positively or negatively. Three (the topic of disclosure/avoidance, reason for disclosure/avoidance, and cohort/age diversity) may be
particularly useful in understanding how mothers and daughters use open communication and avoidance to adjust to breast cancer.

*Topic of disclosure/avoidance.* According to Goldsmith and colleagues (in press) the topic of talk (or avoidance) is important. Various topics present different challenges. Accordingly, a given topic could elicit different responses from various interactive partners. The types of cancer-related topics mothers and daughters may openly communicate about or avoid include death, future plans, treatment and its side effects, bodily changes, sexual functioning, daily life, and feelings and fears. Goldsmith et al. suggest that it is likely that some of these topics are more challenging to communicate openly about than others in certain bonds. Pistrang and Barker (1992), for instance, found that women diagnosed with breast cancer talked openly with their spouses and relatives about mortality much less than other cancer-related topics. Similarly, Lewis and Deal (1995) determined that both diagnosed women and their spouses feel that death is the most challenging topic to talk about. Pistrang and Barker (1992) also note that women feel talking about medical aspects of the disease is easiest. However, women in their sample indicated that disclosures were most difficult in their spousal relationships. These findings suggest that not only are some topics more difficult to disclose, but diagnosed women may prefer to only discuss particular topics with certain relational partners. Thus, what women feel comfortable openly discussing with their mothers and adult daughters likely varies. In turn, the adaptive functioning of their open or avoidant communication would vary as well.

*Reason for disclosure/avoidance.* The reasons individuals have for disclosing or avoiding may contribute to the consequences of these forms of behavior. As such, they likely provide insight into why openness and avoidance can function in adaptive or maladaptive ways. In their review of the literature, Goldsmith et al. (in press) observe that some individuals openly
communicate to coordinate support and reassure each other that they can deal with whatever happens in the future. In addition, people may disclose concerns to reaffirm relational closeness or commitment to one another. Thus, openness for these reasons likely functions adaptively. Numerous reasons for not disclosing also exist: protecting one’s relational partner; reluctance to express emotions; maintain privacy, hope, or normalcy; avoid unnecessary talk; and to preserve identity or relational characteristics. These reasons likely vary in mother-daughter communication experiences. In other words, mothers and daughters likely have various motives for avoiding or disclosing certain topics. Accordingly, their reasons for avoidant or open communication would affect whether or not the behavior is helpful or unhelpful in their adjustment.

_Cohort and age diversity._ Cohort and age differences also influence whether or not open communication is apt to enhance individuals’ adjustment to transitions. Differences between cohorts in terms of whether individuals value open communication reportedly exist (Suitor & Pillemer, 2000). Older generations grew up in a more closed environment. In other words, they experienced a culture in which they were not encouraged to express their feelings and concerns freely. In comparison, younger generations have grown up in a social world that more often encourages and accepts openness. As such, they have different open communication preferences. For instance, couples married in recent decades prefer open, frank discussions in opposition to married couples of older generations (Zietlow & Sillars, 1988). Research demonstrates that such differences influence open communication in the parent-child bond as well. For instance, aging mothers are less likely to be open about problems in comparison to their adult children (Suitor & Pillemer, 2000). Additionally, adult daughters tend to communicate more overtly than their aging mothers (Fingerman, 2003; Motram, 2003). While age affects open communicative behavior, it
also influences individuals’ cancer experiences. Age affects how much couples coping with cancer actually talk about adjustment-related issues (Hilton, 1994; Northouse, 1994). Older patients and their spouses tend to discuss cancer less than younger patients and their spouses (Hilton, 1994). Moreover, age affects women’s breast cancer-related concerns, which are potential topics of discussion (Oktay & Walter, 1991).

In sum, the topic of disclosure/avoidance, individuals’ reasons for disclosure/avoidance, and interpersonal partners’ age all influence families’ openness and avoidant behavior. Moreover, these factors partially determine whether open communication and avoidance of communication function adaptively in families’ adjustment to cancer. As such, these factors warrant closer examination. Social support is another form of adaptive family communication frequently studied during difficult times, such as a diagnosis of cancer. Still, in reviewing the current literature, questions remain in how this communication can function both adaptively and maladaptively in families’ adjustment. This literature is reviewed below.

*Enacted Social Support*

Goldsmith (2004) portrays “social support” as a broad construct that can refer to many social phenomena and processes. In general, family social support is an interactional transaction in which members express support to one another. Across disciplines, there are a number of social support taxonomies (e.g., Cobb, 1976; House, 1981; Krishnasamy, 1996) and conceptualizations (e.g., Caplan, 1974; House, 1981; Weiss, 1974). One conceptualization, enacted support, is a frequent object of interest among communication scholars. Enacted support refers to what people say and do for each other and how such behavior can enhance well-being (Goldsmith, 2004). The behavior, in part, defines healthy family communication (Burleson, Albrecht, Sarason, & Goldsmith, 1994). Therefore, examining enacted support can enhance
scientific understanding of how family communication can function adaptively or maladaptively in individuals’ transitional experiences with cancer.

Unfortunately, across disciplines, researchers interested in social support rarely capture actual communicative behavior. Even though social support is conceptualized as an interactive phenomenon, seldom do scholars actually measure social support by focusing on communication. According to Goldsmith (2004),

Interactions in which individuals discuss their problems and communicate various types of support are a central feature of the multifaceted social support construct and yet these interactive processes are among the least studied components of social support. (p. 4)

Instead, most studies assess support-related interactions between patients and loved ones by means of self-report surveys and tend to focus on phenomena other than communicative behavior (Manne & Schnoll, 2001). For instance, scholars use scales to determine patients’ perceptions of available support (Bloom & Kessler, 1994; Klemm, 1994), number of social contacts or size of their social network (Bloom, 1982; Funch & Marshall, 1983), the number of people they feel they can talk to about their concerns (Northouse, 1988), and the number and quality of their relationships (Koopman, Hermanson, Diamond, Angell, & Spiegel, 1998). How people communicatively enact support does not receive attention. In the scholarship involving social support that examines communicative behavior, three types of support are typically the foci: emotional, informational, or instrumental. Scholars then attempt to link the enacted support with patients’ quality of life (House, 1981; House & Kahn, 1985; Kahn & Antonucci, 1980; Thotis, 1985). This is most valuable in understanding how families’ communicative behavior can function both adaptively and maladaptively in their adjustment to cancer.

First, the category of emotional support refers to both verbal and nonverbal communication of caring and concern. This form is arguably most important in patients’
adjustment (Helgeson & Cohen, 1999). Emotional support includes a variety of caring behavior, such as empathizing, listening, reassuring, reciprocity, affect, and comforting. Family emotional support reportedly contributes to better psychological functioning, including less depression (Edwards & Clark, 2004), less mood disturbance (Figueiredo et al., 1994), and better overall adjustment (Manne et al., 1999; Pistrang & Barker, 1992). Some studies have shown that certain types of emotional behavior (e.g., affect and reciprocity) are associated with better quality of life outcomes (e.g., decreased depression) (Primomo et al., 1990). The second type of support, *informational support*, consists of giving or receiving information to advise or guide a loved one. In a cancer context, these types of interactions can alleviate patients’ confusion about their illness. These behaviors also correlate with less depression (see Helgeson & Cohen, 1999).

Finally, *instrumental support* involves the provision of tangible resources such as transportation, finances, or assistance with household tasks. This type of enacted support has also shown a link to better quality of life for patients. Such interactions can improve patients’ well-being by balancing their sense of loss of control. Financial support, for instance, has been associated with better physical recovery (Funch & Mettlin, 1982).

Once scholars categorize communication into one of these three types of support, they also often try to determine whether they are helpful or unhelpful (or perceived by the patient as supportive or unsupportive). In doing this, scholars are able to examine the adaptive functioning of communication. For instance, both Dunkel-Schetter (1984) and Dakof and Taylor (1990) determined that cancer patients perceive emotional support (specifically showing love, concern, understanding, reassurance, encouragement, empathy, affection, and physical presence) as more helpful in their adjustment than informational or instrumental enacted support. In addition, patients have reported that when loved ones enact certain types of emotionally supportive
behavior (e.g., unrelenting optimism), the individual to whom the support was directed may find it to be upsetting (Peters-Golden, 1982). Therefore, in this context, the behavior may constitute an unhelpful or unsupportive communicative response. Patients in some studies have found other emotionally supportive behaviors unhelpful in their adjustment, for example, minimizing the problem, forced cheerfulness, avoidance/withdrawal, insensitive comments, and being told not to worry (Dakof & Taylor, 1990; Dunkel-Schetter, 1984).

Classifying behavior as either helpful or unhelpful is common among scholars studying enacted support across contexts (see Goldsmith, 2004). The behavior has been an object of studies in various challenging circumstances, including cancer, HIV or AIDS, bereavement, depression, work stress, rheumatic diseases, chronic conditions, and divorce. The research is abundant and potentially revealing. Recently, Goldsmith compiled these findings and created a typology consisting of two lists of communicative behavior individuals use to adjust to difficult life events. One list consists of the most commonly reported helpful enacted support, and the second list unhelpful behavior. This research and Goldsmith’s typology contributed to a better understanding of the adaptive functioning of communication during transitions. Nonetheless, this research has some significant limitations.

To begin with, some of the “helpful” forms of enacted support on Goldsmith’s (2004) list are somewhat specific (e.g., expressed affection). On the other hand, other listed categories of behavior are more abstract and could present a variety of specific acts (e.g., engaged in coping). This limitation is evident in both lists. In addition, many of the same types of behavior listed as “helpful” also appear in the “unhelpful” list (e.g., showing concern). Goldsmith herself acknowledges these restrictions and characterizes the descriptions of behavior in this typology as abstract, general, and contradictory. She explains this outcome in relation to limitations in the
existing literature from which the typology was created. She notes that one significant limitation is that scholars consistently overlook the context in which the support is enacted. As previously mentioned, context influences behavioral outcomes (Goldsmith et al., in press). Thus, this disregard for context is problematic.

Context is a critical, multi-dimensional influential factor in individuals’ interactive experiences. Scholars can view context broadly or narrowly (Goldsmith, 2004). Thus, depending on the lens, scholars may focus on how sociocultural, episodic, and/or relational contexts affect communicative behavior outcomes. Social, relational, physical, and temporal aspects of context are critical considerations in understanding supportive communication and its respective individual and relational outcomes (Albrecht & Goldsmith, 2003). The context in which people enact such behavior determines, in part, its efficacy. Hence, context is necessary for understanding how and why we see enacted support behaviors as helpful or not. Recognizing the context in which behavior occurs is also constraining, as it can limit the generalizability of the findings. However, clear individual differences in communication exist (Goldsmith et al., in press). Moreover, without context, the adaptive functioning of these behaviors cannot be fully understood. Goldsmith (2004) argues that “studying enacted support within a particular context is necessary if we are to ask and answer questions about meaningful, purposeful action” (p. 45).

Scholars’ lapse in considering context as a factor in individuals’ communicative experiences may be attributable to the limitations of their methodological approach. Research involving social support research often entails use of self-report survey methodology. Hence, researchers begin with preconceived assumptions about the behavior one enacts in any interaction involving social support. Unfortunately, their presumptions are artifacts of scales created in non-family, non-cancer contexts. For example, Barrera (1981) and Barrera et al.’s
(1983) Inventory of Social Support Behaviors (ISSB) is one scholars studying various social support contexts widely use. Scholars often use this scale to examine cancer patients’ and their families’ interactive experiences. However, the behaviors on which the scale focuses were derived from the social support experiences of college students and single, low-income mothers. Using this scale to measure social support in response to cancer presumes that the way people communicatively enact and receive support is consistent with how college students or single mothers, for a variety of issues, do. However, among families coping with the life-threatening diagnosis, treatment, and survival of cancer, the enactment of social support may be rather different.

Capturing context is an enormous task. As noted previously, context can be viewed through a broad or narrow lens, and scholars may, therefore, choose from among numerous potential foci (e.g., culture, relationship, age, issue of concern, age, etc.). Closer examination of the current social support literature suggests that two specific contextual factors (the relationship in which support is communicated and individuals’ cohort/age) may warrant close consideration in future research and are particularly appropriate for the focus of this dissertation.

Relational diversity. The relationship in which support is enacted affects whether it functions adaptively or not. Patients report that different forms of enacted support behavior can be helpful from the perspective of one type of interactive partner (e.g., doctor) but not another (e.g. family member). Rose’s (1990) findings suggest that patients prefer informational support from medical professionals and one specific type of emotional support (ventilation) from family. Primomo et al. (1990) discovered that some emotional support behavior (e.g., affect) may only be effective in enhancing patients’ well-being when expressed by family partners. Moreover, Rowland’s (1989) and Wortman and Lehman’s (1985) research reveals that some types of
emotional support (e.g., minimizing the problem) appear to be unhelpful when family or friends, as opposed to other relational partners, express them. Such findings suggest that the potential adaptive functioning of communication depends on the person the patient is interacting with. Certain types of support may only be desirable (and efficacious in adjusting) when particular relational partners enact it.

Although these studies demonstrate that the relational context matters, scholars still fail to appreciate fully the bond as a factor of influence. When they have assessed the bond as a source of variance, they have done so in a broad manner. In studies patients typically only identify the type of relationship the support came from (e.g., friend, family member, or medical professional) rather than specify the relationship (e.g., marital, sibling, or parent-child) about which they are reporting (e.g., see Rowland, 1989). In addition, when researchers actually do examine communication in specific family bonds, they reportedly tend only to concern themselves with marital communication. It is likely that this narrow approach stems from the fact that spouses are widely considered the key sources of support for cancer patients (Pistrang & Barker, 1998; Manne & Schnoll, 2001). The fact that other family bonds (e.g., the mother-daughter relationship) play a role in patients’ adjustment has been largely a matter of neglect. This oversight is very disturbing when one considers that mothers and daughters are reportedly important in breast cancer patients’ adjustment (Burles, 2006; Oktay & Walter, 1991; Spira & Kenemore, 2000). More holistic research appreciating this contextual dimension is clearly warranted.

Cohort and age diversity. A second important yet largely overlooked contextual factor is the participants’ age or place in the life course. Communication is a developmental phenomenon (Nussbaum & Friedrich, 2005; Nussbaum, Pecchioni, Baringer, & Kundrat, 2002; Nussbaum,
Pecchioni, Robinson, & Thompson, 2000). Individuals communicate differently and have distinct communication needs as a function of where they are in the life course (Pecchioni et al., 2005). For instance, older individuals often exhibit more competent communication in comparison to younger individuals because they have more life experiences. Age differences also are in evidence in communicative behavior attributable to cohort variability (Segrin, 2003; Zietlow & Sillars, 1988). Zietlow and Sillars explain that because individuals in different generations grew up in contrasting sociocultural contexts, they exhibit different communication preferences. Segrin (2003) found this also to be true of support communication preferences. In comparison to older generations, younger people’s well-being appears to depend more on receiving social support from diverse sources. Finally, age reportedly is a factor in women’s breast cancer experiences. Age at diagnosis drives cancer-related needs and concerns (Oktay & Walter, 1991). Collectively, this research suggests that age/human development/cohort variability is determinant as a factor of influence in individuals’ support communicative experiences that would appear to require further examination.

The scholarship relating to enacted support is especially useful in showing that family communication can function in both adaptive and maladaptive ways. Interestingly, as evident in the review of literature on open and avoidant communication, the efficacy of enacted emotional support communication in patients’ adjustment entails contextual issues, such as the topic of focus, reason for communicating or not, relationship type, and age. Openness, avoidance, and enacted emotional support communication warrant further exploration in respect to how they function in mothers’ and daughters’ adjustment to breast cancer and, thus, their quality of life. Considering such contextual factors can prove to be useful for designing interventions that guide
breast cancer patients and their mothers/daughters in communicatively adjusting in ways that maximize their well-being.

To ensure information produced by studies is suitable for the development of interventions, scholars draw on a variety of theoretical frameworks in examining the adaptive nature of family communication during stressful transitions (Michie & Abraham, 2004). Following is a review of currently used theoretical perspectives, as well as a less frequently in evidence used, yet valuable theory for understanding communication as central to survival.

*Theoretical Frameworks and Adaptive Family Communication*

The health industry needs to expand its approach to cancer care by integrating family communication into the process. A theoretically grounded approach is essential in influencing the health industry in this way. Health intervention scholars (Dean, 1996; Michie & Abraham, 2004) claim that studies must incorporate theory to generate the type of knowledge needed to create interventions and ensure their efficacy in helping families. According to Michie and Abraham, theories provide an explanation for “psychological processes accounting for the initiation, re-direction or cessation of behaviour achieved by the intervention” (p. 33). Still, to increase the likelihood of ever effecting changes in policy and practice in the health-care industry, health scholars and analysts contend that

[Theory is] the most fundamental prerequisite of a policy science … the absence of theory and effective theory building are serious weaknesses of much of the existing research available for the policy making process for improving the health of populations. (Dean, 1996, p. 20)

Hence, a theoretical framework that establishes connections among family communication, cancer, and adaptation is important.

Unfortunately, currently perspectives for understanding family, stress, and adaptation are not well-suited for the situation to which the study applies since they virtually ignore
communication. Most portray coping in terms of cognitive functioning or merely examine resources (e.g., having a large social network). The exclusion of communicative behavior is surprising because communication is integral to families’ adjustment to strenuous circumstances (Afifi & Nussbaum, 2006; Walsh, 1996). It is illogical then that even though adapting to transitions is an interactive process, scholars do not currently use a theory that focuses on communication as a means of adapting to life’s challenges. Laura Carstensen’s (1991, 1992) socioemotional selectivity theory (SST) is a life-span theory of social motivation that explains communication as a means of survival, in that it allows a person to fulfill goals critical to his/her well-being at various points in the life span. Scholars have not yet used SST to study family communication as adaptive behavior in a cancer context. To show SST’s utility in this study, following is a review of the current theories in family and stress literature. A specific focus showing why these theories are not sufficient in achieving the study goals is presented. This review is followed by an explication of SST and its potential value in developing a more comprehensive understanding of family communication as adaptive behavior after a cancer diagnosis.

Currently Used Theories to Explore Family Communication during Transitions

A number of theoretical perspectives have entered into studies of how families cope with stress and adapt to challenging events (see Afifi & Nussbaum, 2006, for a review). Most theories focus on the resources families need to adjust and emerge resilient in the face of such trauma. A common approach is to conceptualize an individual’s social network as a coping resource (Afifi & Nussbaum). Perspectives like the buffering hypothesis (Kaniasty & Norris, 1997) and support deterioration model (Barrera, 1989) suggest that individuals’ social networks affect their adjustment to stressful events. The buffering hypothesis predicts that a person’s social ties can
alleviate mental and physical distress associated with traumatic circumstances (Kaniasty & Norris, 1997). In opposition, the support deterioration model recognizes that one’s social network may function in the reverse. Support from the network may be ineffective and actually contribute to an individual’s distress (Barrera, 1989). These perspectives are useful in recognizing that individuals’ access to social networks (i.e., their friends, family, loved ones) affect how they adjust to stressful changes (Afifi & Nussbaum, 2006). Thus, one’s social network is a resource in coping. However, these theories do not account for how families’ behavior—specifically, communication—within the social network contributes to their adjustment.

Other scholars have utilized theories that approach stress and coping developmentally. These frameworks again reflect a family-resource focus. For instance, life span attachment theory and intergenerational solidarity theory indicate how family attachment is instrumental in helping families cope with difficult changes (Bowlby, 1979; Cicirelli, 1983, 1991). These theories posit that intimacy develops in family bonds across time. Life-span attachment theory holds that some families adjust to stress better because they have closer, stronger attachments (Bowlby, 1979). Thus, relational attachment is a resource people use in coping. On the other hand, intergenerational solidarity theory (Bengston & Harootyan, 1994) holds that families with relational rules and norms about solidarity (i.e., when to “be there” or help out) emerge from stressful events better than families that do not have such rules and norms. Again, this theory posits that a family resource (established family norms of solidarity) affects families’ adjustment. These theories do not, however, illuminate how families communicate to adjust—or how they communicate attachment and solidarity.
Recent theoretical examinations of family and stress have addressed communicative behavior, but as a narrowly characterized family resource. Take, for instance, the concept of “communal coping.” Scholars drawing on it examine how families cope as a whole or collectively (Lyons, Mickelson, Sullivan, & Coyne, 1998). One of the most valuable and widely tested models within this approach, McCubbin and Patterson’s (1982) Double ABCX family coping theory, even includes a communication component. Communal coping is purportedly an effective way of dealing with stressors because family members combine their resources and problem-solving skills to adjust collectively. As a result of their combined efforts, their coping is more effective (Afifi & Nussbaum, 2006). Unfortunately, rather than examine the interactive nature of communal coping, the model presents communication as a resource (both in and outside the family) for adapting to stress. Afifi and Nussbaum note that although this is true and helpful in understanding families’ adjustment, communication is also a means of coping. Hence, a suitable theory must allow for the examination of how communication adjustment is enacted.

Although each of these theoretical perspectives helps explain how families cope with stress, a theory is needed that makes communication central to the adjustment and portrays it as a dynamic, interactive process that influences wellness across the life span. Carstensen’s (1991, 1992) socioemotional selectivity theory approaches human behavior in this way. The following section consists of an explanation of this theory as well as the rationale for using it as the basis for the present study.

Socioemotional Selectivity Theory: Family Communication as Adaptive Behavior

Laura Carstensen’s (1991, 1992) socioemotional selectivity theory (SST) suggests that communication is central to one’s survival across the life span, particularly during life-threatening changes. Communication allows a person to fulfill goals critical to his/her well-being
and adjustment across the life span. Moreover, this theory predicts that individuals carefully choose with whom to interact to attain these goals.

The theory assumes the following: 1) interaction is necessary for survival; 2) humans interact on the basis of personal goals; and 3) people select goals prior to interacting. According to Carstensen, Isaacowitz, and Charles (1999),

Knowledge- and emotion-related goals together comprise an essential constellation of goals that motivates social behavior throughout life … Socioemotional selectivity theory addresses the role of time in predicting the goals that people pursue and the social partners they seek to fulfill them … in order to adapt effectively to their particular circumstances. (pp. 166-167)

Basically, SST posits that time drives human motivation (i.e., goals) and considers this cognitive influence in predicting how people adapt their communicative behavior to achieve their goals. In this study, SST suggested that when women are diagnosed with breast cancer, they may prefer communicating with certain loved ones (e.g., family) to achieve certain goals (e.g., emotionally related goals) due to their time perspective of life. Such interactions are a critical part of their adjustment to the disease.

Predictions of goals and communicative behavior. Human motives critical to survival direct behavior. Individuals prioritize goals on the basis of perceptions of time (Carstensen et al., 1999). They see time as either limited or unlimited. When one perceives it as unlimited, h/she also perceives the future as uninhibited. In opposition, when time appears to be limited, the future appears to be constrained. These perceptions of time direct one’s prioritization of knowledge- or emotion-focused goals. Individuals perceiving an unlimited future prioritize knowledge-seeking goals, as information is a useful resource in the future. In contrast, individuals perceiving a limited future prioritize goals regarding emotional quality of life. They
prioritize present-oriented needs because they value their present circumstances more so than their future.

Once goals are prioritized, individuals select social partners with whom to interact to achieve the goals. Individuals will choose communication partners who best enable them to fulfill these goals (Carstensen et al., 1999). Future-oriented individuals motivated to pursue information interact with any person who can enhance their knowledge of their social and physical world. On the other hand, people with a limited time perspective seeking emotional stability are more selective. They are more careful about determining with whom to interact, as not everyone can help them achieve emotionally related goals. Such a person is apt to seek interaction with individuals with whom he/she already has a strong, relational history. Typically, they choose close, familiar partners (often family members) because they have greater perceived potential to satisfy one’s socioemotional needs.

Markers of time. As noted, an individual’s goals and communicative behavior are ultimately based on his/her perception of time. One’s perspective of time is typically influenced by his/her place in the life cycle. In other words, chronological age determines how much time we perceive we have left in life (Carstensen et al., 1999). Older adults (e.g., age 75) typically view their time left in life as more limited than young adults (e.g., age 25) (Carstensen, 1992; Carstensen et al., 1999; Lang & Carstensen, 1994). Thus, they prioritize emotional goals and tend to select close, familiar interactive partners (like member of the family) to achieve those goals more often than younger adults. However, one’s sense of time can also be affected by life events. According to Carstensen et al. (1999), “endings” are transitional events that are life-threatening in some way. Individuals may experience such transitions at any point in the life span. These events cause people of any age to view time as limited because their end of life
appears closer. When this is the case, they reprioritize emotion-related goals as older adults do and select close interactive partners, such as kin, to adapt to their circumstances.

*Conceptualizing cancer as an “ending.”* A diagnosis of cancer is consistent with SST’s definition of an ending because individuals coping with cancer experience a temporal shift that leads them to prioritize emotionally salient needs. Compas et al. (1999) note that even though an individual diagnosed with cancer may receive a favorable prognosis, the perception that life is threatened is inevitable for the patient and his/her family. In accordance with SST, cancer patients’ and their families’ time perspective of the patient’s life becomes limited. Moreover, cancer heightens one’s emotional needs. This difficult transition is characterized by overwhelming emotions that can result in distress, anxiety, and even depression (David, 1999). Even though the experience of cancer may vary (e.g., site of malignancy, stage of disease, and type of treatment), all cancer patients have similar emotional needs (Helgeson & Cohen, 1999). They most often pursue emotion-related goals associated with self-esteem, perceived control, feelings regarding the future, as well as emotional meaning and processing (Helgeson & Cohen). Again in accordance with SST, present emotional wellness is prioritized when an individual is diagnosed with cancer.

In addition, interaction is vital to cancer patients’ adjustment. Communication within a patient’s social support network is a determining factor in whether or not his/her emotional goals are met (see Kahn & Antonucci, 1980; Thotis, 1985). Cancer patients tend to seek support via interaction with members of their family (Mallinger et al., 2006). Perceived emotional support is associated with patients’ positive social and emotional adjustment, specifically enhanced role functioning, self-esteem, reduced hostility, and life satisfaction (Jamison, Wellisch, & Pasnau, 1978; Zemore & Shepel, 1989). Emotional support appears to contribute to better physical health
(Ell, Nishimoto, Mediansky, Mantell, & Hamovitch, 1992). When a patient’s mental and social health declines, his/her immunity and other biological processes often do as well, which sometimes results in negative health outcomes (Anderson, Kiecolt-Glaser, & Glaser, 1999). Thus, in accord with SST, communication, particularly within kin bonds, appears to be central to patients’ adjustment. Moreover, this communication is emotionally focused because of patients’ prioritization of emotionally related goals.

Breast cancer fits within the framework of SST as an “ending” transitional event that affects women’s perspective of time, social goals, and, ultimately, communication needs and preferences. As noted, SST posits that, regardless of age, individuals experiencing an ending will select close, familiar partners to achieve emotion-focused goals. Carstensen and colleagues’ studies demonstrate that oftentimes individuals select a family partner as their close familiar partner (see Carstensen & Fredrickson, 1998; Fredrickson & Carstensen, 1990). However, these scholars have yet to clearly distinguish a desire for communication with family partners versus any familiar partner as they have conceptualized familiar partners as inclusive of family, friends, and other close loved ones. As noted, the psycho-oncology literature suggests that family relationships are critical to patients’ adjustment (Mallinger et al., 2006). Hence, it is likely that when individuals are diagnosed with cancer, they prefer family members as communication partners. Still, this possibility remains to be established.

**Extending SST**

In testing SST, Carstensen and colleagues have used a list of 18 potential communication partners that include both novel and familiar partners (see Carstensen & Fredrickson, 1998; Fredrickson & Carstensen, 1990). Of the familiar partners, several family bonds are used (e.g., sibling, younger relative, and immediate family). However, when scholars use this list to
examine participants’ communication partner preferences, they do not distinguish between family and familiar partners. Rather, they only distinguish between familiar and nonfamiliar/novel partners. Scholars group all familiar partners (both kin and non-kin bonds). As a result, familial ties are confounded with familiarity in Carstensen’s procedures. Thus, although family members are often the partners with whom participants prefer to interact, an actual preference for a familiar family member and not just any familiar relational partner has yet to be identified. Fredrickson and Carstensen recognize this limitation in their research and even call for scholarship that differentiates familiar and familial social relationships. Doing so can illuminate the importance of family communication in patients’ adjustment and well-being.

Hypothesis and Research Questions

An overarching objective of this dissertation is to encourage the health industry to expand its approach to cancer care by integrating communicatively focused guidance for patients and their families in adjusting to the condition. The research the dissertation reports had two purposes pertinent to this objective: to establish that patients’ families are integral to their adjustment and well-being and, second, that the mother-daughter bond is an especially important kin relationship in women’s adjustment to breast cancer. Hence, it was necessary to capture how women communicatively adjust in their mother-daughter bond and how their behavior affects diagnosed women’s adjustment to cancer.

Importance of Family Communication in Women’s Adjustment to Breast Cancer

Scholarship concerning psycho-oncology suggests that family communication affects patients’ adjustment to cancer. Carstensen’s (1991, 1992) socioemotional selectivity theory (SST) provided a suitable framework for confirming the importance of family communication in women’s adjustment to breast cancer in its prediction that the communication partner preferences
of individuals reflects their perspective on time left in life. When individuals face a possibly
terminal experience, they construct a limited time perspective and give priority to emotionally
related goals, which can only be fulfilled via interaction with close, familiar loved ones,
particularly kin. SST posits that these interactions are critical to individuals’ adjustment and
well-being. Thus, SST provides a basis for predicting the communicative partner preferences of
women diagnosed with cancer.

As mentioned previously, Carstensen’s procedures to test SST confound familiarity with
family. As a result, it is still impossible to claim that family bonds are preferred over other
familiar bonds. Although the psycho-oncology literature suggests that women diagnosed with
cancer will prefer kin communication partners, tests must focus on individuals’ preferences for
kin bonds specifically, rather than just familiar bonds collectively. The following test procedures,
therefore, appear to be necessary. First, healthy women’s communication partner preferences had
to be compared with those of women diagnosed with breast cancer to confirm that they perceive
breast cancer as an ending transition that changes women’s time perspective, prioritization of
goals, and selection of communicative partners. Thus, women’s communication partner
preferences required examination under the following two conditions: 1) a non-ending context:
healthy women not coping with breast cancer or any other ending; and 2) an ending context:
women diagnosed with breast cancer. Second, since chronological age influences one’s time
perspective, decoupling age from time was necessitated for women in each condition following
three age groups: 1) emerging/young adulthood; 2) middle adulthood; and 3) later adulthood.

Given prior research, women in Condition 1 (healthy women) presumably would exhibit
age differences in social partner preferences. Tests of SST indicate that women in later adulthood
prefer communication in familiar bonds more so in comparison to women in young or middle
adulthood. Therefore, it is likely that they would also prefer communication with family partners more so than younger generations. Hence:

**H1:** Older healthy women will prefer to interact with family partners more than young or middle adult healthy women.

Tests of SST also suggest that age is not the only influence on individuals’ time perspectives. Life-threatening events also influence perception of time. Cancer is a time-centered event. Regardless of prognosis, this diagnosis causes patients and loved ones to consider the diagnosed individual’s mortality (Compas et al., 1999). Although the diagnosis of cancer appears to fit Carstensen et al.’s (1999) conceptualization of an “ending,” it has yet to be tested as an ending event within the SST framework. This raised the question of whether cancer leads women of any age to prefer communication in kin bonds, specifically:

**RQ1:** Does breast cancer function in women’s lives as an ending transition by leading them to prefer kin communication partners, regardless of age?

**Mother-Daughter Communication after a Breast Cancer Diagnosis**

Deborah Tannen (2006) has observed in any context, mother-daughter interactions continue to hold “tremendous power” throughout women’s lives: “Words exchanged between daughters and mothers—in the moment or in memory—can carry enormous weight” (p. 4). Previous research has shown the significance of this bond in a breast cancer context. Mothers and daughters encounter relational changes, and they even share the transition psychologically, biologically, and socially (Burles, 2006; Cohen et al., 2002; Cohen & Pollack, 2005; Oktay, 2005; Oktay & Walter, 1991; Spira & Kenemore, 2000). In light of this, mother-daughter communication likely affects women’s adjustment to cancer. Research focusing on communicative adjustment to cancer in other family bonds suggests that the following three
types of communicative behavior warrant further exploration: open communication, avoidance, and enacted support communication.

*Diagnosed women’s open and avoidant behavior in the mother-daughter bond.* The first focus of communicative adjustment concerns how freely individuals communicate about their experience with cancer or, in contrast, how they may avoid interactions to adjust. These concepts reflect Hagedoorn et al.’s (2000) distinction between “active engagement” (regularly openly talking about concerns, thoughts, fears, doubts, emotional issues, information, and feelings associated with cancer) with “protective buffering” (hiding feelings or concealing information). As Goldsmith et al. (in press) note, “Research on ‘the subtle boundaries and conditions of disclosure’ (Duggan, 2006, p. 101) is a central issue for future health communication research.”

Although a plethora of research suggests that when patients engage in open communication with family members, they adjust better (Figueiredo et al., 2004; Hagedoorn et al., 2000; Hilton, 1994; Mallinger et al., 2006; Ostroff et al., 2000; Porter et al., 2005), both open communication and avoidance can contribute to wellness (Baxter & Montgomery, 1996; Pederson & Valanis, 1998; Petronio, 2002). However, contextual factors affect individuals’ use of open and avoidant communication, as well as the respective outcomes of such behavior (Goldsmith et al., in press). The relationship of focus and age of interactive participants, in particular, affect whether open communication and avoidance function positively or negatively. Goldsmith and colleagues suggest that the topic of disclosure or avoidance also matters, as do individuals’ personal reasons for disclosing and avoiding. These contextual factors presumably all have something to do with why openness and avoidance can function in both helpful and unhelpful ways. However, we do not, as yet, fully understand the process.
By exploring women’s open and avoidant communication, it is possible to establish what cancer-related needs and concerns women share with their mother/daughter, their reasons for doing so, how this communicative behavior functions in women’s adjustment to breast cancer, as well as how age enters into the picture. Of particular interest were the following:

RQ2: What cancer-related topics do developmentally diverse women diagnosed with breast cancer openly communicate about in their mother-adult daughter relationship?

RQ3: What reasons do developmentally diverse women diagnosed with breast cancer give for openly communicating about cancer-related topics in their mother-daughter relationship?

RQ4: What cancer-related topics do developmentally diverse women diagnosed with breast cancer avoid talking about in their mother-adult daughter relationship?

RQ5: What reasons do developmentally diverse women diagnosed with breast cancer give for avoiding cancer-related topics in their mother-daughter relationship?

Mother-daughter enacted support communication. Current research suggests that in comparison to patients with good family support, those without it often have more depressive symptoms, troubled relationships, and cancer-related symptoms (Helgeson & Cohen, 1999). Ultimately, patients need strong family support to enhance their quality of life (Suinn & VandenBos, 1999). Enacted support communication can be classified as emotional, informational, or instrumental in nature, as well as helpful or unhelpful (adaptive or maladaptive). However, the impact of this communication is, in part, a function of the context in which the support is enacted. Specifically, it appears that the relationship and interactive participants’ age/development are important contextual factors in determining whether enacted support functions adaptively or not (Goldsmith, 2004). However, scholars’ methodological approaches limit their ability to capture context. Most use scales based on communication in
other contexts (e.g., college) in other relationships (e.g., friends). A qualitative study would give participants a better opportunity to explain the adaptive functioning of communication by describing the context in which it occurs and their emotional responses to it.

Socioemotional selectivity theory suggests that after a breast cancer diagnosis, emotional goals take on high priority. Thus, specifically emotional enacted support warrants close examination as does the influence of women’s age on their support experiences in the mother-daughter bond. Emotional support encompasses both verbal and nonverbal displays of caring and concern important in diagnosed women’s adjustment to cancer (Helgeson & Cohen, 1999). The nature of the interactions has yet to be revealed in precise ways, however. Accordingly:

RQ6: How do developmentally diverse women diagnosed with breast cancer and their mothers and adult daughters communicatively adapt to breast cancer through enacted emotional support?

RQ7: How does mothers’ and daughters’ enacted emotional support function adaptively or maladaptively in diagnosed women’s adjustment?
Chapter 2

METHODOLOGY

Overview of the Multiple Methods Design

This dissertation has two purposes: 1) to determine the importance of family communication in adjusting to the difficult transition of cancer and 2) to explore how mothers and adult daughters communicatively adapt to breast cancer. This seemed to require a multiple methods design and the collection of both cross-sectional and longitudinal data. A single phase (monostrand) quantitative design served the first purpose and related to Hypothesis 1 and Research Question 1. A multimethods qualitative design served the second purpose, as related to Research Questions 2-7. The sampling, recruitment, participants, measures, procedures, and data analyses are discussed within Chapter 2.

Importance of Family Communication after a Cancer Diagnosis

Sampling

The study required women who represented the two previously described conditions: 1) healthy and not coping with breast cancer or any other ending experience and 2) diagnosed with breast cancer. Participants for Condition 2 included only women diagnosed with breast cancer who had received some sort of treatment (e.g., surgery, radiation, or chemotherapy) within the last 12 months. Two months into recruitment, however, this time range was expanded to 18 months since treatment and after four months, to 36 to ensure an appropriately sized sample.

Decoupling age and time required a cross-sectional design. Thus, women in each condition represented three age groups: 1) emerging and young adulthood (age 18-39); 2) middle adulthood (age 40-56); and 3) later adulthood (age 57+). The age distributions for each developmental period are the standards in developmental research (e.g., see Schaie, 2005).
Although, the third group (later adulthood) typically begins at age 60, this age range was slightly expanded to begin at 57 after recruitment ended. This change was necessary as the recruited women in this group were in the earlier age range of later adulthood (e.g., average age of participants was 61.92). Hence, the age range was altered to assure the recruited sample more accurately represented three developmental periods. Sampling was purposive since predefined groups of women were needed and proportionality was not the primary concern. Rather, the goal was to include women who could best describe experiences relevant to the research topic (breast cancer and communicative adjustment) during particular points in the life span (young adulthood, middle adulthood, and later adulthood).

Recruitment

Following IRB approval, selection occurred in numerous ways. Communication Arts and Sciences helped to recruit participants for Condition 1. They received credit for their participation, which involved asking their mothers and/or grandmothers to participate. Recruitment for women representing Condition 2 was more expansive and occurred over six months (from May-November 2007). Recruitment involved Communication Arts and Sciences’ students, local flyer postings, the university newswire, local hospitals and support groups, local cancer clinics, and cancer Web sites. All ads and flyers included a phone number and email address to which one could refer to if interested in participating.¹

Online recruitment ads appeared on the university newswire and cancer Web sites, including a Canadian site for individuals diagnosed in young adulthood. Recruitment flyers also appeared on bulletin boards in local grocery stores. In addition, several cancer clinics in central Pennsylvania agreed to post recruitment flyers in their offices. One breast health and cancer clinic in Williamsport, Pennsylvania (Kathryn Candor Lundy Breast Health Center) agreed to

¹ Recruitment for Condition 2 also advertised participation requirements for the qualitative portion of the study.
distribute flyers to newly diagnosed women. This center is part of the three-hospital system of Susquehanna Health in Pennsylvania and one of the most comprehensive in the state. It has an array of specialists including surgeons, nurse specialists, mammographers, ultrasonagraphers, radiologists, and pathologists. The Registered Nurses working in this clinic received direction from the Head Nurse, a Breast Health Specialist (who was also my contact with the clinic). She taught her staff how to provide newly diagnosed women with a packet of information immediately after diagnosis. This packet of information included the recruitment flyer. The nurses did not explain the study or what participation would entail. They merely provided the women with the flyer to learn about the study. If a newly diagnosed woman expressed interest in participating at that time, the nurse asked her to write her name, contact information, and the best days/times to be reached on a pre-addressed, stamped postcard. The clinic’s staff mailed the postcards to me. The postcard was general to ensure that women’s health status was not linked with their name in any public manner. Once I received a postcard, I contacted the respondent about participating.

Recruitment also occurred in two central Pennsylvania hospitals. Both are affiliated with the Penn State Cancer Institute (PSCI). PCSI is a network of medical institutions providing care in rural areas (27 counties) of central Pennsylvania. It consists of four partnering institutions: the Penn State University College of Medicine and Penn State Hershey Medical Center in Hershey (HMC), the Lehigh Valley Hospital Health Network in Allentown, and the Mount Nittany Medical Center in State College (MNMC). Services are also now available at the Lewistown Hospital. Together these institutions provide care to nearly 6,000 new cancer patients each year, which is more than any other cancer center in the state of Pennsylvania.
To begin recruitment, I contacted MNMC. This institution is a 201-bed acute-care community hospital located in State College, PA. It provides breast-cancer care via a multidisciplinary team approach that includes physicians, nurses, therapists, nutritionists, rehabilitation specialists, social workers, pastoral care providers, and counselors. I also contacted HMC, specifically the Women’s Health Center, which offers breast-cancer services as well as Radiology Breast Imaging. This hospital is a larger level-1 trauma center located just outside Harrisburg, PA with more than 500 beds. The Cancer Institute also emphasizes interdisciplinary patient care. Medical, surgical, and radiation oncologists jointly determine the best therapeutic care plan for each patient. HMC’s Institute is currently applying for National Cancer Institute designation and wishes to emphasize providing care to rural, underserved populations.

These two recruitment efforts required additional IRB applications with each hospital’s board. Once approval was obtained at each hospital, the following recruitment procedures were initiated. At MNMC, recruitment was conducted in collaboration with the hospital’s Administrative Director of the Cancer Program. A mailing consisting of two letters (one from the Administrative Director and one from me) and a recruitment flyer went to 80 women who participated in the hospital’s breast cancer support group. To ensure privacy, once the envelopes were stuffed and stamped, the Director attached address labels and mailed the envelopes. The Administrative Director also posted flyers in “heavy traffic” areas of the hospital (e.g., cancer treatment clinic, with a cancer navigator, etc.).

At HMC, recruitment was coordinated with the hospital’s Women’s Health Clinic and Breast Imaging via collaboration with the Section Chief Physician of Breast Imaging, the Chief Radiology Technologist of Breast Imaging, and the Women’s Health Clinic’s Head Nurse and Coordinator of Breast Care Services. Upon IRB approval, I visited this center to train the Chief
Radiology Technologist of Breast Imaging and her team of six technologists and two support associates concerning how to distribute information to patients. They each received an instruction card that listed who they should give the information to, namely women having mammogram appointments with a history of breast cancer treatment within the last 36 months. This card further instructed technicians and nurses to give women who qualified an envelope containing a letter from the physician, one from me, and a recruitment flyer. The medical staff did not explain the study nor what participation would entail. They simply provided the women with information about the study to read on their own. The Coordinator of Breast Care Services and the Clinic’s Head Nurse also distributed flyers at several of the hospital’s monthly breast cancer support group meetings. Finally, the Chief Physician had flyers posted on hospital bulletin boards and distributed information to the physicians in Radiology Breast Imaging.

Participants

Three-hundred-three women qualified for Condition 1. Of these, 125 of these women were emerging/young adults. The average age was 19.99 (SD = 1.88) within a range from 18-33. Nearly 100 (N = 98) of the women were in middle adulthood. Their average age was 49.40 (SD = 3.54), and they ranged in age from 40-56. Finally, 80 women were in later adulthood. The average age was 74.73 (SD = 6.74). They ranged from 60-94.

Forty-one women qualified for Condition 2. However, only 39 returned the questionnaire. As with the first phase, the participants comprised three groups (young adulthood, middle adulthood, and later adulthood) in previously mentioned age ranges. Of the 39 women who participated, 9 of these women were emerging/young adults. Their average age was 34.63 (SD = 3.34) and encompassed a range from age 30-39. Another 18 women were in middle adulthood. Their average age was 48.16 (SD = 3.11), with a range from 42-52. Finally, 12 women were in
later adulthood. Their age on average was 61.92 (SD = 4.48) and ranged from age 57-69. Time since treatment was variable. Some participants were currently in treatment (27.5%), 37.5% had had treatment within the past 12 months, and 35% of women had treatment within 12-36 months prior to their participation. They also varied according to stage at diagnosis: 41% were in stages 0 or 1, 27.5% in stage 2, 25% in stage 3, and 5% in stage 4. Four of these women were experiencing a recurrence.

*Procedures*

Once the women agreed to participate, they received an envelope containing materials to complete. For those in Condition 1, this envelope contained a consent form (see Appendix A), demographic questionnaire (see Appendix B), and questionnaire concerning their interactive partner preferences (see Appendix C). For the ones in Condition 2, the envelope included the same materials but also additional information for use in the qualitative phase of the dissertation, as most of these women also participated in that part of the study.

Participants picked up the envelope from a box in my office, received one via mail, or acquired it from the student from the university who had previously contacted them. If women received an envelope by mail, it contained a self-addressed, stamped envelope to use to return the materials. Those picking up the envelope in my office were to return the completed materials in the sealed envelope to a box in my office. If women received an envelope from a student, he/she returned the completed materials in the sealed envelope to my office. These students did not explain any study procedures. They simply gave the envelope to the women they recruited and then returned the sealed envelope upon completion.
Measures

For the first phase of the study, which focused on the first research question and hypothesis, the participants completed forms: a consent form (see Appendix A) and a questionnaire relating to the research condition. For Condition 1, the background questionnaire yielded basic demographic information and served to ensure that none was experiencing any type of ending. For those in Condition 2, this questionnaire also called for information about their breast cancer experiences (see Appendix B).

To obtain information about women’s communicative partner preferences, and test Hypothesis 1 and answer Research Question 1, this involved slight modifications of procedures used by Carstensen and colleagues (e.g., see Carstensen & Fredrickson, 1998) to test SST. In their studies, they presented participants with an 18-card set consisting of a potential partner on each card (Carstensen & Fredrickson). Each description was general so as to apply across ages (e.g., “a younger relative” as opposed to “a grandchild”). Participants identified on the cards with whom they most liked to spend their time. The investigator then divided responses into one of two categories: familiar or novel partners. For the current study, partners appeared on a sheet of paper (see Appendix C). This modification ensured that women not residing in the area could participate. Women in both conditions wrote on the sheet three individuals from the list with whom they most liked to spend their time, in order of preference. I then grouped women’s first choices into one of two categories: family or nonfamily partners.

Data Analysis

Hypothesis 1 addressed whether a time limited perspective, due to being closer to the end of life because of age, leads women to prefer family communication partners. Hence, the social partner preferences of women in the three age groups were examined and compared. Research
Question 1 focused on whether a time limited perspective, due to being closer to the end of life because of a cancer diagnosis, leads women to prefer family communication partners. As in the case of Hypothesis 1, women’s partner preferences were examined and compared across age groups. Chi-square tests of association revealed whether frequency distributions of women’s social partner preferences of kin bonds differed by age groups. Consistent with Carstensen and colleagues’ tests of SST (e.g., see Fredrickson & Carstensen, 1990), such tests of association are appropriate for assessing the relationship between two categorical variables (Field, 2005).

Mother-Daughter Communicative Adjustment Post-Diagnosis

The qualitative portion of the study involved multiple qualitative methods and was conducted within an interpretive paradigm. The goal of this part of the research was to understand the cancer patient and her mother/daughter’s experiences by documenting and analyzing their interpretation of events (van Manen, 1990). A qualitative approach was necessary in this portion of the dissertation to ensure mothers’ and daughters’ communication experiences were captured accurately. This emphasis on the interpretation of insiders increased the potential for the research to reveal new, unexpected factors in the cancer experience (Waxler-Morrison, Doll, & Hislop, 1995).

To ensure the findings are useful, rigor must be attained in the study. Hence, scholars must determine reliability and validity. In the 1980s, the terms “reliability,” “validity,” and “rigor” were replaced in qualitative inquiry with the concept of “trustworthiness” (Guba & Lincoln, 1981, 1982; Lincoln & Guba, 1985; Morse et al., 2002). Lincoln and Guba (1985) suggested new criteria for determining reliability and validity or to be “trustworthy.” To be trustworthy, the research must satisfy the following criteria: credibility, transferability, dependability, and confirmability. According to Morse et al. (2002), “Reliability and validity
have been subtly replaced by criteria and standards for evaluation of the overall significance, relevance, impact, and utility of completed research” (see http://www.ualberta.ca/~iiqm/backissues/1_2Final/html/morse.html). Hence, these criteria are useful in evaluating the trustworthiness of a study after it is complete rather than ensuring rigor throughout the research process. They further state, “Strategies to ensure rigor inherent in the research process itself were backstaged to these new criteria to the extent that, while they continue to be used, they are less likely to be valued or recognized as indices of rigor.”

Today, however, some qualitative scholars argue that indices of reliability and validity should still be used in qualitative scholarship to ensure rigor throughout the research process. Even though scholars in Great Britain and Europe still use the terms reliability and validity in qualitative inquiry, only a few scholars do so in North America (Morse et al., 2002). They argue that these criteria are applicable in all scholarship as “the goal of finding plausible and credible outcome explanations is central to all research” (Morse et al., 2002; see Hammersley, 1992; Kuzel & Engel, 2001; Yin, 1994). Morse (1999) claims that by ignoring the centrality of reliability and validity in qualitative research, scholars promote the belief that qualitative inquiry is unreliable, invalid, lacking in rigor, and, essentially, not science.

According to Morse et al. (2002), the terms reliability and validity should be used in qualitative inquiry. They also argue against introducing parallel terminology and criteria because doing so can marginalize qualitative scholarship from mainstream science. They note,

Compounding the problem of duplicate terminology is the trend to treat standards, goals, and criteria synonymously, and the criterion adopted by one qualitative researcher may be stated as a goal by another scholar. For example, Yin (1994) describes trustworthiness as a criterion to test the quality of research design, while Guba and Lincoln (1989) refer to it as a goal of the research … While strategies of trustworthiness may be useful in attempting to evaluate rigor, they do not in themselves ensure rigor. While standards are useful for evaluating relevance and utility, they do not in themselves ensure that the
research will be relevant and useful. (see http://www.ualberta.ca/~iiqm/backissues/1_2Final/html/morse.html)

Hence, Morse et al. (2002) claim that qualitative researchers should ensure the study’s utility by employing verification strategies throughout the research process (instead of only after the study is complete) thereby making it a criterion to test the quality of the research design (see also Morse, Barret, Mayan, Olson, & Spier, 2002). They argue that the investigator should be responsible for the rigor of the study, rather than the readers or participants (which Guba and Lincoln (1981) note can be a threat to validity).

Verification includes

Checking, confirming, making sure, and being certain … [Verification] refers to the mechanisms used during the process of research to incrementally contribute to ensuring reliability and validity and, thus, the rigor of a study. These mechanisms are woven into every step of the inquiry to construct a solid product … [by] forc[ing] the researcher to correct both the direction of the analysis and the development of the study as necessary (Morse et al., p. 9; see also Creswell, 2007; Kvale, 1989).

I employed verification strategies throughout the research process (e.g., during sampling, data collection, analyses, and presentation of results) to ensure the study design and findings were trustworthy and rigorous. The verification strategies included attention to: investigator responsiveness and flexibility; theoretical sampling and sampling adequacy; methodological coherence/congruence; triangulation; an active analytic stance; an audit trail including conceptual, operational, and reflexive memos; theoretical saturation; and presentation of rich, descriptive findings (Creswell, 2007; Lincoln & Guba, 1981, 1985; Morse et al., 2002).

**Sampling and Recruitment**

Given that the second purpose of the study was to explore how mothers and daughters communicatively adjust to breast cancer and capture the adaptive functioning of their communicative behavior, purposive sampling again seemed to be appropriate. Of importance
was involving women who could best describe experiences relevant to the research topic. All 41 women who qualified to participate in Condition 2 of the quantitative portion of the dissertation also had the opportunity to participate in the qualitative phase. One of the women (a diagnosed young-adult daughter) participating in the quantitative portion declined. Two women (both diagnosed middle-adult mothers) who failed to return their questionnaires for the quantitative part of the study did participate in the qualitative part. The total, then, was 40 diagnosed women. Thirty-eight of their mothers/daughters also participated in the qualitative part of the dissertation. Each participant received $25 compensation.

The sampling criteria were expanded twice after two and four months of recruitment to allow for a suitably sized sample. This helped assure methodological coherence. The goal of methodological coherence is to make certain that there is congruence between the research question and method used.

The interdependence of qualitative research demands that the question match the method, which matches the data and the analytic procedures. As the research unfolds, the process may not be linear … Sampling plans may be expanded or change course altogether. (Morse et al., 2002, see http://www.ualberta.ca/~iiqm/backissues/1_2Final/html/morse.html )

In short, the researcher can adjust the study as needed, in this case to have an adequate sample, to maintain reliability and validity of the study.

Participants

Of the 78 women who participated in the qualitative investigation, 40 had been diagnosed with breast cancer and received treatment within the last 36 months. These women represented three age groups. The middle adulthood age group represented two types of dyads: midlife diagnosed daughters and their mothers and midlife diagnosed mothers and their daughters. Of the diagnosed women, 8 were young adults (all as daughters: Mean age = 34.62, SD = 3.34, Age
Range 30-39), 20 in middle adulthood (13 as mothers: Mean age = 49.42, SD = 2.50, Age Range 44-52; 7 as daughters: Mean age = 46.00, SD = 3.00, Age Range 42-51), and 12 in later adulthood (all as mothers: Mean age = 61.92, SD = 4.48, Age Range 57-69). The remaining 38 women represented the mothers and adult daughters of diagnosed women. Of the mothers or adult daughters of diagnosed women, 25 were emerging/young adults (all as daughters: Mean age = 24.74, SD = 6.94, Age Range 18-37), 5 in middle adulthood (4 as mothers and 1 reporting as a daughter: Mean age = 54.00, SD = 2.35, Age Range 51-56), and 8 in later adulthood (all as mothers: Mean age = 69.86, SD = 7.59, Age Range 58-83).

A total of 35 mother-daughter dyads (N = 70) took part. Three of these dyads also had an additional daughter participate (i.e., a mother and 2 of her daughters) (N = 3). Five diagnosed women participated without a mother/adult daughter dyadic partner. Their mothers/adult daughters did not participate for various reasons (e.g., could not be contacted, refused to participate, or the woman did not want her to participate).

As was noted earlier, sociocultural context is an important factor that influences individuals’ interactive experiences (Goldsmith, 2004). These participants represented a Northeastern small, rural community, primarily. However, other factors, including ethnicity or race, socioeconomic status, education level, and marital status, were aspects of the context. Hence, this sociocultural information on these 78 women was compiled. Among the participants, 98.7% were Caucasian and 85.3% lived on the East Coast. About half of the women had incomes under $70,000 per year, whereas the other half had annual incomes of greater. Half were currently married, 20% were single, 10% were separated, 10% divorced, and 10% were widows. Half the women worked full time, 21.3% worked part-time, 16% did not work, and 17.3% were
Most had a college-level education, with 40% earning a baccalaureate or graduate degree, and 41% having an associate’s degree or some college credit.  

**Procedures**

The participants had completed materials for the quantitative phase of the dissertation. Then upon consenting to take part in the qualitative phase (see Appendix D), they independently completed a slightly modified version of the Retrospective Interview Technique (RIT) graph (Baxter & Bullis, 1986 and Huston, Surra, Fitzgerald, & Gate, 1981) (see Appendix E). This graph provided participants with an opportunity to reflect on mood-altering events they experienced while coping with cancer. RIT graphs appear in studies concerned with experiences across time and serve to reveal how individuals adjust to changes (Metts, Sprecher, & Cupach, 1991). Women were provided a sample version of the RIT graph to reference since they were completing the graph without me present. The participants completed the turning point graph on the day of the interview but prior to it. This graph helped to ensure that their thoughts and memories were fresh in their minds when the interview began. All 78 women took part in an individual, in-depth, life-span interview. A subsample of 10 women (or 5 dyads) also kept a 2-week daily diary of their mother-daughter interaction. Eight subsequently participated in a debriefing interview relating to their diary entries (diary-interview). Those participating in the diary segment were currently undergoing treatment, either radiation therapy or chemotherapy.

Upon initial contact for participation (which either occurred via email or telephone), a date/time was set for women to participate in a life-span interview via telephone or in person. During this contact, they also provided their mailing addresses so that they could receive a

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2 The demographic information specific to each age group of dyads appears in the first results section (findings on openness) to make clear the sociocultural context of women in each age group of mother-daughter dyads.
package containing all materials for both phases of the dissertation. They subsequently received a reminder via email 2-3 days prior to their interviews.

As noted, women received a package containing materials to complete for both phases of the study. If the interview was via telephone, they also received a self-addressed, stamped envelope for returning the materials following the interviews. At the time of initial contact, they learned that once they received the package, they could complete all materials at their convenience as long as they did them prior to the interview date, with the exception of the interview RIT graph. They were to complete the graph independently the day of the interview but before it began. At two different points, participants received explicit instructions concerning completing materials: during their initial contact (i.e., when the interview appointment was set) and again as a print-out of these instructions were in the mailing. The participants received a folder containing a letter from me with instructions attached to a folder. Inside the folder, the left-hand pocket included materials to be completed at any time (with an additional instruction sheet indicating this), and the right-hand pocket included the material to be completed the day of the interview (with an additional instruction sheet indicating this). On the day of but prior to the interview, the participants had an opportunity to raise concerns or questions regarding these materials they may have had while completing them.

Once the in-depth, individual interview was over, the participants placed completed forms in the mail. When interviews were face-to-face, I collected the materials before the interviews began. If one was also participating in the diary-interview portion of the qualitative

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3 It appeared to be appropriate to use these pre-mailing procedures with face-to-face interview participants as well after testing in-house procedures with 5 face-to-face interview participants. At the beginning of their interview appointment, women informants completed all materials for the quantitative and qualitative parts of the study. This approach was more time-consuming and exhausting for participants. Thus, mailing procedures were initiated for the remaining participants. Those who scheduled face-to-face interviews brought their completed materials to the interview.
phase, immediately after the interview she received instructions concerning how to keep the
diary (A print-out of the instructions also appeared at the front of the diary.). If one took part via
telephone, she received this paper diary in the same mailed package containing the other
materials. Those interviewed face-to-face received the diaries after the interview. They were
asked to begin the diaries once both members of the dyad had completed their interviews and
then to return them after a two-week time period. Those taking part in face-to-face interviews
received information concerning a time and place to return the diary to me. Interviews to de-brief
and provide more detailed explanation of the diary entries occurred about 1 week after the
completion of each participant’s final diary entry.

Qualitative Methods

In the qualitative phase of the study, 78 women participated in a life-span, in-depth
interview. A subsample \( N = 10 \) kept a daily diary, and a subsample \( N = 8 \) of these women
participated in a debriefing interview (diary-interview). Following are descriptions of these
methods of acquiring data.

Life-Span Interview Method

The majority of women \( N = 55 \) participated in interviews via telephone. Most lived 60
or more miles outside the campus area. Only 23 women participated in a face-to-face interview
in the Communication Arts and Sciences’ research laboratory. They lived on the university’s
campus or in the immediate geographic area.

The individual in-depth interview was approached using a life-span method in that
women described their mother-daughter communication experiences beginning immediately
before the diagnosis of cancer, across the life span of the disease, and up to the present. This
made it possible to understand the changing nature of the cancer experience, the mother-daughter
relationship, and communicative behavior, as well as to obtain baseline data. This also permitted assessment of women’s experiences when diagnosed at different points of the life span. Modified versions of two comparable interview techniques (Lifeline Interview Method/LIM or “flowing river of life” and Retrospective Interview Technique or RIT) were used. The LIM approach is strongly recommended for life-span studies (Schroots & Birren, 2001), and RIT is also commonly used in life-span and developmental studies of relational communication (Baxter, Braithwaite, & Nicholson, 1999; Baxter & Bullis, 1986; Golish, 2000; Graham, 1997). They are virtually the same method but incorporate different language (e.g., LIM embraces a sociological perspective, whereas RIT reflects a psychological and communicative perspective). Via this technique, participants receive a modified version of an RIT graph prior to the interviews (see Appendix E). As previously noted, this graph went to the participants before the interviews. This graph provides women an opportunity to reflect on their cancer-related experience and their mother-daughter relationship.

Each participant plotted the course of the disease (or its lifeline) on the RIT graph. Time was represented on the horizontal axis, and affect/emotion was represented on the vertical axis. The upper levels on the vertical axis represented high positive affect (happy or pleasant feelings), whereas lower levels corresponded to more negative affect (upsetting, distressful, or sad feelings). On this axis, strength of mood was not specifically indicated on the graph. It was necessary to only identify the positive/negative changes in mood as a result of cancer challenges because the primary concern was how they communicatively adjusted (using open communication, avoidance, and/or enacted support) to manage such feelings and related events.

Instructions for how to complete the graph appeared on the graph itself. They were as follows:
There are no right or wrong answers. Everyone who completes this graph has a unique representation of their experiences with breast cancer.

Please use this graph to plot out turning points you have experienced as they relate to cancer. These turning points are moments when you recall changes in your own emotional well-being. This graph is a chance for you to reflect on your experiences and take some time to recall them. We will use this graph to guide us during part of the interview.

Recall the period before you were diagnosed. Please draw a dot above the label "Pre-Diagnosis" to indicate your emotional state at that time. "Low emotional state" means you had negative feelings at that time and "High emotional state" means that you had positive emotions during that time. If you were dealing with something that was stressful (e.g., marital problems) or uplifting (e.g., recent birth of a child) in some way, please write one word or a brief phrase above the dot to note this. Next, please make a dot above the label "Diagnosis" to represent how your emotions changed once you were diagnosed.

Now I’d like you to make any dots on the graph when your mood changed positively or negatively since you were diagnosed. You may recall changes in your emotions due to a specific event (e.g., having surgery) or it may not be in reference to a specific event (e.g., you just recall a change in your mood for some reason). Please write a brief description of what the turning point was at that time (e.g., “ended treatment”). You may also recall turning points that didn’t specifically relate to cancer but that clearly affected your mood (e.g., death of family member, new marriage in the family, etc.). You may find these important to your experience so please feel free to plot them as well. Do this up until the present day. Once you reach the end of the graph, please rate your present mood above the label "Present Day." Finally, connect the dots that you plotted with a line.

The mothers/daughters of diagnosed women received slightly different instructions. They had to plot two lines. They plotted their perceptions of their diagnosed mothers’/daughters’ lifeline of the disease in addition to their own personal experience with their mothers’/daughters’ disease. This modification permitted better assessment of how mothers and daughters share the breast cancer transitional experience. Following are the instructions they received:

There are no right or wrong answers. Everyone who completes this graph has a unique representation of their experiences with breast cancer.

Please use this graph to plot out turning points you and your daughter/mother have experienced as they relate to cancer. These turning points are moments when you recall changes in your own emotional well-being. This graph is a chance for you to reflect on your experiences and take some time to recall them. We will use this graph to guide us during part of the interview.

You will plot two lines:
1) one line will be your perspective of changes in your daughter/mother's emotional well-being
2) the second line will be your own experiences or changes in your own emotional well-being

Please begin with the first line or your daughter/mother's experiences. Recall the period before she was diagnosed. Please plot her emotional state at that time, above the label "Pre-Diagnosis." "Low emotional state" means she had negative feelings at that time and "High emotional state" means that she had positive emotions during that time. If she was dealing with something that was stressful (e.g., marital problems) or uplifting (e.g., recent birth of a child) in some way, please write one word or a brief phrase above the dot to note this. Next, put a dot to represent any changes in her emotions once she was diagnosed above the label "Diagnosis."
Now please make any dots on the graph when you felt your mother's mood changed positively or negatively. You may recall changes in her emotions due to a specific event (e.g., having surgery) or it may not be in reference to a specific event (e.g., you just recall a change in her mood for some reason). Please write a brief description of what the turning point was at that time (e.g., “ended treatment”). You may also recall turning points that didn’t specifically relate to cancer but that clearly affected her mood (e.g., death of family member, new marriage in the family, etc.). You may find these important to her experience so please feel free to plot them as well. Do this up until the present day. Once you reach the end of the graph, please rate her present mood above the label "Present Day." Connect the dots that you plotted with a line and label it “Line #1.”

Now I'd like you to plot your own personal experiences with breast cancer in the same manner that you did for your mother’s line. Once you reach the end of the graph, please rate your present mood above the label "Present Day." Connect the dots that you plotted with a line. Label it Line #2.

The individual in-depth interview protocol was semi-structured and guided by a script to ensure coverage of pertinent issues (see Appendix F), including exploring experiences with communicative adjustment to cancer, namely mother-daughter open communication, avoidance, and enacted support. The procedures for both the face-to-face and telephone interviews were similar. The same script was used and covered the same matters. The only difference involved was the location of the interview.

To obtain baseline data relating to one’s mother-daughter relationship prior to the onset of the cancer, each interview began with women describing their bond prior to the diagnosis. They then indicated how they felt cancer affected their relationships and whether communication changed. The interviewees also described how they communicatively adjusted (specifically in respect to open communication, avoidance, and enacted support) from the point of diagnosis to the present, their perceptions of their mothers'/daughters’ behavior, and connected these behaviors with their perceived quality of life. The interviews served to elicit information specific to openness, avoidance, and ways in which participants perceived support had been enacted in their relationship. They also described aspects of the breast cancer experience they shared with their mother/daughter, their reasons for doing so (or not), and their level of openness about their experiences. Finally, they shared their completed RIT graphs. This provided a source of further detailed information about the participants. They discussed each turning point they plotted on the
graph, how they felt at that time, how they communicatively adjusted, whether their mothers/daughters were a part of these experiences and, if so, what specific interactions occurred. Before the interview ended, the participants had an opportunity to mention anything they felt was important in understanding breast cancer, mothers, and daughters.

Throughout the interviews, questions were added, eliminated, or rearranged to be responsive to the needs of the participant and faithful to the inductive research design. Such flexibility is especially important if one is to attain rich information about emergent themes and better ensure saturation of categories. Strauss and Corbin (1998) explain that “Saturation is more a matter of reaching the point in the research where collecting additional data seems counterproductive; the ‘new’ that is uncovered does not add that much more to the explanation at this time” (p. 136). Flexibility and responsiveness are critical to establishing trustworthiness and maintaining rigor throughout the research process. Morse et al. (2002) claim that

Responsiveness of the investigator to whether or not the categorization scheme actually holds (and is kept), or appears thin and muddled (and the scheme is changed), influences the outcome. In this way, it is essential that the investigator remain open, use sensitivity, creativity and insight, and be willing to relinquish any ideas that are poorly supported regardless of the excitement and the potential that they first appear to provide. It is these investigator qualities or actions that produce social inquiry and are crucial to the attainment of optimal reliability and validity.
(see http://www.ualberta.ca/~iiqm/backissues/1_2Final/html/morse.html )

Individual in-depth interviews ranged from 38-152 minutes long and, on average, lasted about 90 minutes. All participants gave permission to have their interviews audio-recorded. Of the 78 interviews, 72 were professionally transcribed in full with a basic transcription (words spoken but no utterances; notations of strong emotion such as laughter or crying), which resulted in 2,434 single-spaced transcribed pages of data. One audio file was inaudible/damaged. For analyses, the interview notes and memos were used. In accordance with theoretical analysis, the first 72 transcripts were analyzed. Then I transcribed the final 6 interviews to verify coding
categories and attain consistency. These transcriptions only included pertinent information for theoretical saturation of categories. As noted previously, saturation exists when no new information emerges during coding.

*Diary-Interview Method*

Triangulation is one way that researchers can employ multiple tools to assess the same phenomena and deepen understanding of them (Daly, 2007). Doing so enhances the validity and credibility of findings (Meetoo & Temple, 2003). In this study, the diary-interview method was employed to permit triangulation with findings from the interviews. Findings from the diary-interview method were analyzed as illustrative and descriptive case studies (a case study representing each age group of dyads) and compared with the analyses of the interviews. In multimethod studies, case studies permit triangulation or comparison with data acquired via another method (in this instance, interviews) and can illustrate a phenomenon on a deeper level (Datta, 1997; Yin, 2003). As previously noted, 10 women participated in the diary (5 dyads), with 1 dyad representing a case study of each age group’s experiences. One dyad represented women diagnosed in young adulthood, 2 dyads represented women diagnosed in middle adulthood (one woman as a diagnosed daughter and one as a diagnosed mother), and 2 dyads represented women diagnosed in later adulthood. Before I discuss the case study approach, I present an overview of the diary-interview method.

The diary-interview method involves two means of data extraction—daily diary entries followed by a personal debriefing interview. Diary entries in the study served as a means to document adaptive communication (i.e., open communication, avoidance, and enacted emotional

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4 In the interview data, notable differences existed between young-adult daughters’ behavior when in their twenties and young-adult daughters in their thirties. Hence, in the last age group, one case study represented a diagnosed later-life mother and her young-adult daughter in her thirties, whereas the second case study represented a diagnosed later-life mother and her young-adult daughter in her twenties.
support) *in situ*—in context and in the moment—during a period when the patient was undergoing treatment. As previously noted, only women currently undergoing treatment (either radiation or chemotherapy) and their mother/adult daughter participated in the diary-interview portion of the study. The diary was first pilot tested with three women to determine any necessary changes in procedures and materials. The pilot test also served as a verification strategy to ensure methodological congruence or coherence (that is, that components of the method were congruent with the research question) (Morse et al., 2002).

A longitudinal design was incorporated in collecting data via the diaries (see Appendix G for a sample diary). The diary-interview method as described by Zimmerman and Wieder (1977) permitted more intricate exploration of mother-daughter interactions during the challenging experience of treatment. The diary-interview method enables the collection of time-sensitive, reliable knowledge of behavior within an intensively sensitive context at a highly detailed level from the insider’s perspective. Diaries are also an alternative to observation when this method is invasive (Zimmerman & Wieder). Women coping with cancer is a very sensitive matter; hence, less invasive methods—like diaries—can be optimal. Diaries are also an ideal means for capturing individuals’ communicative experiences longitudinally and as close to their occurrence as possible (Toms & Duff, 2002). By using diaries and interviews together (as is done in the diary-interview method), more detail is generated, and trustworthiness is further enhanced (Conrath, Higmethod, & McClean, 1983; Hilton, 1989; Verbrugge, 1980).

In the diaries, women were to write about their mother-daughter interactions, as well as their feelings regarding those experiences. They were also to reflect on any cancer-related thoughts they chose not to share. They recorded aspects of the interaction, such as location (e.g., via telephone or in the daughter’s home), length, and who initiated the conversation. Recording
such features has been done in other studies utilizing interaction diaries (e.g., see Braithwaite, McBride, & Schrodt, 2003) and has resulted in more descriptive results about interactions that include demographic and frequency information. The participants noted these interactive and affective experiences each day for two weeks. They were to make diary entries as soon after the interaction occurred but no later than bedtime. They had to keep their entries private from their mothers/daughters. They were also to include daily interactions that were not necessarily cancer-related. For instance, a daughter might write about an instance in which she called her mother to talk about what she did that day (e.g., went grocery shopping, drove her children to school, etc.). This interaction could be completely unrelated to breast cancer. These types of interactions were included in recognition of the fact that communication that is not necessarily focused on cancer is also important and may actually function in an adaptive manner. According to Duck (2008), communication scholars too often overlook the influence mundane talk can have on relationships. Thus, to capture women’s communicative adjustment to cancer during treatment fully, their everyday, mundane interactions served a useful purpose.

Upon completion of the diaries, I emailed the participants a reminder to send the diaries in the prepaid, addressed envelope I provided (or to set a time to meet to return the diary). At this point, a date/time for the diary-interview was set. Once I received the diary, I reviewed entries to create a semi-structured interview script for obtaining more detailed information about the woman’s journaled experiences. The diary-interview was conducted by telephone, usually within a week of the last diary entry date. This helped to ensure women could recall detailed information about their interactive experiences. During the interviews, the interviewees discussed specific entries to elucidate and amplify details concerning communicative behavior
and quality of life. This procedure increased internal consistency of the entries. Some portray it as the most reliable method for obtaining diary information (e.g., Corti, 1993).

As a result of time restrictions and problems reaching participants, only 8 of the 10 keeping diaries took part in diary-interviews. They ranged from 11-43 minutes and were 30 minutes on average. All participants gave permission to have their interviews audio-recorded. I transcribed these files. The transcriptions included only pertinent information to provide more detailed information for certain codes and to attain saturation of categories.

Data Analysis

For the approximately 2,500 pages of interview transcripts and 141 diary entries, the analysis conformed to Glaser and Strauss’s (1967) and Strauss and Corbin’s (1998) grounded theory approach. Grounded theory was used to explore data relating to Research Questions 2-7. Research Questions 2-3 focused on how women communicatively adjust to cancer via open communication. Open communication was conceptualized as regularly talking freely about a cancer-related topic (concerns, feelings, thoughts, information, fears, emotional issues, and doubts related to cancer) (Hagedoorn et al., 2000). The questions concerned what cancer-related topics diagnosed women shared with their daughters/mothers, as well as their reasons for doing so. Research Questions 4-5 addressed how women communicatively adjust to cancer via avoidant communication. Avoidant communication entailed actively hiding feelings or information related to cancer (Hagedoorn et al.). These questions had a focus on what cancer-related topics diagnosed women avoided talking about with their daughters/mothers, as well as their reasons for avoidance. Research Question 6 related to how mothers and daughters communicatively adjusted via enacted emotional support and centered on diagnosed women’s mothers’ and daughters’ behavior. Enacted emotional support involved both verbal and
nonverbal behavior communicating care and concern that is important to diagnosed women’s adjustment to cancer (Helgeson & Cohen, 1999). Research Question 7 concerned how enacted support functions both adaptively and maladaptively in diagnosed women’s adjustment. If participants perceived the support as helpful, their communicative behavior was adaptive and helpful in maximizing women’s quality of life. If they perceived the support as unhelpful, the communicative behavior was maladaptive.

Grounded theory involves “the discovery of regularities” (Tesch, 1990). This approach allows researchers to examine data systematically and to establish connections and delimit theory inductively (Miller-Day, 2004). Via grounded theory, scholars can use sensitizing constructs (such as SST) to guide their explorations. Illuminating the participants’ communicative experiences required repeated examination until saturation occurred; that is, no new patterns were evident. As Strauss and Corbin (1998) recommend, analyses were conducted continuously from when data collection commenced and ending when reports were written. This process is also a verification strategy. Collecting and analyzing data concurrently allows researchers constantly to check and recheck. As a result, they can maintain an active analytical stance by thinking theoretically, being able to confirm emergent ideas, and giving rise to new ones (Morse et al., 2002). This “pacing and the iterative interaction between data and analysis” (p. 13) is critical in attaining trustworthiness in the study. This also allowed me to be responsive and flexible throughout the research process, an additional verification strategy (Morse et al.). For instance, during interviews, data were thematized to connect ideas and probe for details on categories of women’s experiences identified as important to the mother-daughter breast cancer experience (Holstein & Gubrium, 1995).
Analytical Process

My position as researcher was to capture women’s experiences in their words. Women’s voices were at the foreground of analyses to bring to life their experiences. Hence, my voice and subjectivity were not relevant as I was capturing their stories, not ours or mine. Rather, my goal was to generate information about how women perceived their mother-daughter communicative experiences.

The analytical techniques of grounded theory were used to examine the in-depth interview and diary/diary-interview data to answer Research Questions 2-7. The result of the analyses was conceptual ordering of the data (or a presentation of themes) to characterize mothers’ and daughters’ communicative experiences when adjusting to breast cancer. According to Strauss and Corbin (1998), conceptual ordering is a precursor to theorizing and “refers to the organization of data into discrete categories according to their properties and dimensions” (p. 19). Analyses were separated by age group and communication phenomena, as well as by interview versus diary data. Hence, different themes emerged as a function of these separate analyses. The procedure yielded information specific to diagnosed women’s experiences at particular points in the life span. Within each age group of dyads, there were also separate analyses for diagnosed women and their mother/daughter. Analytical coding began by examining Research Questions 2-3 (openness), then Research Questions 4-5 (avoidance), and finally Research Questions 6-7 (enacted support).

To become immersed in the data, transcripts, memos, and interview notes were reviewed several times prior to beginning data analysis (van Manen, 1990). The data were then analyzed via the “selective approach” (reading transcripts and coding for conceptual themes) using the
qualitative management computer program ATLAS.ti.5.2  (van Manen; see also Prentice, 2008). The analytical process involved the three steps Strauss and Corbin (1998) have identified.

Step 1 of the analysis was conceptualizing or the discovery of concepts. During this step, the data was open coded. Open coding involves assigning or labeling phenomena by breaking the data down into discrete parts, closely examining concepts, and comparing them for similarities and differences. In this step, conceptual codes were assigned to text and noted in transcript margins.

Step 2 of the analysis was the discovery of categories. This step involves grouping concepts (or concept codes) into a more abstract higher order concept that explains what is “going on” in participants’ experiences. It is important because categories have more analytic power, in that they can potentially explain and predict phenomena. Lists of concept codes for each category were compiled to determine “thematic salience.” Hence, categories are often interchangeably called themes. According to Owen (1984), thematic salience is reflected in recurrence (repeated meaning in more than one interview although it may have been described in different words), repetition (repeated meaning in more than one interview using the same words), and forcefulness (vocal emphasis). For the recurrence criterion for salience, themes were determined when more than half of women reported the experience. To capture the adaptive or maladaptive functioning of behavior, participant perspective codes were also assigned to categories. These codes indicated whether participants diagnosed with breast cancer perceived the communicative experience as positive or negative in relation to their adjustment to cancer. When possible, category names/labels were generated in vivo, or from the participants’ own words, to attain trustworthiness of the findings.
Step 3 of the analysis (the last step) was developing and refining the categories by identifying each category’s properties and dimensions. Each category was developed and refined by considering the context of communication (e.g., age related issues, breast cancer issue of concern, and quality of life) and, when applicable, the related behaviors. When categories overlapped, they were collapsed into a single group or a new way of sorting them was determined (Prentice, 2008). The attributes of each category were also identified to ensure thick description. According to Geertz (1973), thick description provides the domain and detail of participants’ experiences, or in this case, mother-daughter communicative adjustment. In the last analytical step, the categories were reviewed again to identify similar descriptions, quotations, and ideas while making a note of these for descriptive purposes. For an example of this analytical process, see Table 2.1, which presents categories of open communication topics (with conceptual codes and the categories’ properties) for one age group (young-adult diagnosed daughters).

As previously noted, diaries and diary-interviews were analyzed as descriptive and illustrative case studies that represented each age group of dyads to compare findings with the interview data. Hence, grounded theory was used to enact the case study analytic technique of pattern matching. According to Yin (2003), pattern matching involves comparing the findings from case studies with initially predicted results or, in this case, findings from the interview data.

Different verification strategies helped to ensure that sampling was adequate and that theoretical saturation was attained in the analysis (Morse et al., 2002) and involved the following procedures: recruiting more participants, then analyzing their experiences, and determining that their reports reflected categories (themes) that had already been generated and did not produce any new themes (Strauss & Corbin, 1998). These participants confirmed the existence of the
current emergent themes and provided information important in presenting exemplars of the themes (Prentice, 2008). Although frequency was used as a criterion of thematic salience, frequencies were not calculated for organization and presentation of themes. Code frequency is useful only for a structured interview (so all participants receive the exact same questions) and when a sample is random (see Daly, 2007). In an emergent research design, frequency of participants’ responses would be directly related to the frequency of questions. Sampling relates to the kinds of experiences or specific activities to develop theory. Questions were strategic in some interviews but not in others. In other words, as thematic patterns (categories) emerged across interviews, questions were strategically implemented into future interviews as a way to build theory. Thus, frequency of codes does not provide any additional information in this design. According to Daly, “Assigning numbers can be misleading. Rather, the focus needs to stay on the way the presented categories reflect the shared and patterned experiences of participants” (p. 234).
### Table 2.1

Example of Analytical Coding: Categories of Openly Discussed Cancer-Related Topics
In Young Adult Diagnosed Daughters’ Experiences

<table>
<thead>
<tr>
<th>Category</th>
<th>Conceptual Codes</th>
<th>Properties/Dimensions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment Side Effects</td>
<td>Physical effects from chemotherapy</td>
<td>Physical and medical changes and challenges</td>
</tr>
<tr>
<td></td>
<td>Constipation</td>
<td>Emotional changes or challenges rarely discussed</td>
</tr>
<tr>
<td></td>
<td>Diarrhea</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nail apathy</td>
<td>Often talked about in similar way to being sick</td>
</tr>
<tr>
<td></td>
<td>Weight gain</td>
<td>Linked with keeping mother/daughter updated or wanting support</td>
</tr>
<tr>
<td></td>
<td>Nausea</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Change of taste buds</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Loss of appetite</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Memory loss</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fatigue</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mood swings</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Menopause</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hair loss</td>
<td></td>
</tr>
<tr>
<td>Surgery recovery</td>
<td>Lumpectomy and soreness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mastectomy and drains</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reconstruction</td>
<td></td>
</tr>
<tr>
<td>Family Member’s Risk and Prevention</td>
<td>Getting mammogram</td>
<td>Often regarding daughters’ sisters and/or including a sister</td>
</tr>
<tr>
<td></td>
<td>Genetic testing</td>
<td>Related to “Why did this happen to me?” questioning</td>
</tr>
<tr>
<td></td>
<td>Family history</td>
<td>Need to protect self and others</td>
</tr>
<tr>
<td>Medical Decisions</td>
<td>Lumpectomy vs. mastectomy</td>
<td>Usually discussed after decision already made</td>
</tr>
<tr>
<td></td>
<td>Full or partial mastectomy</td>
<td>Usually do not want advice rather validation</td>
</tr>
<tr>
<td></td>
<td>Shaving hair off early</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Having reconstruction</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Infertility prevention</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Getting chemotherapy</td>
<td></td>
</tr>
</tbody>
</table>
Presentation of Analyses

A final verification strategy that ensured transferability involved the presentation of analyses: thick, rich description (Creswell, 2007). Findings were presented using the participants’ words with contextual considerations, rather than extracted out of context. This was particularly important in illuminating why some behavior functioned adaptively at times and maladaptively in other instances. In addition, exemplar examples served to depict categories and present a holistic, rich, understanding of women’s experiences. For instance, exemplars included important contextual factors like the breast cancer related issue of concern (e.g., coping with hair loss during chemotherapy), age-related issues (e.g., particular concerns related to a woman’s developmental phase of life and/or its relation to her mother-daughter bond dynamic), as well as women’s perspectives of quality of life (e.g., the experience helped their adjustment by alleviating their anxiety).

In Chapter 3, the analyses of the interview data appear first. These results are divided into three sections: 1) themes or categories of open communication; 2) avoidant behavior; and 3) enacted emotional support. These results are also organized by age group: 1) young adulthood; 2) middle adulthood; and 3) later adulthood. For the second age group, results were further subdivided as some diagnosed women reported as a mother, whereas others reported as a daughter. Hence, results are presented according to four groups.

The analyses of the diaries and diary-interviews follow these results and are presented as case studies. These analyses are again presented according to the four age categories. As noted previously, these analyses addressed all three aspects of communication in the research questions. The diary and diary-interview analyses provided more detailed information and permitted examination of communicative behavior on a deeper level (Yin, 2003). These analyses
also allowed for triangulation and comparison with findings from the in-depth interview data. According to Creswell (2007), triangulation also enhances the trustworthiness of the study and can help to confirm the findings from the primary analyses.

For the diary case studies, these results are presented according to Yin’s (2003) single case study, embedded design. This design involves the use of a single case for several units of analysis. In this study, the units of analysis were openness, avoidance, and emotional support. This part of the investigation included one diary for each age group. Each is presented according to Creswell’s (2007) 33-33-33 division of results: description of setting (contextual background), themes, and interpretation of results. A thorough description of context is included. Pertinent information about the mother-daughter relationship is followed by an analysis of emergent themes and a comparison of these findings with the interview results.
Chapter Three

RESULTS AND FINDINGS

Overview of Results and Findings

This study was conducted in two phases as related to the following two purposes: 1) examining the importance of family communication during the cancer transition and 2) exploring the adaptive nature of mother-adult daughter communication when women are diagnosed with breast cancer. The quantitative results related the first purpose and involved Hypothesis 1 and Research Question 1. The qualitative findings addressed the second purpose of the dissertation, which entailed answering Research Questions 2-7.

Examining the Importance of Family Interaction in Adjusting to Cancer

Evidence relating to Hypothesis 1 and Research Question 1 ostensibly could extend SST by confirming that women with a limited time perspective (due to age or the ending experience of breast cancer) prefer communication in their kin bonds. All statistical analyses involved the use of pertinent programs in the Statistical Package for the Social Sciences (SPSS).

Hypothesis 1

Hypothesis 1 concerned the communication partner preferences of 303 women in Condition 1 (healthy women): 125 women were in young/emerging adulthood, 98 in middle adulthood, and 80 in later adulthood. From the perspective of SST, individuals exhibit age differences in social partner preferences. The hypothesis was that healthy older women prefer communication with kin more than young/emerging adult or middle adult women. The findings provided support. Women in Condition 1 had significantly different interactive partner preferences based on the participant’s age, $\chi^2 (2, N = 303) = 50.04, \rho < .001$. A moderately strong relationship between partner preference and age emerged for healthy women ($V = .406$).
Only 43.2% of emerging/young adult women reported a family member as their first partner choice in comparison to 76.5% of women in middle adulthood and 87.5% of women in later adulthood.

Research Question 1

Research Question 1 focused on the social partner preferences of 39 women diagnosed with breast cancer (Condition 2) in three age groups (9 young/emerging adulthood women, 18 in middle adulthood, and 12 in later adulthood). It was expected that age would decouple from time in this ending context. Therefore, no age differences would exist in participants’ preferences for communication in kin bonds as a result of having a limited time perspective. Interestingly, however, there were age differences in communicative partner preferences, \( \chi^2 (2, N = 39) = 7.23, p < .05 \), with a moderately strong relationship between partner preference and age for women diagnosed with breast cancer \( (V = .431) \). Only 44.4% of emerging/young adult women identified a family member as their first choice in comparison to 83.3% of women in middle adulthood and 91.7% of women in later adulthood.

Additional Analyses

The surprising results for Research Question 1 led to additional analyses. Research in psycho-oncology suggests that cancer affects women’s time perspective upon diagnosis and makes it more limited. Moreover, cancer fits within the SST conceptualization of an ending experience. Still, the unique nature of this diagnosis as a time-centered event is unclear. Cancer is not a terminal diagnosis in the sense that not all individuals diagnosed with cancer will die of cancer. Although the diagnosis itself causes individuals to consider their mortality, the extent of this change in time perspective is not fully understood. Two disease-related factors likely affect
the magnitude and length of women’s time perspective change: stage at diagnosis and time lapse since treatment.

*Stage at Diagnosis*

The stage at diagnosis (0-4) is an indicator of the severity of the breast cancer and, therefore, how threatening it is to one’s life. As such, the stage is likely a factor that affects women’s perspective of the amount of time left in lives. It is most likely that a woman diagnosed in later stages (e.g., 3 or 4) will feel that her life is more threatened in comparison to one diagnosed in earlier stages (0-2). Hence, it is plausible that women in later stages will have a more limited time perspective. In turn, they would prefer communication with kin more than women diagnosed in the earlier stages. To explore this, women in Condition 2 were divided into two groups: 1) women diagnosed in stages 0-2 ($N = 25$); and 2) women diagnosed in stages 3-4 ($N = 13$). One woman in later adulthood was excluded because she did not provide information about her stage at the time of diagnosis. Because two categorical variables (each with two categories) were used (a 2x2 contingency table), Yates’ correction was also employed to control for a Type I error (Field, 2005). A significant difference between the two groups, $\chi^2 (1, N = 38) = 6.13, \rho < .05$, surfaced. There was a moderately strong relationship between partner preference and stage at diagnosis was found ($V = .402$). All women (100%) diagnosed in stages 3 or 4 preferred family partners in comparison to only 64% of women diagnosed in earlier stages (0-2).

As 100% of women diagnosed in the later stages (Group 2) preferred family partners, no age differences were evident among the three age groups (4 women in young/emerging adulthood women, 4 in middle adulthood, and 5 in later adulthood). Regardless of age, women diagnosed in stages 3-4 experienced a time perspective shift that presumably led them to prefer communication in kin bonds. Additional analyses involving age differences in Group 1 (women
diagnosed in stages 0-2) (5 women in young/emerging adulthood, 14 in middle adulthood, and 6 in later adulthood) indicated that when women were diagnosed in earlier stages, age-related differences still existed in partner preferences, \( \chi^2 (2, N = 25) = 11.15, \rho < .01, (V = .668) \). None of the women diagnosed in young/emerging adulthood preferred kin communication partners, in comparison to 78.6% of women diagnosed in middle adulthood, and 83.3% of women diagnosed in later adulthood. Hence, it appears that when women are diagnosed in earlier stages, their time perspective is not necessarily limited.

Collectively, these findings suggest that the stage in which women are diagnosed does affect their time perspective and their social partner preference. Women diagnosed in stages 3 and 4 have more limited time perspectives than those in stages 0-2. Thus, women diagnosed in later stages prefer communication in kin bonds more so than women diagnosed in earlier stages. In addition, women diagnosed in later stages prefer communication in kin bonds regardless of age. Women diagnosed in earlier stages do not necessarily exhibit a limited time perspective or prioritize communication in their kin bonds.

**Time Lapse since Treatment**

Another factor warranting exploration is the time lapse since one’s last treatment. Women continue to have regular follow-up appointments and tests for five years after radiation and/or chemotherapy treatments end. However, the salience of their diagnosis and the implications it has on their perspective on how threatened their lives are likely dissipates once they are “in remission” or “survivors” of the disease. These characterizations vary. Some women have been told they are survivors or are in remission once they end treatment and have negative test results. Other women perceive they are survivors once they have their five-year post-treatment appointment with negative test results. Hence, the time-centered nature of this
factor is somewhat abstract and not well understood. Nonetheless, it is possible that time since last treatment affects one’s time perspective.

The sample of women in Condition 2 varied in time since last treatment. Some were currently in treatment, whereas other women’s treatment had ended as much as 36 months prior to their participation in the study. It is likely that those either recently diagnosed or in treatment feel that their lives are under greater threat than ones not in treatment (or women considered in remission or survivors of the disease). To explore this possibility, women were divided into three groups: 1) women currently in treatment ($N = 11$); 2) 0-6 months post-treatment ($N = 8$); and 3) more than 6 months post-treatment ($N = 20$). No significant differences were in evidence: $\chi^2 (2, N = 39) = 1.19 \rho = .55$. Only 70% of women 6 months post-treatment preferred kin communication partners in comparison to 87.5% of women 0-6 months post-treatment, and 81.8% of women currently in treatment. In another analysis, women were divided into two groups: 1) currently in treatment ($N = 11$); and 2) treatment ended ($N = 28$). The two groups did not significantly differ, however: $\chi^2 (1, N = 39) = .21 \rho = .65$. Those in treatment preferred communication with kin partners slightly more (81.8%) than women not in treatment (75%).

**Mother-Daughter Adaptive Communication**

Research Questions 2-7 dealt with how mothers and daughters communicatively adjust to breast cancer after one woman has been diagnosed with the disease. Three means of capturing their experiences were: 1) individual life-span interview; 2) longitudinal daily diary; and 3) diary-interview (debriefing interview). Diagnosed women and their mothers or adult daughters were interviewed separately about their experiences ($N = 78$). Those going through treatment (either radiation or chemotherapy) also kept a 2-week daily diary as did their mother/daughter ($N = 10$). Eight participated in an interview involving their diary entries. Triangulation of methods
increased the trustworthiness of findings and also allowed for development of a deeper understanding of these communicative phenomena during the cancer transition.

Three aspects of communication adaptation were the foci of the analyses: 1) diagnosed women’s open communication with their mother/daughter (Research Questions 2-3); 2) diagnosed women’s avoidant communication with their mother/daughter (Research Questions 4-5); and 3) diagnosed women’s mothers’ and daughters’ enacted emotional support communication (Research Questions 6-7). In the analyses, special attention was directed to the context in which the participants enacted such behaviors. Context affects the adaptive nature of communication. The findings also illuminated women’s perceptions of how these communicative experiences affected their quality of life.

The results for Research Questions 2-7 fall into four sections. The first three sections cover analyses from the individual in-depth interview data. The first section discusses thematic analyses for Research Questions 2-3 (openness) from interview data. These analyses are introduced according to dyadic type, according to the diagnosed woman’s age: 1) young-adulthood diagnosed daughter-mother dyads; 2) middle-adulthood diagnosed daughter-mother dyads; 3) middle-adulthood diagnosed mother-daughter dyads; and 4) later-adulthood diagnosed mother-daughter dyads. The second section applies to analyses for Research Questions 4-5 (avoidance) and follows the same pattern of organization. The third section covers the analyses for Research Questions 6-7 (enacted emotional support) by age group. The final section presents the case study analyses for the diary and diary-interview data.

Research Questions 2-3: Diagnosed Women’s Open Communication

Research Questions 2-3 explored the openness of communication of women diagnosed with breast cancer in respect to: 1) cancer-related topics and 2) reasons for sharing. Interviews
from both diagnosed women and their daughters/mothers were analyzed to reveal more fully the context in which their experiences occurred.

Young-Adult Diagnosed Daughters’ Open Communication with Their Mothers

The following findings are based on interviews with 7 young-adult daughter-mother dyads and a 1 single diagnosed daughter (N = 15). The eight diagnosed women ranged in age from 30-39, with an average of 34.62 (SD = 3.34). Three were married, one was engaged, and four of the women were single. Five were diagnosed with stage 2 breast cancer, 2 women had stage 3 cancer, and 1 woman was in stage 4 (this woman had a recurrence). All had undergone surgery (a mastectomy), radiation, and chemotherapy. Four women were still in treatment, and the other four had some sort of treatment within the previous 18 months. Seven of their mothers participated. Their mothers varied in age from 52-74, with an average of 59.29 (SD = 7.45). Half the mothers were middle adults and half were in later adulthood. Four mothers were married or remarried, one was in a long-term relationship, one was divorced, and one was a widow.

Disclosed Cancer-Related Topics

The following cancer-related topics were recurrent in the data: treatment side effects, family members’ risk and prevention, and medical decisions (see Table 3.1).

Treatment side effects. Most of the diagnosed participants reported openly discussing with their mothers their experiences with side effects from surgery, radiation, and chemotherapy treatments. Breast cancer treatment affects women both physically and emotionally. However, daughters were mostly concerned with the physical aspects of their side effects (e.g., fatigue and surgery recovery). Only some described sharing the emotional aspects of these side effects. They openly discuss the emotional experience of the physical side effects of infertility and hair loss.
Diagnosed daughters openly communicated with their mothers the physical side effects they experienced during treatment. They talked openly about fatigue, appetite loss, nausea, nail disorders, and memory loss (also called “chemo fog” or “chemo brain”). They also communicated openly about surgery recovery, particularly two common procedures: lumpectomies and mastectomies. In these instance, the daughters talked with their mothers about their struggles with managing drains, wound cleaning, and soreness. Some recalled explaining procedures they had to follow to cope with side effects after surgery. For instance, daughters discussed with their mothers the procedures they had to follow to prevent one serious side effect, lymphoedema, which causes a woman’s arms to swell and become numb after surgery due to lymphatic fluid build-up. To prevent this outcome, one must rigidly restrict arm movement (e.g., lifting) post-surgery. One daughter, whose career involved lifting, noted how she explained this side effect risk to her mother. To prevent lymphoedema, she had to change her career. Her mother sometimes questioned this decision:

My mom knows I'm scared of lymphoedema … I just explained to her why I can't do my old job … [I said] “Mom, I have this - I can get this lymphoedema thing.” It was just a swelling of the arm … I can get that and this is how to prevent it and that’s it. (14b)

Rarely did daughters discuss with their mothers emotional effects of treatment (e.g., depression or anger). However, their open communication concerning three physical side effects (infertility, hair loss, and weight gain) at times included mention of their emotional aspects. To begin, the daughters sometimes shared with their mothers the physical side effects of menopause and infertility. Chemotherapy-induced menopause was a common side effect for those in young adulthood. Although this side effect can be temporary, it can also be permanent. Most of the young-adult daughters did not have children. They were concerned about being able to have children in the future and shared this emotional concern with their mothers. Sometimes the
daughters focused their disclosures purely on physical aspects of the side effects, for instance fertility options in the future (e.g., harvesting eggs before treatment) or coping with hot flashes due to menopause.

More commonly, diagnosed daughters communicated with their mothers about their emotional experience with hair loss. They frequently described involving their mothers in the emotional preparation for hair loss. For instance, some mothers were involved when daughters first had their hair cut short before treatment (women often have such a haircut to help buffer the trauma of hair loss). The daughters also sometimes asked their mothers to join them in shopping for wigs before they began chemotherapy treatment. Once they lost their hair, the daughters were sometimes open with their mothers about their emotions regarding the shocking, devastating nature of this loss. Many recalled talking about how upsetting it was to have their hair come out in handfuls or “clumps.” One, who had recently had a recurrence, recalled sharing the traumatic nature of this side effect with her mother:

I think the most devastating thing both times was the hair loss. I mean I bawled. I was so upset … I mean I had a mastectomy and reconstruction—but you can hide those things. But the hair! You know you have wigs that are good and stuff but it is a huge, huge, HUGE part of yourself and it is devastating. I mean that’s probably my lowest part, and it sounds vain but it’s really, really devastating. (34b)

Mothers seemed to sense their daughters’ frustration with this side effect, especially their feelings of loss of control in terms of how and when their hair fell out. They seemed aware of how emotional of a loss this was for daughters.

Finally, participants sometimes shared with their mothers their emotional challenges with weight gain during chemotherapy. Weight gain was a common side effect of chemotherapy because the women were also taking steroids. Although most of the mothers had never been diagnosed with cancer themselves, this side effect was often easy for mothers and daughters to
relate to. One mother who had not been diagnosed herself but had struggled with her weight in the past shared her daughter’s emotional experience with this side effect:

She called me yesterday and she was so excited because she lost 2 pounds … It’s really hard. She’s very frustrated. She says “I will not go to a certain size.” But I was there [having weight gain]. I know what she’s going through. It’s hard—yes. (21a)

Family members’ risk and prevention. A second common topic diagnosed daughters openly shared with their mothers addressed their family members’ risk and prevention in developing breast cancer. This topic concerned such measures as mammograms, genetic tests, and exploring their family medical history of cancer. Often, the discussions involved a third party, such as the diagnosed daughter’s sister(s).

Most discussions centered on understanding their disease risks as well as a need to protect oneself. One daughter expressed this concern in her discussions with her mother:

I do tell her, “Well, you and my sister need to get checked” or whatever, in the hopes that they can prevent something … She does harp on my sister like “Okay, you gotta get your mammogram done! You gotta get this done!” That drives my sister crazy but in the same sense, she doesn’t want her to go through what I went through. (34b)

Some daughters also felt that their openness about these concerns was characteristic of their lives and their communication becoming more health conscious or focused.

Some of the daughters described openly talking about more complex steps for prevention. These women had the option of taking genetic tests to determine whether they carried a gene (BRCA) linked with breast cancer risk. In these instances, their mothers, daughters, and sisters also had the option of having genetic testing conducted. Not surprisingly then, for these dyads, family history and genetic testing became a focus of discussion. Daughters and mothers recalled openly communicating about family history as they contemplated why the daughter was diagnosed. They also discussed benefits/cons of genetic testing (e.g., knowing or not knowing you carry the gene). Sometimes these discussions were strictly private ones between the mother
and daughter. Privacy seemed most critical when the women were waiting on genetic test results to protect younger daughters or sisters who would be affected by the outcome.

Medical decisions. Diagnosed daughters openly discussed their medical decisions with their mothers. Most described talking about decisions regarding treatments. For instance, some had to decide whether or not to have chemotherapy. Others recalled having to choose to have either a lumpectomy or mastectomy. A few involved their mothers in these discussions quite intensely by talking through pros/cons of decisions and going to appointments together. However, most stated that they would inform their mothers of their decisions after they had made them, rather than seek their mothers’ advice or involvement. As one daughter stated,

It’s more reflecting on test results. Because any decision like with my mastectomies or anything that I have done like that has pretty much been my decision and like my husband’s—we talking together and stuff. I think anything I’ve shared with her has been just to tell “This is what I’ve done. This is what I’m going to do.” (34b)

Many mothers also seemed to understand that when their daughters discussed their decisions, they were typically informing them, not asking for their insights or approval.

Reasons for Openness

The following reasons for disclosure were recurrently in the data: to protect mother and seek support (see Table 3.1). These demonstrate ways daughters’ open communication can function adaptively in adjusting to breast cancer. The following review makes clear precisely how.

Protect mother. Open communication was enacted to protect their mothers and prevent negative outcomes like the mother worrying, the mother misunderstanding something, or the mothers being unnecessarily surprised by information because she did not hear it from the daughter first. Although these motives sought to protect mothers’ wellness, daughters seemed to feel a sense of responsibility for their mother’s well-being. Thus, they acted to prevent any
unnecessary distress for them. Doing so likely also enhanced daughters’ own peace of mind and adjustment. These motives seemed to be connected to topics of openness that concerned daughters’ treatment side effects as well as updates regarding medical appointments and tests. Many daughters were aware that their mothers worried about them. These daughters felt that by keeping them informed of how they were doing, they could lessen their mothers’ anxiety or prevent unnecessary worry. One daughter talked about this motive in relation to updating her mother after having medical appointments:

I call her right away and tell her … She wants to know things right away too. Like if I don’t call her right after I have a doctor’s appointment or something, she gets worried. [Then she’ll call and say] “Oh! How was everything? You didn’t call me!” (34b)

To protect their mothers, daughter also sometimes kept them informed to prevent any misunderstandings or surprises. One daughter who lived in a small town and worked at the same company as her mother noted making sure to inform her mother first before other family members or friends talked to her:

I think that she wasn’t surprised. Anything that I told her she didn’t hear from anybody else, which I think would be hard for a family member if they heard it you know from a friend … I think it was very important for her to know the truth all the time. (21b)

Seek support. Daughters discussed openness in an effort to attain support from their mothers in three areas: 1) wanting someone there; 2) wanting advice; and 3) wanting reassurance. At times, the daughters recalled wanting their mothers with them at important physician appointments. For instance, they wanted their mothers there for moral support because receiving test results could be “scary.” However, they also wanted their mothers’ advice and reassurance. These motives for support seemed most often to be about side effects of treatment, particularly hair loss, and sometimes medical decision-making. For example, some daughters mentioned asking their mothers for insight on wigs they found or how to deal with hair loss.
Others recalled disclosing in an effort to secure their mothers’ advice on medical decisions. Although most daughters told their mothers about decisions after they had made them, some reported actively involving them in their decision-making. One described her motive for support with decisions:

She was very involved … I think if she wasn’t there, the tendency to maybe not following through or not taking the doctor as seriously might—I don’t know … I think I always visualize her as a person to help me make the right decisions. (22b)

A mother recalled talking through each decision by weighing the pros and cons with her daughter, as well as her husband, the daughter’s father. Still, many other daughters simply wanted their mother’s reassurance about their decisions once they had been made. Mothers seemed to understand that their daughters were seeking reassurance rather than advice when they disclosed this information. As one stated,

I think I always agreed with what she said. I never disagree or put her down … She checked everything pretty thoroughly and I was glad that she did include me because I know some people, they think it’s real private and won’t discuss it … I told [my children] too if something bothers you, talk about it. Don’t hold it in and hold it back. I said, then nothing gets fixed. (34a)

When daughters’ mothers recognized that their daughters only wanted to inform them of their decisions (and were not seeking advice), this motive for disclosure seemed to function adaptively as daughters were content with their mothers’ responses. However, when mothers did not understand their daughters’ motives for disclosure (e.g., that they wanted reassurance not advice), the daughters did not always perceive the interaction as helpful in their adjustment.  

Midlife-Diagnosed Daughters’ Open Communication with Their Mothers

The following findings derived from interviews with 5 middle-adulthood daughter-mother dyads and 2 single diagnosed daughters (N = 12). These 7 diagnosed women ranged in

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5 Because this open communication is also tied to a support interaction, its adaptive functioning is examined more intricately in the section on enacted support (see discussion of validating decisions in young-adult dyads’ experiences of open communication motives).
age from 42-51 and had an average age of 46.00 ($SD = 3.00$). Six were married, and one daughter was in a long-term relationship. Five were in stages 0 or 1, 1 was in stage 2, and 1 daughter was in stage 4 (this woman had a recurrence). All 7 had undergone surgery (lumpectomy or mastectomy), 2 also had radiation therapy, and 2 women had undergone chemotherapy. Only one was still in treatment at the time of the interview. Four had received treatment within the previous 12 months, and two daughters within the previous 24 months. Five of the daughters’ mothers participated. Mothers ranged in age from 65-83 and averaged 72.60 ($SD = 6.58$). The mothers were in later adulthood. Four were married and one was a widow.

**Disclosed Cancer-Related Topics**

The communicative behavior in this group of dyads was notably different from that for the other age groups in terms of the degree of openness. However, the daughters in this category openly talked about similar cancer-related topics with their mothers. The following cancer-related topics were recurrent: *treatment side effects, diagnostic testing and results*, and *medical decisions* (see Table 3.1). Like the topics openly discussed in young-adult daughter-mother dyads, these centered mostly on medical information and facts. However, the communication context varied slightly.

*Treatment side effects.* Daughters in the middle category openly shared with their mothers their experiences concerning treatment side effects. It is important to note that the focus was the physical side effects. Unlike young-adult diagnosed women, diagnosed middle adulthood daughters did not report sharing emotional side effects associated with any care regimen with their mothers.

Many daughters recalled that treatment side effects were topics that came up frequently. These conversations tended to be more casual than serious in tone. The daughters reportedly
talked openly with their mothers about the following physical side effects: loss of appetite, change in taste buds, breaking out in rashes, hot flashes from chemotherapy-induced menopause, headaches, problems with digestion, nausea, and vomiting. Discussions consisted of daughters explaining and complaining about the side effects they experienced. Their disclosures were similar to telling their mothers how they felt when they were sick or ill (in a non-cancer related scenario). The daughters recalled keeping the discussions factually or medically focused. For example, one daughter explained that she openly discussed only “health issues” (i.e., side effects) with her mother:

Health issues—I was pretty open with her about things like that. You know, it’s like nothing tastes right and I don’t have an appetite or I’m starving. And I want to eat this and this is something I usually can’t stand. That kind of thing was weird. (24b)

Daughters’ disclosures concerning side effects seemed to help mothers determine when and when not to call their daughters. One mother noted how the open communication would work for her. She referred to side effects in a similar fashion (physically focused) to the daughters:

She was pretty open about how it [chemotherapy] affected her and how she felt about it and that was usually, you know, when you’ve got a headache and you don’t want to move your head. You sure don’t want to talk to anybody. And so I would wait until she felt like talking, or she would call me when she finally felt better. (10a)

*Diagnostic testing and results.* Daughters also openly disclosed to their mothers the diagnostic tests they received and their respective outcomes. They reported openly talking with their mothers about appointments for tests and test results and sometimes disclosed this information voluntarily. However, other women recalled only sharing such information if their mothers asked them to.

As in the case of side effects, the daughters frequently mentioned being careful to supply only factual information related to medical updates. As one daughter stated, “I didn’t give her a
whole lot of information” (35b). Even though daughters shared only factual information and did not go into details, their mothers seemed to appreciate their daughters’ keeping them informed about their medical appointments and experiences. Doing so seemed to help the mothers understand how their daughters were doing. Many mentioned keeping calendars themselves of their daughters’ appointments. One indicated this in relation to her daughter’s reconstruction appointments: “She had several trips to prepare for the reconstruction … She’s very open about it and I was too. I appreciate the fact that she was close to me in that regard” (24a). Daughters seemed to be at ease in disclosing this information with their mothers so long as it remained factual or medical in nature.

Medical decisions. Diagnosed middle-adulthood daughters spoke openly with their mothers about the medical decisions they made. Such decisions included whether or not to have a mastectomy, reconstruction choices, and treatment options (e.g., radiation and/or chemotherapy). However, these were not necessarily interactive. In other words, mothers were never involved in the decision-making process. Rather daughters provided information about medical decisions after they had already made them alone or with some other loved one. This communication was similar to that which young adult-daughters reported. One middle-adult daughter noted communicating in this manner: “I didn’t say ‘What do you think of that?’ I might have said, ‘Do you have any questions?’ Or something like that … My husband and I really made that decision up front” (11b).

Unlike the younger age group of daughter-mother dyads, these mothers seemed to understand that their daughters were not seeking their opinion when they shared with them their medical decisions. Many mothers also recognized that these were personal decisions for their daughter, and possibly daughters’ husbands, to make. Interestingly, mothers sometimes admitted
that they purposely did not offer their opinions. They most often described this behavior in reference to daughters’ decision to have a mastectomy. Mothers often indicated they felt the daughter should make the decision herself.

Only one daughter recalled her mother’s interjecting an opinion after she had openly talked to her about a decision she had made. She indicated how her mother’s response led her to no longer openly share her decisions:

I told her that I was doing research and I was talking to people too and I said I think that based on what I am finding out, I am going go ahead and do, you know, what I feel is best. And I just listened to what she said but I didn’t tell her I was not going to listen to it … I had already made my decision … She would talk to somebody she knew and she got back to me and she said “You should not have that” and “You should not have radiation.” But, you know, that is how she reacts and that’s why I didn’t discuss with her because she couldn’t just objectively talk about the information. She just got emotional right away. (35a)

Reasons for Openness

Surprisingly, daughters rarely offered reasons for their openness. Rather, they merely reinforced that they consciously stuck to topics that were medical or factual (see Table 3.1). As this was the most frequent communication pattern women displayed in explaining their motivation for talking about certain cancer-related topics, I discuss this reason (keeping talk factual) below.

The previously reviewed topics daughters openly discussed with their mothers indicated that they only disclosed factual and medical aspects of their cancer experience. It was rare for them to talk openly about emotionally related cancer topics. In fact, when directly asked what they shared with their mothers, daughters often responded by saying they shared only factual information.

Reasons for this restriction varied. A few interviewees felt that their mothers did not fully understand the cancer process. Because of this, it was best to keep any conversations about their
cancer strictly factual. One daughter noted, “I was sort of the one educating her” (5b). Some daughters explained that because their mothers wanted to “keep track” of the appointments or procedures, it was easier to focus on medical or factual information. Finally, other daughters felt it was too traumatic for their mothers to talk about anything cancer-related except for the physical aspects as one daughter observed:

    I think it was hard for her too. I think she didn’t absorb it. It was like, it was almost like she was [the one] hearing that cancer diagnosis. You know how you—the patient—right away doesn’t hear it? I think that was what happened to her. I don’t think she really heard what I was saying the first few times I talked to her about it. (35b)

For daughters, then, by openly communicating only about physical aspects of breast cancer, they minimized distress both for themselves and their mothers. Hence, this motivation is somewhat tied to a desire to protect their mothers as well as themselves from emotional distress.

    All of the daughters’ mothers were in later adulthood, a generation that tends to be more closed in terms of emotional expression. In addition, most of the daughters were in early stages (0-1). Many only had a surgery for treatment, and experience that may be more medically focused and less emotionally charged.

    *Midlife-Diagnosed Mothers’ Open Communication with Their Daughters*

    The following findings relate to interviews with 12 middle-adulthood mother-daughter dyads (2 dyads had 2 daughters) and 1 single diagnosed mother (N=27). Only 12 of the 13 diagnosed women returned information about their background although some of this information emerged in their interviews. Diagnosed women ranged in age from 44-52, with an average age of 49.42 (SD = 2.50). Ten were married, 1 was in a long-term relationship, and 1 was divorced. Most women were in stage 0 or 1 breast cancer (N = 8), two women were in stage 2, and three mothers had stage 4 cancer. Two of these women had experienced a recurrence. Of the ten women who reported full treatment histories, all had undergone surgery (mastectomy), 7
also had radiation therapy, and 6 also had chemotherapy. Three women were still in treatment, three had undergone treatment within the past 6 months, four had within the past 24 months, and one within the prior 36 months. Fourteen of these mothers’ daughters participated. The daughters ranged from 18-29 and had an average age of 20.64 ($SD = 2.90$). All were young adults. Nine were single, and five were engaged or in a long-term relationship. Many of them still lived with their mothers at the time of diagnosis, as well as during treatment.

**Disclosed Cancer-Related Topics**

Mothers’ communication with their daughters was often factually based, much as was the case of the other middle adulthood dyads’ experiences. However, these mothers and daughters had unique experiences in comparison to the other age groups. The mothers seemed to agonize more about which cancer-related topics to share with their daughters because they were concerned about their vulnerability. Hence, although mothers may have discussed some cancer-related issues with their daughters, they typically did not go into detail. Daughters were also aware of this aspect of their interactions concerning cancer. Moreover, the mothers often admitted that because their daughters lived with them at the time of their diagnosis and/or during treatment, their daughters were unavoidably exposed to their cancer experience.

Still, as with the other dyads, these diagnosed mothers openly communicated with their daughters about similar cancer-related topics. The following cancer-related topics emerged recurrently in the data: *treatment side effects and procedures* and *daughters’ prevention* (see Table 3.1). Although the topic of cancer talk was similar to other mother-daughter pairs, the dynamics of their interactions were different, as indicated below.

*Treatment side effects and procedures.* As with the previous dyads, mothers often shared with their daughters their experiences relating to treatment, namely their recovery from surgery
and struggle with side effects. In addition, similar to later-life mothers, midlife mothers described their experiences with treatment procedures to their daughters. Both mothers and daughters recalled that these discussions focused mostly on what mothers underwent physically, as well as the logistics or mechanics of the treatment procedures.

The mothers talked openly with their daughters about their side effect experiences with fatigue, hot flashes, and hunger cravings, but tended to only disclose “basic things” or the physical aspects. They also admitted that they rarely gave their daughters details. One described her openness with her daughters in this manner:

What they do know is that I have horrible heat flashes now and that type of thing so they do know about that part of it. But I’m not sure if they know how much of a big deal they think that is. I tend to downplay medical type things. (26a)

Mothers often seemed to disclose such information to their daughters to help them better understand what was happening to them but kept details related to feelings to themselves.

The mothers also talked about and showed their daughters their surgical scars throughout the healing process. One recalled using the Show Me book (a well-known publication displaying women’s mastectomies) so that her daughters could look at other women’s bodies in case they were uncomfortable looking at hers. Mothers shared the physical aspects to help their daughters better understand their experiences. Sometimes the daughters were interested in seeing the physical changes. Others did not want to discuss or try to visualize their mothers’ surgical experience. Interestingly, this difference in comfort level was often notable when the mothers had two daughters at home. One daughter described how seeing her mother’s scars helped her understand the bodily changes she had to endure and felt this openness helped her withdraw less from her mother. She also compared it to her sister’s experience:

My sister doesn’t deal with blood … She would probably pass out … I saw every aspect of her side effects and it was not too fun. Like she had drainage pipes on the side and the
fact that those were constantly pulling and it’s like—no, it’s not right. Something shouldn’t be coming out of your body from inside like that—has to hurt. So it’s like seeing that and realizing how much pain she actually is in made me realize like, all right, I guess I got to be a little bit more receptive to this than I am. (16b)

The mothers reported sharing with their daughters the logistics and procedures involved with treatment. At times, they did so over the telephone to daughters who were away at school. In other instances, they brought their daughters to radiation or chemotherapy treatment. This was not a common occurrence, as most daughters were in school, and the mothers had their treatment during the day. However, many mothers recalled bringing their daughters to treatment at least once so that they could see what the visits involved. Mothers seemed to be attempting to minimize any fears their daughter had. As one stated in relation to her chemotherapy appointments, “I was just trying to take the scariness out of it for them” (16a). The mothers and daughters often indicated that such openness did have that effect. One noted that by being open, her daughters would have a role model in case they ever had to face the disease in the future. Unlike the other dyads, mothers’ openness seemed to relate to educating their daughters about the experiencing to minimize fears they may have had.

*Daughters’ prevention.* Daughters’ prevention was also a common topic among the daughters and mothers. They talked freely about genetic testing, mammograms, and family history. Unlike young-adult daughter-mother dyads, this openness centered on how daughters must proactively protect themselves from developing the disease. Sometimes, the discussions arose after daughters expressed their concerns about developing the disease to their mothers. However, mothers often initiated these talks. They indicated that they wanted their daughters to understand that breast cancer was an important matter about which they should be concerned but did so in a manner that would not alarm them unnecessarily. For instance, mothers often reassured their daughters that their chances of developing the disease were not high. As one said:
I want her to be concerned with that. I do want her to be sure she starts getting checked early and that kind of thing … Telling her that as long as she does the proper things and being checked and that type of thing, it’s very treatable now. (26a)

Although the mothers often discussed daughters’ prevention efforts, both noted that this was not a major concern, since the daughters were young. Still, most mothers brought up the topic at least once and stressed the importance of talking about prevention. The mothers tended to initiate these conversations periodically throughout the cancer experience. The daughters recalled these talks occurring once in awhile, which seemed to make sense to them in light of their age. At times, the discussions coincided with mothers showing their daughters their surgical incisions so that daughters could see what happened to them during treatment.

Some daughters were not receptive to their mothers’ openness and even admitted actively avoiding certain topics of conversation. Others seemed to want their mothers to talk about such matters. For instance, one recalled talking to her daughter the day of her diagnosis about her own prevention and asked her to have a “workup” as soon as possible. The mother recalled her daughter’s response, “I want to.” Additionally, the daughters sometimes talked about wanting to engage in prevention immediately. At times they even noted being upset when their doctors refused to give them a mammogram until they were 35 (Most were in their twenties.).

Interestingly, these daughters sometimes admitted they felt guilty about being concerned with themselves. One observed that she felt reassured but guilty at the same time:

She told me like I better always go get mammograms and she didn’t go. She skipped a year and the lump could probably have been caught earlier. So she said she’s never do that again and that I should go. But she’s also said that most people’s breast cancer isn’t hereditary … It made me feel a little bit better but then it made me feel bad that I was worried about myself getting it when she actually had it. (26b)

Mothers also described feeling guilty but for different reasons. They reportedly felt guilt because their daughters had to consider that cancer might be part of their future, something they regarded
as unfair because their daughters’ lives were just beginning. Possibly related to this, some mothers mentioned their doctors’ telling them not to “burden” their daughters with this topic yet.

More often than not, the mothers and daughters openly discussed breast cancer prevention. Doing so seemed to be particularly important to the mothers’ well-being in knowing their daughters would be careful in the future. However, some daughters seemed to be very uneasy discussing this matter. They tended to withdraw and, if possible, avoid this topic.

**Reasons for Openness**

Some daughters were living at home with their mothers because they were still in high school at the time of diagnosis or were home for a summer or holiday vacation from college. Living with their mothers influenced how much mothers talked about cancer with them. Mothers often noted that it was impossible for their daughters not to know certain things (or for certain things to be discussed) because they lived at home. This did not appear to be a reason for openness, but rather an indication why daughters were exposed to certain things. The only concrete reason mothers consistently gave for openly communicating about cancer with their daughters was that their *daughters wanted to know* (see Table 3.1). This motivation seemed to have the greatest influence on what cancer topics mothers decided to openly talk about with their daughters. Although it is similar to what other age groups reported, this motivation was cast as *wanting to know* and directly related to the daughters’ comfort level with their mothers’ diagnosis versus desire for information concerning how the mothers were doing.

Mothers often mentioned being open only as much as their daughters wanted them to be or when their daughters wanted to know things. As one mother of several daughters put it, “I’m open with them if they want the information. It’s there. It’s not that they want it exactly” (20a). Many mothers noted wanting to be open with their daughters. However, they felt that their level
of openness or what issues they were open about depended on their daughters’ wanting to know about those experiences. These mothers seemed to understand that their daughters had varying comfort levels in hearing details about their mothers’ experiences. The mothers also indicated that their daughters’ comfort level was important because of their young age. Because of this, they recognized that their daughters did not always want to talk about certain matters. They also noticed that for cancer to surface in a discussion, they often had to initiate the subject.

The daughters’ desire to know varied. Some recalled daughters wanting to know “everything” and always asking about “what’s next.” These daughters tended to ask their mothers questions often. One mother recalled her daughter saying, “Well, the more information I have will certainly help me in the future when I make my own decisions” (27a). In opposition, other women recalled daughters not wanting to talk about cancer ever. Often there were two daughters, one of whom was comfortable with the subject and the other not.

Mothers felt, at times, it was important for their daughters to acquire information. They integrated these topics during interactions in which they thought the information would be more easily received. For instance, mothers talked more openly about cancer when the topic had already been raised (e.g., they were talking about a friend’s diagnosis, something came up on television, or the mother had a doctor’s appointment). Although the mothers seemed to understand that their daughters’ maturity affected how open they could be, avoidant behavior from their daughters sometimes was very difficult to negotiate.6

Later-Life Diagnosed Mothers’ Open Communication with Their Daughters

The following findings related to interviews with 11 later adulthood mother-daughter dyads (1 dyad had 2 daughters) and 1 single diagnosed mother (N = 24). The 12 diagnosed

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6 This avoidant communicative experience was a notable aspect of mother-daughter communication in this group of dyads. Hence, it is discussed further in this group’s experiences with avoidant behavior as well as enacted emotional support (see talking versus withdrawing).
women ranged in age from 57-69 and averaged 61.92 ($SD = 4.48$). Eight were married, two separated or divorced, 1 divorced/remarried, and one was a widow. Only 7 knew the stage of the disease: 3 women were diagnosed with stage 1, 3 in stage 2, and 1 at stage 3. All had undergone surgery (lumpectomy or mastectomy), 9 also had had radiation, and 7 had undergone chemotherapy. Three mothers were in treatment at the time of the interview. Six had some sort of treatment within the previous 12 months, two within 18 months, and two mothers had treatment within the last 36 months. Eleven mothers’ daughters participated but one did not return her background information. The daughters ranged in age from 21-51, with an average age of 31.10 ($SD = 8.85$). All daughters were young adults (but most were in the 30-40 age range) with the exception of one woman who was in middle adulthood (age 51). Four daughters were married, one divorced/remarried, three in a long-term relationship, and two daughters single.

**Disclosed Cancer-Related Topics**

As true of the other age groups, women diagnosed in later adulthood openly communicated about cancer issues, as well as medically related topics with their daughters. Mothers spoke openly about three topics: treatment side effects and procedures, diagnostic testing and results, and daughters’ prevention (see Table 3.1). Although these women often did not initially provide their daughters with extensive details about these topics, since their daughters were inquisitive, they typically responded by opening up more with their daughters. Each topic is described below.

*Treatment side effects and procedures.* Later-life mothers openly discussed with their daughters their experiences with cancer treatment. Their disclosures consisted of sharing general information about what treatments they were receiving, as well as any side effects they encountered from radiation, chemotherapy, and surgery. Sometimes the mothers volunteered the
information. Other times, the daughters expressed a desire for the information, following which the mothers then began to share. When mothers discussed cancer-related issues, they tended to share physical or medical aspects of treatment primarily. Hence, like those in other dyads, these mothers did not typically communicate about any emotionally related aspects of treatment. Some recalled updating their daughters concerning treatments they would be undergoing. Often, these interactions focused on the logistics of mothers’ treatment experiences, particularly when they stopped or started a new treatment regimen. One mother reported telling her daughters how she went to her radiation treatments during the week:

I didn’t really describe anything or go in to a lot of details. I told them I had to go every day, five days a week at 9:30 I had to be there. It took me longer to drive to the hospital than to get treatment! You know, that was kind of a joke, like I got to be there by 9:30 but I’ll be back by 10! It was really quick unless you had to wait for some reason. I never gave them a lot of details. Maybe after the first time and that was it. (23a)

The mothers in this age group also noted how they disclosed to their daughters their experiences with side effects associated with these treatments. Again, their openness typically related only to factual information. Side effects mothers talked about included memory loss from chemotherapy, breast tenderness from radiation, leg cramps, stomach upset or nausea from medications, headaches, reddening of skin from radiation, fatigue, mouth ulcers, and constipation. Many mothers recalled describing their “yucky” or “creepy” days to their daughters. However, they reportedly did not give their daughters many details about the side effects, but restricted their accounts to physical changes or challenges they were encountering. Some even mentioned that they would not openly talk about their treatment experiences unless their daughters asked.

Some mothers also shared with their daughters experiences relating to mood swings from chemotherapy. Although this side effect is often associated with emotional changes, their
disclosures tended to concentrate on the medical effect from treatment rather than the emotional challenges of dealing with this side effect. The daughters confirmed that their mothers’ openness regarding any treatment was medically focused. Yet, they also seemed to be aware that their mothers were struggling emotionally. One daughter who knew her mother had severe bouts of depression during chemotherapy (because her father told her), reflected her mother’s selectivity:

She [my mother] was like, “Well, it seems like the first day or after chemo, I feel this way and I don’t like to eat very much” or “These are the things I like to eat. On the second day, I feel this way.” Especially with the first part of chemo. Like I said, she left out the depression or at least didn’t explain it to the full extent but was always like, “Here’s how it goes.” (9b)

Another daughter reported a similar experience:

It was never emotional. It was always very, if I could say “clinical.” It was all about the treatment. It was all about the drugs. It was about prognosis and never, never intimate [like] “How does it feel to me …” (23b)

Although the mothers admitted they did not share much about the emotional aspects of the disease, their daughters often mentioned being concerned about their mothers’ emotional health. At times, the daughters learned about their mothers’ sadness or depression from other loved ones (e.g., the daughters’ fathers or grandmothers). Yet, many times, they reported being able to sense it themselves both over the telephone and in person. It is noteworthy that although this topic was not one diagnosed mothers openly discussed, their daughters frequently talked about it in their interviews. As the mothers were of an older generation, they may have been less apt to express freely their emotions. Nonetheless, it was often a pressing concern for their daughters.

*Diagnostic testing and results.* The mothers recalled that what they shared about diagnostic tests was factual in nature and related to such matters as PET scans, bone scans, MRIs, genetic genomic testing, biopsies, and mammograms. They also reported talk about the
procedures involved and what the tests entailed, as well as what the results of tests meant. For instance, one mother noted:

When they said they wanted to do the biopsy … I was on the phone with [her daughter] and just let [her] know that they wanted the biopsy. I said [to her], “Actually I’ve been reading on this and only 8 percent of the time does the calcification [on the mammogram] mean anything.” (42a)

When the mothers shared information about procedures and talked about the results of the tests with their daughters, they often did so in conjunction with discussions of treatments.

Some women recalled keeping daughters “updated on all the reports and what they meant and what it means for them” (42a). Some daughters recalled their mothers being detailed in their explanations of test results. As one observed:

She’s very detailed. You know, my mom took notes on everything so she wanted to talk about it … she still needs to. She talks about it … She told me word for word everything that happens and I just listen. (19b)

Some mothers recognized that daughters wanted specifics concerning the test results, sometimes more so than the mother did. As one mother stated, “[My daughter] wants to know about … my tests, how my tests come out, because I still have a lot of tests. I guess they are more specific now—they want specifics, more details now you know” (12a). As with communication about treatments, sometimes mothers initiated this discussion. Other times, they shared information only after their daughters asked them to.

Daughters’ prevention. Mothers frequently communicated about prevention for their daughters. They told them about discussions with their physicians about daughters’ future risk and actions they needed to take to minimize their potential for developing the disease. These daughters were in young adulthood (age 21-39), with the exception of one, a midlife adult. When the daughters were closer to age 40, discussions seemed to be more frequent in comparison to women with daughters who were still in college. Mothers recalled talking to their daughters
about getting mammograms, doing self-exams, and becoming more health conscious. Like midlife mothers, some later-adult mothers felt their daughters did not appreciate their openness. One mother described such an interaction with her daughter who was in her early 40s:

I said to her “Have you scheduled your mammogram yet?” [And she says] “No, I haven’t done it yet, Mom.” And I’ll say to her, “Well, you’ve got to do that. You’re supposed to do that now.” And then she’ll say, “Well, you know, so and so down the street just had a mastectomy and she went for her mammogram the week before or two weeks before and nothing showed up, and she does the self breast examination and she found the lump herself.” So her attitude is like, which is really kind of dumb, she’ll say something like “So, you know, look at that!” And I’ll say to her, “Do you do self breast examinations?” No! No she doesn’t! But that’s the way she is … I don’t know why. I just don’t understand that. Especially in this day and age and with my condition. (17a)

On the other hand, some mothers stated that their daughters were interested in prevention. They openly communicated about this topic more easily and felt their daughters wanted to know how this disease could affect them at their age. Some mothers felt it important not to preach, instead to “drop a hint.” One mother described how she openly communicated her concerns about prevention to her daughter in this way:

Because they are younger, they may think they don’t have to go there that often but I don’t bring it up very often though. I might bring it up after I’ve had one, then just, kind of it’s on my head, you know. [So I say] “I had mine last week. Have you got your appointment?” And that’s it. That’s all I do. That usually is enough. (23a)

Daughters seemed to realize that their mothers’ openness about prevention was an effort to protect them from developing the disease. Some admitted being resistant to or scared of having a mammogram. One in her early 30s described this fear as follows:

I’m worried I’m going to have it. I don’t think I do. I’d probably be able to tell but I just—I’m going to do it. I’m going to do it. That’s just something I’ve been trying not to do. I know I have to. It’s like one of those things that you know you’re going to do it and you know you have to, but you really don’t want to. I will though. (32b)

Other daughters did not hesitate to see their doctors after their mothers talked to them about prevention. As one recalled:
I don’t even know if it would’ve been necessary for Mom to even tell us that we would have to do that because we knew we would have to do that now. I think it made her feel better knowing that we were going to do that. (17b)

This group of dyads’ experiences was similar to those of middle-adulthood mother-daughter dyads. However, daughters of mothers diagnosed in later adulthood seemed to understand that by taking preventive steps, they helped ease their mothers’ mind. Hence, these daughters realized that being open to talking about their own prevention was helpful to their mothers’ adjustments to their own conditions. Although these daughters were also young adults, the majority were about 10 years older than the midlife-diagnosed mothers’ daughters. This age difference likely affected comfort levels as well as in understanding the significance of their mothers’ openness regarding this topic.

Reasons for Openness

Mothers consistently mentioned one reason that motivated them to be open with their daughters regarding cancer-related topics. Women stated that they disclosed because their daughters wanted to know (see Table 3.1). Unlike the daughters of middle-adult mothers, these daughters wanted information concerning how their mothers were doing. Mothers described various aspects of this reason and why it led to their being open.

Many of the mothers stated that they were open with their daughters about cancer-related topics because their daughters wanted to know what they were experiencing. Some indicated that they were open because they somehow just knew their daughters wanted to know. Other mothers knew their daughters wanted to know because they explicitly expressed this. One mother recalled, “Like she said to me, she didn’t want me to hide my feelings no matter what I was feeling” (4a). Daughters recalled having similar interactions. One described how her mother censored information early on. The daughter’s maternal grandmother would then disclose to her
what her mother was experiencing. This daughter recalled addressing this with her mother: “I said something like, ‘Mom, you have to tell me how you feel. Like I want to know. I want to help you.’ And she’s like, ‘I know but I don’t want you to worry’” (32b). As this daughter pointed out, daughters seemed to want to know this information to have a better sense of how their mothers were doing.

Some mothers felt that if they did not openly communicate with their daughters, they would be upset, as one said: “I know that if they were not fully informed, they would be very upset with me for not telling them” (19a). Other women felt their daughters would be worried if they were not open, as the following mother explained:

I just assumed [they] would want to know. And [they] did want to know. I mean I didn’t have to worry that they would want to know. It was just understood that there would be—it was significant enough. I think they might have been concerned if I weren’t sharing information. (42a)

Daughters also often adamantly stated that they wanted to know “everything.” They felt that by knowing what was going on, they could help their mothers adjust better. Daughters also expressed that not knowing would be even more worrisome. Knowing everything seemed particularly important to daughters who could not be with their mothers physically because they lived far away. One daughter in her early twenties described wanting her mother to be open for this reason:

If I could really picture everything and really know exactly the process and exactly what she was going through, it helps make it more real for me but in a good way. I remember really feeling the change from when it was just this big nebulous scary thing to okay. This is how it’s being dealt with. These are the treatments. These are the steps. It was able to make it more specific for me, especially because I wasn’t there … Making it as specific made it more comfortable. It didn’t make it this big, giant, scary thing … I wanted to know everything. I wanted to know all the details and she had been reluctant to tell me … I thanked her for protecting me but I said that’s not the way I want to do this. I want to hear about everything. I want to know it all. I want to know the specifics. I think that probably set the course. It did set the course for how the whole thing was going to go. She knew at that point I wanted to do this as a peer and as an adult and not to have it
be like she was my mom and trying to protect me. I think that would have been way scarier for me. That was a big time. (9b)

Like their daughters, mothers seemed to feel being open helped them adjust better. Many of these women felt that it enhanced their relationship with their daughter in a new way, making it more intimate. As one mother stated, “I was glad [she wanted to know]. I wanted that to happen” (4a).

Research Questions 4-5: Diagnosed Women’s Avoidant Communication

Research Questions 4-5 concerned the avoidant tendencies of women diagnosed with breast cancer. Two aspects of avoidance were examined: 1) cancer-related topics women avoided talking about with their mothers/daughters; and 2) their reasons for avoiding these topics in this relationship. As with the analyses for openness, interviews from both diagnosed women and their daughters/mothers served to reveal the context of their experiences more fully than the survey data could. As in the previous section, women’s experiences are presented by age group, beginning with the reflections from mother-daughter bonds when the woman was diagnosed in young adulthood. Avoided cancer-related topics recurrently identified in the data appear first followed by women’s reasons for avoidance. The recurrently identified reasons for avoidant communication illuminate the ways in which avoidant communication can function adaptively for mothers and daughters coping with breast cancer.

Young-Adult Diagnosed Daughters’ Avoidant Communication with Their Mothers

These findings are based on the experiences of 7 daughter-mother dyads and 1 single diagnosed daughter (N = 15). Both mothers’ and daughters’ perspectives were analyzed to more fully capture the context in which their avoidant experiences occurred.
Avoided Cancer-Related Topics

Diagnosed young-adult daughters reported avoiding topics they perceived as negative: death and mortality, uncertainty about the future, and distressful topics (see Table 3.1). Each receives attention below.

Death and mortality. Daughters rarely, if ever, discussed death with their mothers. They recalled avoiding any talk about their own mortality. However, many of them admitted that this was a concern. At times, they struggled with the fear that they might die. They described confronting their future mortality by themselves or with another loved one rather than sharing these concerns with their mother. One daughter who had been diagnosed twice, having had a recent recurrence, shared her struggle with this:

I’ve cried sometimes and broke down. Like “I can’t believe I have this. I don’t want to die.” … I think that’s one of those things you have to work through yourself. Like it’s just one of those stages that you go through and you either, you either get through that stage, or you let the stage destroy you. (34b)

Some daughters mentioned that they may have talked about this concern with their mothers before. Yet, they stressed that if they had, it was likely a rare or single occurrence. They recalled that they openly communicated about their mortality with a husband, sister, or friend. Most mothers, too, did not recall ever discussing their daughters’ mortality. The daughters’ talking about death even excluded any discussion of another woman’s passing. For instance, many of the daughters knew other women fighting the disease. When these friends passed away, the daughters did not share this with their mothers.

Uncertainty about the future. Daughters’ uncertainty about their future was also a topic they avoided. Their concerns about the future were related to two different fears. First, daughters commonly noted that they had concerns that the breast cancer would come back in the future or recur. Still, they rarely expressed this fear to their mothers. Second, some daughters reported
having a concern about whether they would see their children grow up. One daughter saw this as
a prominent and emotional concern. She recalled mentioning it once to her mother but never
again bringing it up. Like discussions of death/mortality, many women recalled bringing up this
topic with a husband, sister, and/or friend.

Distressful topics. Daughters also recalled avoiding topics they characterized as negative
because they were uncomfortable or upsetting. One such topic was the daughter’s body image
and sexuality. Many women described struggling with body image as they adjusted to changes in
their breasts after receiving a mastectomy and/or reconstruction. Sometimes, their concerns
about body image affected feelings relating to sexuality. One daughter described this challenging
adjustment in the following way:

I don’t talk too much about like the whole idea of the mastectomy and losing body parts … Like now I am getting my energy back, just getting my sex drive back. I know I have
like all the issues that a woman will say like, oh gosh, like fooling around with a boy and
how is this going to work? But I don’t really talk to [her] about that because I don’t want
to talk to them [parents] about my sex life. (38b)

Like other diagnosed women, this one daughter reported that instead of sharing this concern with
her mother, she talked about it with female friends or men with whom she was intimate.

Another distressful topic daughters avoided talking about with their mothers was their
feelings of sadness. One recalled never sharing her emotions with her mother and only
discussing medical facts associated with her experience. Daughters also avoided distressful
topics that concerned their mothers’ behavior. For instance, some recalled moments during
treatment in which their mothers’ behavior hurt them and avoided any communication about
such moments with their mothers. Some never even told their mothers when they did something
that upset them. Related to this topic was daughters’ avoidance of their mothers’ negative talk.
This involved disclosures about their personal concerns and problems. Daughters did not seem to
want their mothers to discuss their own distressing emotional states, whether these concerns were in reference to troubles in their personal lives or about the daughters’ cancer. Mothers often admitted avoiding such topics as well. One daughter recalled trying to avoid subjects of this nature in her conversations with her mother:

Some subjects you just don’t bring up. I don’t like bringing up subjects when she’s first talking about things that she thinks are wrong like just in her life or something. I think it’s annoying. I’d rather say “How’s the weather today? This is what the kids are doing and here’s what my doctor said to me.” And be done with it. Where she likes to dwell on certain things and it’s like, oh my goodness! (34b)

Reasons for Avoidance

Diagnosed women had a principal reason for avoiding cancer-related topics: to mutually protect mother and self (see Table 3.1). Their motivations were instrumental in helping them adjust in healthy ways. As noted, some of the topics about which daughters avoided talking were ones they perceived as distressful. As one daughter stated, “I think it helps me be stronger when I don’t see someone else breaking down in front of me” (34b). Another daughter reflected on how her mother often involved her in her personal problems and leaned on her for support, which was also characteristic of her mother before her diagnosis. This daughter recalled being distressed by her mother’s behavior when she talked about her parents: “Why did they not recognize that this is big? I have a lot going on and - you know, I can’t exactly take care of everything, the way they want me to” (33a).

Daughters also avoided topics to protect themselves from their mothers’ reactions which they believed most likely would be negative. For example, one daughter learned that her mother was telling her friends and family details about her experience—details the daughter had disclosed to her mother in confidence. The daughter saw her mother’s email correspondence with other women in which they were discussing her experience. She felt her privacy had been
invaded without her permission. She avoided further discussions to protect herself from this outcome:

She was sharing my thoughts and feelings and everything with basically everyone she knew … That is a problem! … They were talking about me and I just wasn’t happy with that … [Now] I just give her the [medical] facts. I will never talk about my feelings. (33b)

Some daughters also recalled censoring what they shared with their mothers to protect their mothers from negative effects. These daughters avoided topics to prevent their mothers from experiencing unnecessary distress or worry. Oftentimes they avoided showing their concerns about their uncertain future, as when waiting for test results. For example, one daughter shared her experience about recently finding another lump. She admitted that she had not shared this with her mother. She stated,

I didn’t tell her that … I didn’t want to worry people unless – in case it had been nothing … I’ll deal with it if I have to deal with it … There’s not necessarily anything to deal with right now. So it was a wait and see kind of thing. (15b)

This example of daughters’ avoidant communication was similar to how they sometimes delayed telling their mothers about their diagnoses. Many recalled waiting to tell their mothers that something was wrong until after the lump had been biopsied and had a definitive diagnosis.

Daughters also avoided telling their mothers about their fear of recurrence to prevent their mothers from experiencing distress. Many daughters were adamant about avoiding this topic of talk, so as to not worry their mothers. As one daughter stated, “No. God no! No one knows about that … There’s no point in putting out stress to my mom. Knowing that I’m worried! No, no, no, no. Why worry her? No way.” (14b). Many women avoided discussions about their own mortality for this reason as well. One daughter talked about how this topic of talk would only cause her mother and father distress:
I don’t want to upset them … I don’t think breast cancer is going to kill me but if it does, I decided that would be okay too … I haven’t informed them with that because they would not be fine with that. I think that will just be too much for them to think about or to bear … But once I realized that, it was almost like this huge weight was lifted. I feel free like it doesn’t make me sad or anything. I just felt good. (38b)

**Midlife-Diagnosed Daughters’ Avoidant Communication with Their Mothers**

The following findings emerged from interviews with members of 5 middle-adulthood daughter-mother dyads and 2 single diagnosed daughters ($N = 12$). Both mothers and daughters frequently described not being avoidant in respect to cancer-related issues. Rather they felt that they just did not talk about certain topics. As a result, daughters and mothers provided little information about specific avoidant behavior.

**Avoided Cancer-Related Topics**

Although diagnosed daughters did not frequently mention open communication with their mothers about many different cancer-related topics (e.g., hair loss, emotional side effects, body image), the only topic they admitted avoiding, albeit somewhat indirectly, was *future uncertainty and death* (see Table 3.1). Although a few women admitted that they once talked to their mothers about issues related to future uncertainty, they described it as a rare occurrence. More commonly, women did not discuss this. Cancer-related topics that were characterized as future uncertainty included mortality or death and seeing one’s children grow up.

However, diagnosed daughters did discuss these topics with other loved ones, namely their husbands or friends. They often mentioned they did not feel that they consciously avoided these topics with their mothers, possibly because most were diagnosed in early stages and, thus, their experience with breast cancer was not as life-threatening in comparison to other women.
Reasons for Avoidance

Daughters diagnosed in midlife also did not readily provide reasons for avoidant behavior. This is not entirely surprising as they also did not feel they actively avoided cancer-related topics. Yet, in reviewing their discussions of what topics they openly talked about or avoided (however indirectly), two reasons emerged that are suggestive of daughters’ motivation for avoidant behavior: protect mother and talk to others (see Table 3.1).

Protect mother. Some women mentioned their concern that disclosing to their mothers would only cause them more worry. One woman tied her concern to her mother’s age and struggles with anxiety. Another woman referred to being apprehensive to talk openly about her cancer for fear she would upset her mother by “laying” too much on her: “Sometimes you do not want to lay that much on, you know what I mean?” (7a). These daughters’ mothers were in later adulthood. Their average age was 70 years old. Moreover, the mothers often did not live geographically close by.

Talk to others. Although diagnosed women in this age group did not feel they actively avoided topics, they admitted to talking about certain topics only with their husbands, sisters, and/or girlfriends. Sometimes, women felt that those were just issues about which they could more easily share with these particular loved ones. In addition, it seemed that these daughters could interact in more depth about certain issues with other individuals than their mothers. Although less prominently (and hence, not reported as an emergent pattern), this avoidant behavior also emerged in other age groups.

Midlife-Diagnosed Mothers’ Avoidant Communication with Their Daughters

The following findings are based on interviews with 12 middle-adulthood mother-daughter dyads (2 dyads with 2 daughters) and 1 single diagnosed mother (N = 27). Their
experiences were similar to middle-adult diagnosed daughters’ in that avoidance was described in relation to issues not coming up versus actual avoidance. Their experiences are described in detail below.

Avoided Cancer-Related Topics

Mothers and daughters indicated that certain topics did not come up—sometimes because they felt it was not something they had thought about (e.g., death/mortality), other times because they were too busy, and still others because it never surfaced in any conversation. However, they often explicitly stated that they did not perceive non-mention avoiding communication or particular topics. Rather, the topic did not seem applicable to their experiences with cancer.

Mothers frequently mentioned actively avoiding talk about one cancer-related topic: negative affect (see Table 3.1). Daughters also seemed to be aware that their mothers avoided this subject.

Many mothers indicated keeping their emotional distress to themselves. Some women recalled experiencing negative affect related to side effects (e.g., their feelings were more sensitive), as well as their emotional concerns about cancer in general. They reported actively hid any distressful feelings from their daughters. As one mother stated, “I tried not to get really upset … I have to turn my emotions on and off” (30a). In turn, daughters also recognized that their mothers avoided this topic. When asked whether her mother shared any emotional distress, one daughter stated, “I think she was experiencing stuff like that, but she never really talked about it with me.” Some daughters said that they knew their mothers shared those feelings with other people (e.g., a close friend).

Although mothers talked about consciously avoiding this subject in discussions with their daughter, at times it was unavoidable because the daughters were still living at home. One mother described this type of situation. This woman described not being able to control her
emotions all the time because the treatment and medications minimized her ability to do so.

Since both her daughters lived at home, they were often together:

I think I would have kept that [sad emotions] internal. I don’t think I would talk to either of them about it. Although what seemed to happen for me was like I would cry very easily about things. That was very obvious to them because out of nowhere, they would be kidding or whatever, and I seemed ultra sensitive to things … I felt like I could cry at the drop of a pin and I was very sensitive … They obviously noticed and they probably felt like they had to walk around things a lot and be more cautious because there were frequent episodes where I would just cry. (26a)

Although daughters and mothers noted such instances, they rarely discussed them or sought to determine how their mothers were feeling. Often, they simply ignored the matter. Interestingly, although both mothers and daughters seemed to be aware that negative affect was frequently a struggle for the mothers, it was nonetheless a topic that they consistently tip-toed around.

Reasons for Avoidance

Midlife-diagnosed mothers’ reasons for avoidant communication of cancer-related topics had to do with their daughters’ well-being. Many mothers avoided this type of talk to prioritize their daughters’ wellness. As noted, most daughters were young (average age of 20). Their behavior was especially influential on mothers’ openness and avoidant communication. Hence, it is not entirely unexpected that diagnosed women would be especially concerned about how their daughters were handling the diagnosis. The mothers identified two reasons for avoiding this talk to prioritize their daughters’ wellness: daughter does not want to talk about it and protect daughter (see Table 3.1). These reasons also arose in the presentation of mothers’ and daughters’ openness experiences.

Daughter does not want to talk about it. Both mothers and daughters mentioned many cases when daughters did not want to talk about anything cancer-related. For some mothers and daughters, this characterized their relationship throughout the cancer experience. Although
mothers worried about their daughters’ withdrawal, they seemed to feel their daughters’ avoidant behavior was sometimes helpful to their well-being and adjustment. This was also important to mothers who tended to worry about how their daughters were coping. One mother explained how she made sense of her daughter’s withdrawal behavior: “It is a way to protect your mind from too much heavy stuff” (20a). Daughters often did not want to hear about their mothers’ treatment side effects, medical decisions, or concerns regarding genetics and their need to take preventive steps to avoid developing the disease. Daughters reportedly showed avoidance by changing the subject, ignoring their mother, making jokes, staying away from their mothers, leaving the house, going to their rooms, or blatantly telling their mothers that they did not want to talk about it. In response to their daughters’ avoidance, mothers avoided cancer-related talk.

Mothers interpreted daughters’ avoidance in different ways. For instance, they sometimes felt that their daughters were too young and not ready to deal with certain cancer-related topics. In these instances, they portrayed the daughters as ignoring the topic or making light of it. One mother reflected on her daughter’s avoidance in this way when she tried to talk to her about genetics and prevention. This mother had tested positive for a breast cancer gene and had additional surgery (removed ovaries) to prevent a recurrence. As a result, she was especially worried about her daughters’ potential for developing the disease. Her daughters, who were in their early twenties, did not want to talk about this issue. The mother recalled:

I know they really don’t want to talk about it. I mean, it’s too much to deal with it right now. It’s overwhelming to think about—worrying about breast cancer and them getting it … Every now and then if I have an opportunity I’ll say something but they probably don’t like it that I say something … It is really hard when you’re a mother, though, because you do want to talk to your children about it, but when they don’t want to talk about and then so you really have to—it’s a fine line of not being obsessed with it … You would like them to come to you or something or just so they come to terms with it … I think I would bring it up if it came [up]. I wouldn’t bring it up myself. I think I would bring it up if we were doing something together or we found out somebody else got breast cancer or something like that that would bring up the topic … They wanted to
ignore it for now. I think that’s fine … [Referring to one daughter] She’ll deal with it when she needs to deal with it. (20a)

The mothers often felt that their daughters avoided cancer talk because they were protecting themselves. Their daughters presumably were upset about the diagnosis, and avoidance was their way of coping. Because of this, these mothers often felt it was necessary to mirror their daughters’ avoidant behavior.

The daughters also often described their avoidant communication in ways that appeared to validate their mothers’ experiences, such as claiming to withdraw to protect themselves. As one daughter stated, “If you have to talk about it, it makes it more real so avoiding it kind of made it less real” (26b). One daughter who was a senior in high school when her mother was diagnosed, described such an experience:

I didn’t really know how to react to it so I kind of hid from it and I kind of blocked it out of my mind … just like looking at her and knowing that she might not be there next year like killed me … I was angry about it but I don’t think that’s why I pulled away. I pulled away ‘cause that’s like the only thing I knew that I could do to help myself through it because I’d be a mental wreck … It was easier for me at the time just to shut it out of my mind and just pretend nothing was happening … Once she stared chemo it hit me that like, hey! I got to accept this or else it’s just going to keep haunting me for this entire thing. So I finally did … I shut everybody out at first. And I was just like I’m in my box and you’re not going to come in. (16b)

This daughter eventually talked more openly after going to a therapist. A few other mothers talked about having their daughters see a therapist or counselor to help them stop avoiding the subject and start talking.

Some mothers recalled avoiding topics because their daughters had always been uncomfortable or queasy about medical subjects. Daughters often found this avoidance as natural for them, in that they could not stand the thought of anything medical (e.g., blood or surgery). Their mothers also talked about the avoidance as consistent with their daughters’ comfort level with physical or health issues. However, most mothers mentioned their daughters not wanting to
talk about cancer in relation to the stress it caused. Avoiding or withdrawing was daughters’ way of minimizing their own distress.

Although the mothers seemed to understand that this avoidance was what their daughters sometimes needed, the daughters often felt guilty about their behavior once their mothers entered recovery or survivorship. As one daughter observed, “Looking back, I probably could have been a little more focused on her and asked more questions about how she was doing and things. But just selfishly, I don’t know. Maybe I thought I couldn’t handle the answers” (36b). These daughters recalled how difficult it was for them to see their mothers vulnerable, weak, and upset. Still, daughters often felt the avoidance was helpful and necessary. As one daughter stated, “It is kind of better that she did not tell me some of the stuff because it was hard for me … it would have made it worse.”

Protect daughter. Mothers also avoided topics because they wanted to prevent their daughters from feeling distressed. These mothers did not avoid talk because their daughters withdrew, but because they knew it would upset their daughters. They avoided talk about cancer to keep their daughters from worrying about them. Many made reference to the difficulty in avoiding talk in relation to the daughter’s needs and well-being, as one mother in discussing withholding information from her daughters about her diagnostic tests said:

I would hope that I was open with them and yet, by the same token, I don’t think I went overboard explaining things. Maybe I didn’t give them enough information but I tended to just gloss over things. I did not want them worrying about it … I just wouldn’t say anything because I didn’t want them to be concerned … I didn’t tell them much because they were already going through enough and they were both going back to school … I didn’t want them worrying about me. So I didn’t add all that other stuff to them. I just kind of didn’t want them to see that emotionally. (26a)

Many mothers noted avoiding cancer discussions because they felt it would only distress their daughters and distract them from their own lives. Many of these mothers’ daughters were
starting or returning to college and involved in extracurricular activities. One mother reported feeling this way:

I really didn’t want to tell her anything. I figured she had enough to adjust to going away to school and being in [sports]. You know I think she had plenty to deal with to get adjusted to. And I wouldn’t be selfish hurting her with all that until I needed to tell her. (29a)

Some mothers noticed that their daughters were worried and, hence, avoided talk. As one mother said:

She had a bad time with it. So now I’m not too honest with her unless I’m sure … If it’s serious then I’ll tell her. In the beginning I tried to tell everything. Now I think it’s too much for her emotionally. (30a)

Mothers were aware that their avoidance did not always please their daughters, even if they were trying to protect them. For instance, one mother recalled keeping information from her daughter that she eventually found out about. This mother became quite ill after her first chemotherapy treatment and had to be hospitalized. She and her husband did not call to tell their daughter because she was away at college. They did not want to disrupt her studies. When they did finally tell her (after the mother was home from the hospital), their daughter was furious and even responded by withdrawing from her mother communicatively. Similarly, another mother recalled not telling a daughter who was studying abroad about her diagnosis until she returned home. This daughter was also angry at being kept in the dark. These daughters recognized that their mothers did not disclose to protect them. However, they felt that they could often tell when their mother hid things and that not knowing what was wrong caused them worry. As one daughter noted:

She does not want to make me feel bad about it or something like that. I do not know if that makes sense … It would kind of bother me a little bit that she did [that], but I think she did it because she would try and hide it. And sometimes she could, but sometimes she was not good at it. (30b)
The young women in this cohort indicated that they did not always want to know or even talk about their mother’s experiences related to cancer. Notable, however, is that the daughters always wanted to know when something serious had happened (e.g., mother being hospitalized) but, at the same time, did not necessarily want to hear all the details of their mother’s experiences (e.g., side effects) or to talk about cancer topics all the time.

*Later-Life Diagnosed Women’s Avoidant Communication with Their Daughters*

The following findings are based on interviews with 11 later adulthood mother-daughter dyads (1 dyad had 2 daughters) and 1 single diagnosed mother (N = 24).

*Avoided Cancer-Related Topics*

Mothers avoided talking with their daughters about two cancer-related topics: future uncertainty and death and negative affect (see Table 3.1). The nature of mothers’ and daughters’ avoidant experiences with these is the subject of interest.

*Future uncertainty and death.* Mothers admitted that they rarely, if ever, talked to their daughters about their future-oriented cancer concerns. These topics included mortality/death, survival rates, recurrence, and struggles with uncertainty about their own health in the future. Some mothers felt it necessary to bring up their potential death just once because, as one stated, “We don’t know what’s up tomorrow” (19a). Several admitted to being scared about death but did not discuss their fears. As one mother indicated, “No, I haven’t shared that with very many. I don’t want to share it with them [her children]. You know that’s one thing I don’t think [my daughter] and I have really said is about death” (4a).

Daughters recognized that this topic was absent from their interactions. One recalled her parents in a sense, banning it from their communication: “Pretty much immediately, either my mother or father or both of them said, ‘Nobody’s talking about dying.’ I’m sure [this was] one of
the first things my mom said after she told me about being diagnosed” (9b). Daughters also
seemed to understand that even though it was not discussed, survival remained a concern for
their mothers. One daughter recalled the topic coming up once but never again.

I know the kinds of things she is thinking about and the kinds of things that make her
upset or depressed through this whole thing. Questioning how long she’s going to live. I
know that kind of stuff stresses her out and that type of stress for my mom stresses me
out … We haven’t really talked about that directly. Before radiation we addressed it
minimally … I know it’s on her mind but we haven’t really talked about it all. (41b)

Some mothers felt death was unnecessary to talk about because they did not believe they were
dying. These women sometimes referred to the high survival rate with breast cancer. Other
times, they noted that mentally, they were just not “there” in their experience with the disease.
Hence, like midlife-diagnosed women, these mothers often clarified their avoidance in relation to
the nature of their cancer experience. Yet, they also admitted talking about it once and then never
bringing it up again in contrast to the earlier age group whose members did not discuss the topic
at all.

Mothers and daughters also recalled that they rarely talked about recurrence or
uncertainty about the future. Most mothers were open in the interview about their fear of
recurrence but admitted they did not share that worry with their daughters. Daughters seemed to
 recognize that their mothers lived with these concerns, even after treatment. One recalled sensing
these concerns each time her mother went for follow-up appointments.

I know that she worries about [recurrence], but she doesn’t bring it up much. I think when
she goes for her exams, you know, we’re all worried. And then, you know, her tests. But
when she comes home she’s like, “I’m okay.” And we’re like, “Oh good. We’re all
coming over.” (17b)

Like their mothers, the daughters also avoided bringing up this topic. Many daughters reported
that they let their mothers raise issues because they did not want them to feel uncomfortable or to
have to think about cancer if they did not want to.
Negative affect. Mothers also rarely disclosed to their daughters any negative emotions they had throughout their cancer experience. They confessed to trying to hide their emotions from their daughters. As one stated, “All the negative feelings that I have, I tried to keep personal” (19a). This avoidance was noteworthy in how women talked about their side-effect experiences.

Even though their mothers were not forthcoming about their emotional distress, daughters were keenly aware of their mother’s emotional states. Moreover, they realized that their mothers particularly avoided any talk about feelings of depression. Depression or feelings of extreme sadness are a notable challenge many women encounter due to hormone changes from chemotherapy, as well as the psychological trauma of the diagnosis. Still, mothers rarely talked about the challenges posed by emotions in the mother-daughter bond. Even when mothers did share their feelings, daughters typically described them as glossing over. One daughter described her mother as avoiding a full disclosure of her feelings in the following:

She would say, “Oh I’m not feeling good today” or “I’m kind of down.” But [my dad] was the one that said [to me] “These days a week, after she’s had chemo, she’s depressed. Seriously depressed.” And made sure that I understood that it was not just like “Oh, I don’t feel very well” … He made sure I really understood what she was dealing with. (9b)

Daughters also reported that they could sometimes sense their mothers’ depression in their tone over the telephone or visually see it in their expression. Other times, daughters learned of their mother’s struggles with depression from another family member (e.g., their fathers or grandmothers). Yet, like their mothers, daughters avoided talking about negative emotional states with their mothers. This avoidant behavior may be associated with an understanding (both on the part of the mother and daughter) that older generations are less comfortable freely expressing their emotional feelings due to their experiences growing up in a more closed sociocultural
environment. Young-adult diagnosed women tended to talk openly about medical experiences with their mother but did sometimes disclose their emotions related to those experiences.

**Reasons for Avoidance**

Mothers had two strong motives for avoiding cancer-related talk with their daughters. Like previous dyads, these mothers avoided communication with their daughters to protect them. Unlike the other dyads, however, these mothers had an additional reason for avoidance: to maintain privacy (see Table 3.1).

*Maintain privacy.* Many mothers indicated that their reason for not openly talking with their daughters about certain cancer-related issues was to maintain their privacy. Numerous mothers explained that they were “very private people.” Some felt that because they valued their privacy, they preferred to talk about issues like death and future uncertainty with their husbands, not their daughters. As one mother observed, “Being a private person, I would’ve preferred not to have to do that unless it was necessary” (19a). Mothers admitted not telling their daughters “everything” because they felt they would then lose any sense of privacy. This motive seemed to be the reason mothers did not disclose to their daughters their negative emotions. One mother explained this by saying:

I don’t want everybody to know how I feel. You know sometimes you want to hide your emotions. Sometimes like I say—if I’m too down, you know, if I’m down I don’t want to [answer] “What’s wrong?” I don’t always want to tell what I’m thinking … You know maybe I have an ache or pain somewhere that I’m concerned about … But I don’t always tell them that so—She doesn’t need to know everything. Sometimes she thinks she should. (4a)

Daughters often recognized that their mothers valued their privacy even though most daughters discussed this in relation to their mothers’ behavior with hair loss. Often, the daughters reportedly attempted to talk to their mothers about not wearing their wigs and instead wearing a pretty scarf or even nothing once their hair started growing back. As one daughter said, “She
would never go in public without her wig on … She was always covered” (19b). Mothers sometimes admitted avoiding these talks as their daughters did not understand that the wig was also a means of maintaining privacy. One mother explained, “A scarf around my head still tells people I have cancer. My wig does not. [My daughters] finally just stopped saying anything ‘cause they knew I was not going to change my mind” (41a).

For mothers diagnosed in later adulthood, privacy seemed important. They were guarded in terms of how much of their cancer experience they wanted to expose. As such, their desire for privacy influenced their avoidant behavior with their daughters about their cancer experience.

*Protect daughter:* Many mothers, in this cohort, recalled avoiding talk about cancer because they did not want their daughters to worry or be upset. In addition, by avoiding talk, mothers felt they were not making a “big deal out of it.” This effect seemed to be particularly important in making sure their daughters were not overly upset by their mothers’ diagnosis. Mothers had this concern because they also knew their diagnosis was, on some level, upsetting to the daughter. They seemed to feel that by not talking about anything cancer-related, their daughters would worry less.

Sometimes avoidant behavior involved censoring information, and at other times, mothers delayed telling their daughters things. For instance, some mothers recalled waiting to share bad news (e.g., positive biopsy results) because they did not want to ruin their daughters’ day. One mother described her avoidant behavior for this reason: “Somehow I thought [the news] would change how [her day went] … I really felt like well, I am going to wait about telling news like that …I was thinking about protecting her, but how silly is that?” (9a). Daughters were also aware their mothers shielded them from information to prevent their becoming emotionally distraught or, as one daughter put it, a “mental case.” One daughter who
struggled with serious anxiety talked about understanding why her mother displayed avoidance: “I really think she was more concerned about my emotional [state] … I think she was more concerned about not upsetting me at all” (42b). One mother even confessed to avoiding cancer-related talk because she felt responsible for negatively altering her two daughters’ lives because of her diagnosis. She discussed her reasoning for her avoidant communication:

All three of our lives are drastically changed from a year ago. And I hate that. And so the less I can [talk about it]—bad enough that we’re doing appointments and surgeries and all other kinds of things. So I don’t do it when it’s not absolutely necessary. (41a)

Like those in the other age groups of diagnosed women, these mothers felt a sense of responsibility to their daughters from additional, unnecessary distress. However, unlike daughters of mothers diagnosed in midlife, daughters of women diagnosed in later life did want this information. For them, not knowing what their mothers were going through was even more distressful.
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Research Questions 6-7: Enacted Emotional Support

Research questions 6-7 concerned diagnosed women’s experiences of enacted support communication from their mothers/daughters. Both the women’s and their mothers/daughters’ interviews were analyzed. Numerous types of behaviors surfaced. Some enacted support communication was perceived as helpful and, thus, always adaptive in diagnosed women’s adjustment to their condition. Other supportive communication ostensibly functioned both adaptively and maladaptively. Context appeared to be what best accounted for the variability.

Emotional communicative support behavior that appeared consistently to function adaptively is the initial focus. Patterns of communication that could function both adaptively and maladaptively follow. The role of context was derived from participants’ own words. These descriptive experiences are important in understanding why women perceived the support as helpful or not. As in the previous sections, the analyses unfold by age group beginning with reflections from mother-daughter bonds when the woman was diagnosed in young adulthood (see Table 3.2).

Diagnosed Young-Adult Daughters’ Experiences of Enacted Support with Their Mothers

The following findings are based on interviews with 7 young-adult daughter-mother dyads and 1 single diagnosed daughter (N = 15). Women diagnosed in young adulthood were targets of support from their mothers that they described as primarily adaptive or as functioning in both adaptive and maladaptive ways.

Adaptive Enacted Emotional Support

Four types of enacted support communication were recurrently in the data as consistently functioning in an adaptive manner: listening, showing affection, being humorous, and doing
things to cheer me up (see Table 3.2). Following are descriptions with quotations from the interviews that provide exemplars.

Listening. Daughters felt that their mothers’ carefully listening to them was helpful in their adjustment. Listening was especially important when daughters shared their emotional feelings and concerns with their mothers, which was not a common disclosure for daughters. In these instances, daughters admitted that they wanted their mothers simply to listen, to let them talk, often without any input. One daughter described her need for this type of support: “Sometimes you just like to vent … She’s always willing to listen” (34b). When mothers listened, daughters felt they had the opportunity to vent, express their concerns, and cope with cancer in their own way. One daughter expressed how her mother enacted this type of emotional support: “She doesn’t correct me or tell me how I feel” (22b).

Mothers seemed to understand that, at times, their daughters needed them just to listen. Hence, they remained silent and allowed their daughters to deal with their concerns as they needed. For instance, one mother stated, “I just listen … She has to deal with it the way she has to deal with it. So I don’t like to put in my two cents” (22a).

Showing affection. Showing affection always helped daughters in their adjustment to cancer. Several daughters recalled receiving affection from their mothers more frequently soon after the diagnosis. Most often, they received more hugs from their mother. Mothers also recalled saying “I love you” frequently. At times, this form of enacted support represented an effort to provide comfort to the daughters. Such affection was especially comforting for daughters who experienced hair loss due to chemotherapy treatment. One reflected on how upset she was when her hair fell out in clumps quite quickly. She recalled, “I came out of the shower crying and she put her arms around me … [she was] taking me in her arms and letting me cry because it was a
shock” (13b). In addition, mothers showed affection to comfort their daughters when they received upsetting information. For instance, some recalled moments when their daughters were emotionally upset and sometimes cried after receiving disappointing test results from their physicians. During such times, mothers noted how they consoled their daughters with a hug.

**Being humorous.** Daughters indicated that humor was especially helpful in coping with their cancer experience. One daughter noted that humor “kept us on air.” Often, humor centered on treatment side effects or outcomes, specifically changes in the daughter’s body. For example, women joked about hair loss, mastectomies, plastic surgery, and menopause. Their humorous behavior ranged from jokes to teasing. One dyad even went to laughter therapy together. All of the daughters in this cohort felt that telling jokes, teasing, and laughing together made the atmosphere was more comfortable and, hence, the adjustment to cancer easier.

A common way of enacting this support was for mothers and daughters to create humorous nicknames. These nicknames typically referred to bodily changes after treatment. For instance, women adopted various nicknames to characterize their hair loss. These names included Uncle Fester (from *The Adams Family* to describe women’s bald head), Easter Chick (to describe the soft fuzzy nature of their hair as it grew in), and Groucho Marx (to describe a daughter’s eyebrows, as one brow grew back growing up and the other brow was growing downward). Some women even had nicknames for their tumors and breasts (e.g., Frankenboob) that were removed.

Other women recalled finding humor in unexpected situations. They noted that humor functioned adaptively by lightening up the serious nature of the cancer experience. For example, one mother-daughter dyad recalled joking every time the daughter’s three-year-old son put on her wig. Another mother-daughter pair focused on the “ridiculousness” of the cancer experience.
This daughter recalled that she frequently experienced side effects that were considered less common (e.g., losing eyelashes after chemotherapy). She and her mother reportedly used humor to cope with these extreme bodily changes:

I was one of those freaks that “Oh, this hardly ever happens to anyone that all their eyelashes fall off.” You know what I mean? I was always like the exception so it became a joke. We kicked about it. You know like I always say “You know what? It’s still not as bad as having both your breasts removed!” That just became the joke. (21b)

In addition, a daughter recalled that she and her mother joked about their experiences with menopause. This daughter experienced chemotherapy-induced menopause and her mother happened to be going through natural menopause at the exact same time. This mother and daughter were even taking the same medication. The diagnosed daughter went into detail how she and her mother laughed together about their side effects, especially the hot flashes.

Exhibiting the humor, “We love being in menopause together!” (14b), she said

Doing things to cheer me up. Mothers often made special efforts to cheer up their daughters throughout their cancer experience. These included sending funny cards, care packages, flowers, and books. Daughters also recalled that they especially appreciated it when their mothers took them out to dinner or lunch. Several daughters recalled that this type of support helped them feel better able to deal with the disease.

This type of emotional support communication tied particularly to daughters’ treatment experiences. Mothers often sent their daughters things to cheer them up when they had a lot of “down time” at home alone as a result of being in treatment. For instance, some mothers sent their daughters care packages or funny notes. They also often accompanied their daughters to treatment sessions. One daughter recalled, “Right after my first chemo treatment, we went out to lunch and we got a manicure/pedicure. [She laughs.] … Then she took me shopping!” (22b).
Mothers further enacted this emotional support by doing things to celebrate various milestones throughout the cancer experience (e.g., the end of treatment). Both mothers and daughters felt that celebrations lifted their emotional state. Some daughters even celebrated with formal trips abroad or to the beach with their entire families to commemorate key points in their cancer experience. One mother recalled several celebrations that were instrumental in cheering her daughter up:

Her friends had a benefit for her right before she entered treatment ... That was enormously uplifting for her ... And then after she finished treatment it was her birthday and we arranged a hall and we had a birthday party for her. And she really enjoyed that! (33a).

Enacted Emotional Support that Functions both Adaptively and Maladaptively

Some supportive communication daughters experienced with their mothers functioned adaptively at times but maladaptively at others. The following patterns of enacted support communication were recurrently identified in the data as functioning both positively and negatively: being there, mothering, staying positive, and validating decisions (see Table 3.2).

Being there. Daughters and their mothers frequently stated that the most helpful enacted support daughters received from their mothers was simply their “being there.” Mothers often expressed this support verbally by telling their daughters that they were there for them, no matter what. As one mother stated, “Many times I’ve said, ‘You’ve got me, and I’ve got you’” (13a). When mothers could not physically be there for their daughters (e.g., during surgeries), they often verbally expressed that they were “there.” For instance, mothers told their daughters they were there with them in spirit. Some women even told their daughters to do things to remind them that they were there with them. For example, one told her daughter to squeeze her own hand, and that meant she was there with her.
Daughters also described consistently having a sense or feeling that their mothers were “there” for them. For them, the expression meant they could rely on their mothers in coping with breast cancer. The sense that their mothers were there for them seemed to put daughters at peace. As one stated, “I would say it made it easier—the fact that she was by my side … My mother was by my side” (22b). Another daughter stated, “She always did what she said she was going to do. I could always count on her” (21b). Interestingly, when asked, many mothers admitted that they rarely asked their daughters if it was okay to “be there.” Rather, they merely assumed that their daughters wanted them to enact this type of support or that it was the right thing to do.

“Being there” typically referred to supportive communication in two contexts: health advocacy/partnership or companionship. First, diagnosed women discussed this form of communication in relation to their mothers being present in the health setting. Some mothers acted as their daughters’ advocates in doctors’ appointments and during treatment. One daughter described how her mother enacted the support of “being there” in this context:

She took a very big part of being my partner. She made sure she was there with my first—when I first sat down with the doctor to talk about the type of cancer I had ... And she would always drive me to my chemo treatments. She like set the standard for everyone else. (13b)

The participants reported numerous types of behavior their mothers enacted in the health setting that conveyed to them that their mothers were emotionally supporting them by being “there.” For instance, some mothers helped their daughters remember questions to ask doctors and also listened and talked to them about medical decisions. Mothers seemed to feel that being there in this context was important, particularly if the daughter was not married. As one mother stated, “[Me being there] is having someone to share it with, because she’s by herself” (38a).
The adaptive functioning of mothers “being there” as a health advocate or partner depended on certain factors. “Being there” functioned adaptively when daughters and mothers worked together in the health setting. As one mother indicated:

We go to the doctor’s. I go with her and she talks and then I ask questions. And a lot of times she’ll have me write things down for her so she can have a record of it … They gave a whole lot of information and, you know, there are so many questions. We just wrote them all down and we looked at the question. And so I had the questions and I would ask [her] “Is it okay?” to make sure because I think when anyone goes to the doctor in a situation like that, they could be telling you stuff but you don’t really hear it or you can’t remember. (22a)

Daughters seemed to appreciate their mother’s advocacy in this sense. Many noted that support in this context was helpful because the experience itself was so shocking. They recalled that because of the shock, it is often difficult to remember everything health professionals say during appointments. This adaptive functioning of “being there” in health interactions was especially helpful during chemotherapy treatment when daughters struggled with “chemo fog” or “chemo brain,” a side effect that adversely affects short-term memory. One daughter pointed out:

Chemotherapy kind of gives you a bit of a brain fog, they call it, and sometimes you forget things and can’t remember things that are told to you. So you really need somebody there that will listen to what the doctor or whomever is saying and if you forget, to be able to tell you … and getting them to explain the treatment and when I have had problems with the treatment to, you know, try helping me speak to the doctor or person in charge to get things changed for the better. (13b)

“Being there” in the health setting also functioned maladaptively at times. This occurred when mothers asked too many questions, became emotional or confused, or neglected to negotiate their role with the daughter. In these circumstances, the mother’s presence became a source of distress for daughters. When this was the case, most daughters did not invite their mothers to future medical appointments or treatments. One daughter shared such an experience:

She went along to the initial appointment where they told me what stage it was and things like that and it really, really upset her and she was really confused. So then I didn’t want her to go to the appointments like that because I just thought it was too upsetting for her
… I had mixed emotions [about her coming] … I think it was more stressful … She hung on certain words they said … Sometimes she makes me a little more nervous when she’s in there cause she’ll ask too many questions … She’ll drive me crazy like just picking or something, you know like nagging me. Like “Oh did you do this? Or you need to ask them what? Why is this?” (34b)

Mothers often recognized when “being there” was not emotionally supportive or helpful to their daughters’ adjustment to cancer. For instance, they seemed aware that, at times, they asked too many questions. However, even though they were concerned about the consequences of this behavior, not all mothers associated it with why their daughters eventually shut them out or monitored their involvement in the health setting. It also seemed particularly important for mothers to negotiate their role with their daughters for “being there” to function adaptively in the health setting. For instance, a daughter recalled finding out that her mother was asking her physician questions without her knowing. She mentioned being upset with her mother’s behavior and feeling frustrated about her mother’s inability to understand why she was upset. She expressed her frustration saying, “I understand that I am her daughter, but you still shouldn’t be having conversations with my doctor about me … And again, I was wrong for thinking there was anything wrong with that!” (33b).

The second context in which women characterized their mothers as “being there” was when their mothers provided them companionship—usually in daughters’ homes. The adaptive functioning of this type of emotional support depended on a number of factors. Daughters indicated having their mothers made them feel less alone. They also felt that by having their mothers with them in their homes it gave them something other than their condition of which to focus. As one daughter stated, “It was nice to have [her] around too and nice to have the company when you’re just kind of laying on the couch all day” (15b). Daughters’ mothers seemed to want to be there as well. One mother said, “[I was] wanting to make sure I was with
her all the time, didn’t want her by herself, you know? Just listening to her talk, her concerns…” (38a). Often, the mothers were thrilled that their daughters wanted to spend time together, particularly when they perceived their daughters as independent.

When this enacted support functioned adaptively, these instances were times in which daughters wanted their mothers’ companionship. One, whose mother came and stayed with her, noted wanting her mother there while she underwent treatment. She recalled how therapeutic their companionship was for her:

When I was done with treatment it was kind of depressing because we didn’t have these sleepovers anymore … We’d stay up those nights when she slept over. We’d stay up those nights and talk. But not necessarily about the whole cancer thing. I think it was more like camaraderie. You know, like old times type of thing [reminiscing]… It made us feel more—well, you always feel good when you talk to your family about the way things were, like there’s a part of your childhood that helps make up who you are and I think when you bring those feelings back, then I guess it’s like healing in a way. (21b)

“Being there” as a daughter’s companion also seemed to function more adaptively when the women respected each other’s space. As one daughter stated, “Sometimes you just want to be alone.” Sometimes both mothers and daughters seemed to be aware of one another’s need for space. One mother recalled that it was often difficult to leave her daughter but that it was necessary. She reflected on a time in which she left her daughter alone for an extended period to visit another ailing family member:

I didn’t want to go anywhere without her … because for all these past months, she’s been right there beside me. And I feel like if she’s with me, then everything is okay because I know she’s okay … It did me good [to leave her daughter alone] and it did her good. Gave her some, you know, a little bit of alone time and it gave me some. (13a)

Mothers noted that they eventually gave their daughters more and more space when they seemed to be feeling better, were ending treatment, or were not bothered by being alone.

Space was important in whether or not “being there” as a companion functioned adaptively. When mothers did not give their daughters space, their companionship was not
helpful in their adjustment to the disease. At times, mothers’ presence competed with their
daughters’ husbands’ presence. Other times, too much time together resulted in personality
clashes, as one mother observed:

The trouble is I think, we’re a lot alike and you know how that is. You can just go at each
other. And then I’ll tell her, “I think it’s time for me to go home and are you feeling okay
and good enough? If not I’ll stay” (34a).

Daughters also described a need for space but for different reasons. They described feeling
responsible for their mothers being there. Also, some daughters felt they could sense their
mothers’ emotions about the disease. Even if they wanted their mothers with them, sometimes
the mothers stayed too long. As one daughter stated when her mother was leaving after an
extended stay, “I’m ready to have my space back!” (15b).

Consistency also contributed to whether support functioned adaptively in either the health
setting or as a daughter’s companion. When mothers were not consistently “there” for their
daughters, they questioned mothers’ priorities. Some even felt that their mothers were not putting
their feelings and needs first. Several daughters discussed situations they felt conveyed to them
that their mothers were only “half” there. Interestingly, all of these experiences occurred during
the daughters’ treatment of surgery or chemotherapy. These daughters all made reference to
moments when their mothers gave greater priority to their own feelings and needs or their
siblings’ rather than their daughters’. In these daughters’ experiences, the mother had been
conveying to the daughter that she was “there” (e.g., being there at the daughter’s appointments,
in her home, or at the hospital). However, she then abruptly pulled away. Some daughters, for
instance talked about their mothers going on unplanned vacations during their treatment. One did
so right after the daughter’s first chemotherapy treatment. Daughters also recalled their mothers
putting their sibling’s needs ahead of their own. In these cases, daughters felt their mother
disregarded their feelings or the seriousness of their experience by prioritizing the needs of a sibling. One daughter described feeling like, “I can’t even have cancer!” (21b). When mothers were inconsistent in this way, daughters felt their mothers’ behavior was odd and confusing to them.

Mothers rarely mentioned such experiences. When they did, it was in reference to the daughters’ experiences with their siblings. These mothers also mentioned that they still struggled with trying not to give greater priority to one child’s needs, even when one daughter had cancer. As one mother explained, “I have two. I try to keep it equal. It's hard to do that sometimes” (33a).

Mothering. Mothers also enacted emotional support by “mothering” their daughters. Many of the daughters felt that the diagnosis increased their mothers’ maternal behavior. Daughters made sense of this change in behavior as their mothers’ maternal instinct kicking in. One woman described this support in saying:

“It seems like they go into doting mode. They want to be the first ones there. They want to be there to know everything, to help. And I think they just go into that mode where they need to fix it and they can’t.” (34b)

Mothering consisted of calling daughters to check in on them (often every day), asking them questions to make sure they were taking care of themselves, and trying to be helpful. One daughter characterized her mother’s “doting” as follows:

“Oh my God! She would make sure I was eating or try to eat or drink. “Have you drank today? Did you drink water? You have to drink something. You know you have to drink something. Did you take your meds?” It was a typical mom situation kind of thing like when your kid is sick.” (14b)

Women differed by relationship in terms of how much mothering they experienced. However, the daughters typically perceived that the mothers wanted to be of assistance (e.g., come over to
help in any way), comforted them (e.g., being affectionate), and made sure they were doing okay (e.g., calling frequently to check in on them).

Whether this behavior functioned adaptively or maladaptively in emotionally supporting daughters depended on the daughters’ perceptions of whether the support was excessive. The daughters noted that their mothers’ calls and questions let them know they were concerned about them. Many diagnosed women felt this expressed concern was comforting. However, others felt that when the calls and questions were too frequent, mothering communication was not helpful. Several daughters admitted this type of support could even become annoying. One daughter described feeling that it was important that mothers not “overdo it” or overreact:

She was calling, calling, calling constantly. I totally understand that she was worried or whatever. It did get annoying after a while and I’m like “Mom I’m fine … I will call if I’m not fine” … It was like every day and drove me insane every single day. And I’m like “Oh my God! I’m fine!”… I said “Mom, you don’t have to call every day.” [She said] “I don’t care. I just want to make sure you’re okay.” I’m like “Mom I’m fine. If I’m not going to be fine, I will call you.” (14b)

When daughters felt the mothering support was excessive, they mentioned becoming upset with their mothers and even cutting conversations short. Some mothers seemed to understand daughters’ need to not be over-mothered. One mother who lived some distance from her daughter described being careful not to overdo the mothering support of calling and checking in:

I’d just check in periodically … I have to remember, too, that she’s not feeling well this day [treatment days]. I mean, I think I would phone when I knew she was having a treatment or whatever. I’d phone a couple of days later to give her a chance to recoup a little bit and then see how things were. Or, you know, I’d phone [her daughter’s husband] when she was in the hospital and stuff and see how things were and stuff like that. But I wasn’t on the phone [a lot]. I kept thinking, you know, when you’re sick, the last thing you want is 50 million people phoning you to see how you’re doing, even if it is your mother. (15a)
Daughters’ experiences also suggested that a sense of control was a key factor in whether they found the mothering to be helpful or not. For mothering to function adaptively, daughters seemed to want some control of their mothers’ support. For example, it was important for daughters to determine if and when they needed their mothers’ help. This sense of control seemed especially important because daughters felt such a loss of control because of their medical condition. They noted feeling torn between understanding their mother’s need to mother with a need for control themselves. They mentioned their need for control because the disease had robbed them of so much control over their lives. One daughter summed this dilemma up:

I think it was just - it was hard for her just because here her daughter has cancer. She wants to be there and help her. And me, like I like to be independent and I don’t like to ask for help from people. So that made it hard for her because you know she is living at a distance. I think - she sat there [and was like], “I want to be there for my daughter. And I want to help her and here she is fighting me on it.” You know what I mean? But you know when you’re diagnosed with cancer you lose that sense of control over your own body yourself, and any little bit of control or independence you can have you want. So that makes it hard. (34b)

The daughters’ dialectical struggles with feelings of control, in respect to whether mothering functioned adaptively or maladaptively, depended on whether the mothers respected their daughters’ need to call the shots. For instance, one daughter recalled her mother being fine with her not answering the phone when her mother called to check in on her. On these occasions, she simply left the message that she just wanted to see how the daughter was and to give her a call when she could. Another daughter recalled her mother allowing her to decide whether or not she needed her:

I like it in that she will offer “Whatever you need. Just tell me.” But not you know - not pushy about it. Not “Oh I want to come down there. I’m coming down. I’m taking care of you!” You know she never did that. So she sort of left it up to me and I liked that. I was sort of like “OK I actually need you to come down now.” [And she was like] “Okay, yeah. I’ll do it and I’ll figure out what to tell them [at work] that I’m not working that week” … So yeah I had asked her and she was really happy when I asked. She wanted to be wanted that way and didn’t want to impose that on me and ask … So she was really
excited. (15b)

*Staying positive.* Women described various forms of enacted emotional support from their mothers that centered on their remaining positive in their outlook as they struggled with body image, lost their hair, expressed emotions, or awaited for test results. Although mothers admitted that talking positively to their daughters was sometimes difficult as they too felt the strain of coping with cancer, they felt it was nonetheless necessary. Many of the daughters also felt that mothers’ positivity was critical to their adjustment and survival.

Mothers engaged in positive talk in many ways including reassurance, encouragement, being optimistic, and maintaining a positive attitude when they talked with their daughters. They also told their daughters stories of other survivors to reassure them. They sometimes complemented their daughters for how strong they were, how beautiful they looked during treatment and hair loss, and how proud they were of them. Mothers recalled that positive talk was important in “pumping up” daughters when they seemed down. As one mother stated, “If you had a positive attitude, you could come through a lot things. And without one, sometimes they just didn’t make it” (13a). Several mothers noted the importance of this quality on multiple levels. One mother recalled the power of her daughter’s positivity on her own attitude:

I remember her saying once when she went to the cancer clinic and they had a group and they put her in. And she said, “I was probably one of the youngest ones there.” She says, “But there was this one lady there.” And she says, “I just felt so bad for her, Mom, because I just really felt like she wasn’t going to make it because of her attitude. Like she was so whiney, and it was almost like she wasn’t fighting. You know, you’ve got to fight! You can’t say, ‘Why me?’ You’ve got to say, ‘Hey, it’s me!’” … Her positive attitude has made my attitude better. (15a)

Some daughters felt that being positive was how they and their families approached life. One daughter bluntly stated that it was an outlook of “Shit happens … Get over it” (14b). Many women also felt that any negative talk was pointless, saying “You’re in it for the long haul.
There’s no turning back” (15a). Daughters seemed to feel their mothers shared this outlook and that positive talk was behavior they jointly enacted. According to one daughter:

It’s both of us … I think we always try to take something good out of it. Let’s just look at it, see where it’s taking us, where can we go with it, and hopefully we come out a better person after it.” (21b)

In contrast, some daughters recalled that their mothers’ positive behavior ran counter to the norm. Regardless of whether the positive talk was new for mothers and daughters, for the most part, positive talk was often helpful in daughters’ adjustment. The mothers’ enacted support helped minimize their anxiety and gave them hope. Mothers also often recognized that their positive talk helped minimize their daughters’ worries. One daughter recalled how she worried about test results she was waiting on. She felt that when her mother responded positively it was helpful:

I say, “You know I talked to [the hospital]. They said this.” She may say “Oh that’s great! That’s good news!” Or I’ll get her opinion on something, like “Oh so what do you think? Do you think everything’s going to be okay?” And she’s like, “Oh yeah. I don’t have any bad feelings. I think things are going to be fine.” She is positive in that sense and sometimes I’m like “Are you just saying that?” You know? It’s so unusual for her! [She laughs] … She’ll tell me not to worry about something, which is surprising coming from her. But if I say, “Oh my gosh! I got to go through this test. I hope everything’s okay. Oh my gosh! I hope it doesn’t come back!” And she’ll be like “[Daughter’s name], don’t even worry! Everything’s going to be fine. You’ll be fine. If it is something, we’ll deal with it.” … Sometimes I just need to hear that. (34b)

Some women admitted that although they appreciated the positive talk from their mothers, at times, they took their mothers’ words with a “grain of salt.” In these instances, daughters felt that nothing could make them feel better. This experience often coincided with daughters’ loss of hair or struggling with body image after a surgery. For example, after her mastectomy, one daughter reflected on feeling “free” to choose clothes more easily because she was no longer large breasted. However, at the same time, she had difficulties adjusting to her new body:
I remember going out to some mall … I had always been kind of top heavy. It was weird for me to be flat … I was like [to my mother] “Everybody has boobs!” and I just kind of like put it out there. And she was like, “You will be getting well again soon.” … I don’t know if there’s anything she can say that was really helpful … I was feeling bad … I had to just kind of work it out on my own so I don’t think that she handled it like good or bad or anything—I don’t know if there’s anything she could really do. (38b)

Positive talk functioned maladaptively when daughters felt that their mothers were also being dismissive of their feelings. As one stated, “As long as it’s just talking positive and not crossing over [my feelings], it’s helpful. Once [she] crosses over something then it’s not helpful.” In this case, the daughter recalled her mother minimizing her concerns about recurrence. “Sometimes she goes, ‘You don’t really have to worry about that because you’re young and your doctors are on top of things’” (13b). Another daughter described a similar experience when she expressed her frustration trying to find a bathing suit that fit her after her mastectomy:

I have a big divot under my arm [from the surgery]. And the first time I went bathing suit shopping I was with my mom and that was one time I remember [her saying] “Well it doesn’t look too bad.” And I’m standing there. I came home bawling. I was really—that really upset me. Because that’s when it really hit me that this was—bathing suits are not made for people without breasts … I think that was one of those [instances] where you don’t understand. Like I remember saying to her she didn’t understand because she wasn’t the one going through it … I needed to talk to someone else who went through it. (21b)

These daughters felt their mothers’ positive talk minimized their emotions. As a result, their mothers’ communicative support was unhelpful in their adjustment. One mother’s reflection indicated that it may be necessary for mothers to respond in a way that allows daughters to express both positive and negative emotions. She talked about this when describing her own daughter’s struggles with adjusting to cancer:

Sometimes when she was down [and I was] trying to convince her that it was going to be okay, you know, it was going to get better. I think sometimes she was very, very tired and down … You know, you can’t go through something like that and not have the ups and downs. (13a)
Validating decisions. Daughters also needed their mothers’ validation. This type of enacted emotional support communication was most important when daughters shared their treatment decisions with their mother. As previously noted, daughters often told their mothers about their care decisions (e.g., whether or not to have a mastectomy) after they had made them. Hence, daughters were not looking for their mothers’ input. They were not sharing their decisions in an effort to talk through them. Daughters noted that in these instances if their mothers validated their decisions, this support was especially helpful in their adjustment to breast cancer.

Mothers enacted validation by reaffirming daughters’ decisions, agreeing with them, not questioning their decisions, and not suggesting what they should do. It was especially important for daughters to feel that their mothers had faith in their decisions. One daughter said this: “She just always, you know, believes exactly what I believe and is totally behind how I feel about everything and you know, just knows that I am strong” (15b). Mothers admitted not always agreeing with their daughters’ decisions. However, rarely did they voice this. Instead, they told their daughters that they believed in what they were doing. One mother reflected on her reasons for doing so even when she felt her daughter should make a different decision:

She had all the facts and she knew what all the consequences were. And she had the facts and like nobody—I don’t think anyone can know what they would do if they were in that exact position unless they were in that position ‘cause she had the facts and all the information … It’s her choice. (22a)

Sometimes, daughters received validation from their mothers after they followed through with decisions (e.g., having a mastectomy or getting genetic testing). Other women’s mothers expressed their validation beforehand. When mothers enacted this emotional support communication, daughters felt it helped in adjusting to living with cancer because this response
did not burden them with underlying pressure, it minimized their negative emotions, and it showed them that their mothers believed in them. As one daughter stated:

She just kept it real simple and just said, “Yeah, you know, whatever you think you need to do” or “That makes sense—whatever makes sense to you.” … She was never like “Well, you know, you really should do” [or] “I understand how you feel but you know this is why you should to that” … You never felt like there was this underlying pressure from somebody. (15b)

Another daughter recalled that it was important that her mother never questioned her decisions because questioning would have added to her negative distress. This woman recalled how hard it was to adjust to her hair loss, and in an effort to adapt, she invested in several wigs. She recalled how her mother’s validation helped her adjust:

[She] never questions why would I be spending money on wigs, which I am glad because I am kind of [feeling] guilty, like I shouldn’t be spending money. It was like one of the things I just needed to do. (38b)

For this supportive behavior to even be enacted by mothers, it was critical that they understood that their daughters were not asking them for their insight when they openly talked about their medical decisions. Several mothers seemed to comprehend this as one mother summed up:

She was just talking to me saying “These are my options, and I don’t like this option, and I would prefer not to do this if I didn’t have to. And I’m going to look into it some more and see what else I can do.” You know, things like that. I don’t think she was asking my permission … I’ve always said, “You know what? It’s your body. You know your body better than anybody. And it’s your mind too … If you are not comfortable with it, it’s not going to be good for you … It wasn’t a matter of saying “Oh what do you think of this?” It was a matter of “This is what I’m looking at right now.” (15a)

When mothers did not understand this need, they failed to demonstrate faith in their daughters’ decisions. Consequently, their responses negatively affected the daughters’ adjustment.

Ultimately, a lack of validation (and even disagreeing with daughters’ decisions) resulted in the daughters withdrawing from her mother. Daughters recalled that when their mothers failed to
validate their decisions, they either cut them off in conversation, changed the subject, or refrained from talking to their mothers about their decisions in the future. Behavior that functioned maladaptively in this context included the mothers questioning their daughters’ decisions (e.g., “Are you sure?”), arguing with them about decisions, or letting the daughters know they opposed the decision. For instance, one daughter recalled her mother not agreeing with her when she decided to have a mastectomy instead of a lumpectomy. The daughter felt her decision was appropriate because it gave her the “best shot” at survival. This woman recalled her mother arguing with her on other decisions as well. She eventually completely shut her mother out of any of her breast cancer experience. Interestingly, mothers in these cases seemed to be aware that their daughters were not seeking their permission and that their opinions did not motivate their daughters’ decisions. Nonetheless, they sometimes continued to engage in this non-validating communication.

Midlife-Diagnosed Daughters’ Experiences of Enacted Support with Their Mothers

The following findings are based on interviews with 5 middle-adulthood daughter-mother dyads and 2 single diagnosed daughters (N = 12). As in the young-adult daughters’ dyads, some behavior always functioned adaptively, whereas others’ behavior functioned variably in their adjustment.

Adaptive Enacted Emotional Support

The following types of enacted emotional support were recurrently identified in the data as always helping diagnosed daughters adjust to breast cancer: being there, listening, and being humorous (see Table 3.2). Two of these types of emotional support (listening and being humorous) also surfaced in young-adult dyads as behavior that was always helpful. However, being there, in young-adult dyads, functioned in both adaptive and maladaptive ways. In
contrast, middle-adult daughter-mother dyads found this type of enacted support to be consistently helpful. These types of communicated support are described below beginning with how mothers emotionally supported their daughters by *being there*.

*Being there.* Daughters frequently felt that their mother was most emotionally supportive to them by just “being there.” This type of enacted emotional support included mothers being physically present during surgery and treatment. However, unlike young-adult dyads, their presence entailed only physical presence, not serving as a health advocate or partner in fighting cancer. None of the mothers appeared to be involved in doctor-patient discussions (with the exception of one mother who was also a nurse), and most were there just to “be” with their daughters or keep them company. Women recalled knowing that their mothers did not want them to be alone, whether it was at an appointment, treatment, or even at home.

The diagnosed women also described “being there” in relation to being present in the daughters’ home during treatment and recovery. Some mothers even moved in with their daughters for an extended time period. At times, the mothers seemed to be most helpful in instrumental forms of support (e.g., housework, helping with the daughters’ children, and caregiving for daughters while healing). This finding is noteworthy. Even though diagnosed daughters were consistently asked about helpful emotional support, they tended to focus on instrumental forms of support as defined by scholars. Some stated that this form of support was most helpful and important to them—what they needed most to adjust.

Daughters also frequently referred to “being there” as a nonverbal, unspoken sense of presence that allowed daughters to know their mothers would be available in any way and at any time they needed. Daughters described this form of support as something they knew they could
constantly rely on. For instance, one daughter noted how her mother created this intuitive sense of “being there” to support her as she adjusted to breast cancer:

I think just knowing that she’s there … Knowing that I can count on her. And no matter what, she’ll do it if she can … It’s not something you can put your arms around or define, and it’s always been there. It’s not something new … It was always there … She always told me, “If there is anything you can give to your child, it’s something I hope I’ve given to you, is I’m always there.” (11b)

Daughters seemed to feel that having their mothers “there” brought them comfort and made them feel loved. Most daughters observed that this communication was how their mother always supported them. Most daughters said something like, “That’s just her.” Only one daughter felt the behavior was out of the norm. Nonetheless, she too welcomed her mother’s “being there” support and felt that it helped her adjust. She recalled this experience as follows: “She really wanted to be here … She wanted to be around … I don’t usually see a tender side of her and that was probably the closest thing to it. And that was kind of special.” (35b). Many women also indicated that they felt that this form of support was helpful for mothers’ adjustment as well as theirs. These daughters believed that allowing their mothers to “be there” for them helped them feel more at ease with their daughters’ condition and well-being. Daughters may have understood this maternal need as most were mothers themselves.

Many daughters reported that they never had to ask their mother for anything or tell her to “be there.” Rather, the mother just undertook this support at her initiative. Additionally, mothers often admitted that their daughters never asked them to be there for them. Daughters sometimes told their mothers that it was not necessary for them to be there physically. Some mothers did as their daughters told them but other mothers joined them anyway. Daughters seemed to accept and appreciate this. As one daughter explained, “She just wanted to be there.”
**Listening.** Many daughters felt that their mothers’ listening support was helpful in their ability to adjust to the diagnosis. Women in this cohort described their mothers’ listening behavior as “being a sounding board.” They also sometimes associated this enacted support with being there to listen when they needed to talk. Hence, this form of communicated emotional support seemed partially connected to daughters’ intuitive sense that their mothers were there for them (i.e., *being there*).

As in the young-adult dyads, diagnosed daughters in the middle adulthood group referred to their mothers enacting this type of support when they voiced their fears of getting through it. Some also felt that listening was important when they shared with their mothers the medical decisions they had made. By mothers listening to them, the daughters felt that their mothers “accepted” their decisions. Many described this support as helpful *any* time they needed to talk. One daughter said: “She didn’t always have all the right words or sometimes she didn’t even answer me. She just listened to what I had to say and that was okay” (11b).

**Being humorous.** Interviewees also recalled that humor was adaptive in their adjustment. They noted that this form of support consisted of talking about funny memories they had experienced over the course of the cancer, saying goofy things, as well as talking about funny television shows. One mother recalled periodically sending her daughter cute cartoons to lift her spirits. Although this type of support was not as prominently in these women’s lives as in the younger group of dyads, it nevertheless seemed to lighten the air of the cancer experience in the same adaptive manner. One mother felt that this was important in her daughter’s mental well-being saying, “I was just trying to keep her spirits up … brighten her day” (10a).
Enacted Emotional Support that Functions both Adaptively and Maladaptively

The following types of enacted emotional support appeared to function both adaptively and maladaptively: mothering and staying positive (see Table 3.2). These two types were also characteristic of young-adult daughter-mother dyads and were also sometimes helpful and sometimes not in their interactions. Middle-adulthood daughters’ descriptions varied slightly from the younger dyads’ experiences, however.

Mothering. Daughters acknowledged “mothering” as a form of emotional support that included calling to check in daily (or quite frequently) in addition to asking the daughter questions in a mothering way (e.g., Are you eating? Are you getting enough rest?). The daughters saw this type of support indicative of an increased focus on their health and a heightened concern mothers had in making sure their daughters were doing okay. They sometimes described this support as their mother’s “way.” They also seemed to understand that when mothers supported them in this manner, the mothers believed they were doing something to help their daughters. In turn, mothers were cognizant of the fact that they were emotionally supporting their daughter by enacting “mothering” communication. They admitted that they were especially worried about their daughters. One mother, noting that it could function maladaptively, stated, “I might have hovered a little bit more than maybe she wanted to but she never voiced it. Sometimes you have to back off a little too” (11b).

Most believed that this behavior helped daughters adjust. For instance, one daughter talked about how “mothering” encouraged her to take care of herself. She admitted that when her mother asked her whether she was getting enough rest, exercising, and eating right, she tended to watch what she ate or tried to manage stress better. Other daughters seemed simply to accept this type of support and, at the same time, appreciate it. Their acceptance could be linked to the fact
that the daughters understood its importance to their mothers’ adjustment. As evident in their description of “being there,” daughters felt this type of support was also helpful to their mothers’ well being. They needed to “mother” their daughters. More than half the daughters had children of their own (in comparison to only 2 of the diagnosed young-adult daughters), which may account, in part, for their increased understanding of their mothers’ need to “mother” them.

Only a couple of daughters mentioned how the behavior functioned maladaptively. It was not helpful when their mothers overdid it. One woman indicated how the behavior sometimes made her feel abnormal and like something was wrong with her. Mothering seemed to convey to her that she was to be pitied. Another daughter reported being irritated. She shared her experience with her 80-year-old mother’s behavior and how she overdid it:

She always calls me and checks up on me …. And if she doesn’t get me, I mean she’ll freak and she’ll start calling my friends. And so literally I have to tell her where I am at all times … It was a little excessive … I don’t care that she checks in on me but she can’t panic if she can’t find me. (5b)

Such maladaptive functioning was consistent with young-adult dyads’ experiences. Still, middle-adulthood daughters typically framed this support as helpful. Moreover, they frequently revealed an understanding of the mothers’ need to engage in this behavior.

**Staying positive.** Daughters often discussed positive talk as a way their mothers emotionally supported them. This type of support included their mothers verbally encouraging them, reassuring them, and complimenting them on how they were doing. Mothers encouraged their daughters to keep fighting or reassured them they were coping well. They also reassured their daughters when they disclosed fears or concerns about what could happen in the future. Daughters felt that their mothers talked positively throughout the cancer experience. Sometimes mothers provided this type of support when daughters were feeling “yucky” from treatment side effects.
Daughters noted that this type of talk was helpful in their adjustment. As one explained, “She was very, very positive and very upbeat right away … That was a really good thing to hear right off the bat” (10b). Mothers also admitted trying to point out positives and always to maintain a positive atmosphere. One mother mentioned her firm belief in enacting this type of emotional support:

I’ve learned from experience. I am 70 years old and I’ve learned from experience that it doesn’t do any good to think about it and sit around and mope. You know, you have to get up and go out and do something to make you feel better. (7a)

These descriptions seemed to mirror young-adult daughter-mother dyads’ experiences. However, women in the middle adulthood dyads did talk about one form of communicative behavior that conveyed positivity those in the younger age group did not—reframing. Mothers often reframed situations their daughters encountered in a more positive light. According to the daughters, they felt their mothers’ ability to reframe situations was particularly helpful in their adjustment. For instance, one mother reframed her daughter’s anxiety about the diagnosis (the “what ifs”) by telling her to focus only on what they knew for sure. Another mother reframed her daughter’s complaints about her husband (who was not helping with the children and housework during her chemotherapy treatment) by telling her of situations that could be worse. A third mother reframed the seriousness of her daughter’s disease by focusing on how happy she was that the diagnosis was not terminal (a revelation she had after the Virginia Tech tragedy). All of these instances of reframing seemed to help daughters rethink how they were doing and made them feel better about their situations.

Although the daughters frequently talked about how helpful positivity was in their adjustment, two situations indicated that talking positively may not be helpful at times. One daughter mentioned not really wanting to hear her mother’s positive talk when she was feeling
bad from treatment side effects. She just wanted to “lay there.” Another daughter said that initially her mother’s positivity made her feel as if she did not realize how serious the situation was. She reported this response: “I think my initial reaction to her being so positive was almost like, ‘No it’s not! What do you mean? How can you think like that?’” (10b). These situations are similar to the younger dyads’ recollections of how positive talk is not always adaptive. For midlife-diagnosed daughters, positive talk was not helpful when it simultaneously minimized or dismissed daughters’ present or “in-the-moment” feelings.

**Midlife-Diagnosed Mothers’ Experiences of Enacted Support with Their Daughters**

The following findings are from interviews with 12 middle-adulthood mother-daughter dyads (2 dyads had 2 daughters) and 1 single diagnosed mother (\(N = 27\)). Middle-adulthood mothers primarily talked about how their daughters supported them by focusing on ways to adapt to their present circumstances. Hence, findings are more heavily focused on adaptive than maladaptive communication. Nevertheless, this group of mothers and daughters did discuss how certain types of emotional support communication could function both adaptively and maladaptively.

**Adaptive Enacted Emotional Support**

Six types of enacted support communication that always seemed to function in an adaptive manner emerged from the analyses: *listening, showing affection, being humorous, staying positive, staying normal, and being there* (see Table 3.2). Five of these types of support characterized previous dyads’ experiences. However, a new form (*staying normal*) important to women’s adjustment emerged. In sync with the previous two age groups of dyads, *listening, showing affection, and being humorous* always functioned adaptively. Moreover, unlike young-adult diagnosed daughters, but consistent with diagnosed midlife daughters’ reports, *being there*
always functioned in a helpful manner. Interestingly, unlike the previous dyads, the current cohort of women felt that *staying positive* was always helpful emotional support.

*Listening*. As in other mother-daughter dyads, it was important to mothers in this group that their daughters listen to them. They were not very descriptive in characterizing this form of emotional support, however. Typically, they simply reported that it was important to them that “she just listened” (30a) or that “listening was helpful” (39a). At times, the support elicited a sympathetic response (e.g., “I’m sorry you feel this way”) or a positive comment (e.g., “Things will get better”). More commonly, mothers and daughters described this behavior without reference to any verbalizations on the daughters’ part. Daughters often talked about providing this type of support because they did not know what else to do. One daughter stated that it really was the only thing she could do to support her mother: “I don’t know if there is anything you can say” (26b). Another daughter had similar thoughts about why her support took this form. She recalled being her mother’s “sounding board” as she discussed her treatment decisions: “I knew that it was just kind of for her to talk them out and hear them out loud” (36b).

*Showing affection*. After their diagnoses, mothers recalled a noticeable increase in the amount of affection they received from their young-adult daughters. The daughters also recalled that they displayed this form of support more frequently than ever before. Showing affection included giving hugs, saying “I love you” and kissing the mothers. Mothers found this to be atypical of their daughters’ behavior. As these daughters were all young adults, it is likely that they were showing this emotional support for the first time since adolescence—a time of separation for mothers and daughters.

Mothers found this type of support helpful in their adjustment because it made them feel more normal and loved. They also seemed to be appreciative because it was new behavior for
their daughters. The mothers frequently noted that the behavior was not “normal,” that it was “a lot more frequent than it had been,” or indicated that it was “never [done] before.” One mother indicated how noticeable of a change this was to her:

She never really gave me a hug or kiss me or say “I love you” before this all happened. Completely changed. She says she loves me all the time, texts me that, gives me a hug now all the time when she sees me. That was not [my daughter]! (28a)

Some daughters also admitted that this type of support was new to them. They felt that they could enact this support after seeing their mothers being affectionate. Other daughters indicated that the diagnosis made them become more “open” to this type of emotional support. Still, other daughters mentioned wanting to behave in this way for the “first” time in their relational history. As one daughter said:

There have been a couple of times where I kind of put my arm on her back, and I would never have done that, I think, before. I never felt the urge to do something like that … I knew she was having trouble … I remember just looking at my mom, making eye contact with her, and putting my arm behind her. (29b)

Mothers also reported valuing this type of support because it became a pattern of communication in their relationship. Their daughters showed this kind of support more consistently by expressing their love every time they said hello or goodbye, each night before they went to bed, or making sure that it occurred on daily basis. One daughter described her reasoning for consistently displaying affection when engaging in certain interactive activities with her mother:

Whenever I got off the phone I have to—well, I do not have to say it. It’s always like “Alright—bye—I love you. Alright—bye—I love you. Alright—bye—I love you. Alright—bye—I love you.” Put the phone down now! And if you try to leave, it is usually I give her a hug no matter what or where I am going … [What if] something happens? Then you are going to feel bad that you did not give her a hug. So that is always in the back of your mind. (30b)
Being humorous. Mothers and daughters often made reference to their use of humor to cope with breast cancer. Like those in other dyads, humor was particularly helpful to mothers’ adjustment because it made the issue “lighter.” As one mother recalled, “We buried a lot of this in funny stuff … You know try to make light of it and try to giggle about it, because that’s all you can do” (16a). Moreover, mothers felt that humor served to protect their minds from trauma, to help them stay strong, and to keep things normal. Although it seemed that mothers often were the source of the behavior, daughters also displayed humor by making jokes, giving their mothers nicknames, and being sarcastic.

Typically, humor reportedly helped mothers cope with their “losses.” These included the loss of a breast, loss of hair, and loss of menstruation. For instance, daughters often joked with their mothers about being jealous because they did not have to deal with bras, large breasts, or having a period. Daughters also used nicknames for their mothers as their hair grew back (e.g., Chia-Pet). Daughters recalled joking about their mothers’ drains after they had a mastectomy (e.g., one daughter called them her mother’s grenades), as well as their remaining breast (e.g., Unaboob). One mother shared how her daughter joked with others about why the mother was home from work: “She would tell people this spring ‘Oh no my mom doesn’t have cancer! She’s just home to be my wedding planner!’” (6a). Another daughter mentioned using a nurse’s cap she found from a Goodwill store each time she would give her mother an injection at home to have “fun with it.” Daughters often mirrored their mothers’ humor as one noted in the following excerpt:

We were making dinner one day and my mom goes [to my dad] “Do you want the [mother’s name] special?” Cause we were having chicken. He’s like “What’s that?” and she’s like, “One breast, two legs. Do you want one?” And I’m like “Mom! Stop!” … She’s learning to accept it and joke around it. It’ll be good stories for later on! (16a)
Staying positive. Interestingly, diagnosed mothers always felt that daughters’ staying positive was helpful in their adjustment. This was in contrast to the other groups of dyads, in which this form of emotional support reportedly functioned both adaptively and maladaptively. In opposition, mothers diagnosed in midlife felt this support was always adaptive. This difference seemed partly tied to mothers perceiving the support affected them differently for reasons related to having a young-adult daughter. Although mothers felt staying positive made them feel strong and let them know their daughters believed in them, they also observed that positive talk let them know that their daughter was doing okay. This type of support included daughters reassuring their mothers, maintaining a positive outlook or talking positively, encouraging their mothers, and, in a few instances, giving their mothers compliments. Mothers sometimes associated such behavior with their daughters opening up more.

Many of the diagnosed women felt that this type of support was important for both mothers’ and daughters’ well-being. As in the other age groups, sometimes they felt that positivity was a family norm. Yet, the mothers really wanted their daughters to have a “positive outlook” regarding their situation. When daughters did act positively, this behavior really uplifted their mothers’ spirits and made them feel comfortable with how the daughters were coping. As one said:

She just believed that I had the strength to do this … “Believe. You know, just believe in yourself.” And it was like the word in the house … That’s what she would tell me. It was almost like it came full circle. It was like what you preach and what you teach comes back. (29a)

Daughters often portrayed this sort of support as having reciprocal effects. Seeing their mothers’ strength made them strong and positive. However, they also admitted that type of support was something they did when at a loss concerning what else to do. They wanted their
mothers to be happy. Daughters also seemed to feel a responsibility to be positive because that was how their mothers had behaved with them in the past.

Interestingly, mothers often mentioned enacting positive talk in response to their daughters’ communication. For instance, when mothers seemed to be struggling, daughters said encouraging things like, “You’re doing fine,” or reassuring their mother with, “It’s going to be okay.” Mothers frequently reciprocated by saying something like, “I know it’s going to be okay. I’m just really tired,” or “I’m going to be fine.” Mothers seemed to reciprocate positive talk to ensure their daughters they were okay. Such exchanges seemed to facilitate mothers’ adjustment because they otherwise worried about how their daughters were coping.

*Staying normal.* It was also especially important to mothers that their daughter enact support that conveyed to them things were normal for them. Normality was a subject of frequent mention in this age group as important to helping mothers adjust to the situations. Mothers frequently found this type of emotional support as most helpful in their adjustment. As one mother observed, “I may have discussed this with them, that keeping things normal … there was no reason to change anything because what’s best for me … for all of us is to go along as we normally are” (26a). Mothers wanted their daughters to maintain their normal routines and to “keep life as normal as possible” (29a). They felt that daughters provided emotional support by sharing with them about their lives, engaging in mundane talk, continuing their lives as usual, maintaining good grades, and acting as if the diagnosis was not all that big a deal. One mother explained how she perceived this as supportive and key to her adjustment:

I wanted to know what she was doing … Because that made me feel comfortable to know if she was continuing to go, you know, out to lunch with friends or going to her study groups and all that. I wanted to know that she continued on and wasn’t sitting there dwelling on me or anything else … For her to continue her life as she is, that’s actually, that’s comforting to me. That makes me feel the comfort I need to do what I need to do … As long as I know she’s doing what she needs to be doing, continuing with her work
and her schoolwork, going to go to all her tests, participating in cultural events that she
likes. That actually brings me so much comfort. I can sit here and do what I need to do
for myself and not be worried about her. I can concentrate on myself more so … For her
to be continuing to do that, just like I wanted her to, has been helpful for me. It’s been a
good thing. (39a)

Daughters also felt that it was important to maintain day-to-day activities, such as
watching television together at night, doing their chores on certain days, or as one daughter put
it, continuing to do “the things we would have done together before” (20b). Some daughters
noted that “staying normal” served as a distraction from cancer. This was important in
preventing their mothers from becoming depressed. In addition, the daughters found that by
sharing their lives they also helped mothers feel needed, or as one daughter stated, “Like she is a
big part of our life and like we need her” (28b). Daughters felt this effect uplifted their mothers’
spirits and kept their relationship as it was—normal. One explained:

That’s important to like not focus 100% on the cancer and just like not stopping that part
of the relationship. So I think it’s important to maintain some sense of normality. I think
my mom would have gotten upset or angry if I stopped telling her things just because I
didn’t want her to have to deal with them or think about them or something. Just because
she had cancer. (6bb)

Similarly, daughters often indicated that not staying with their normal routines likely would have
been maladaptive. One daughter felt that altering her behavior would have made her mother feel
worse. She felt it was important to keep “the normal routine down instead of altering everything
and making them feel like everyone’s shifting everything around me and I’m such a problem”
(16b).

Being there. “Being there” was an important way in which daughters supported their
mothers. Interestingly, however, this form of emotional support was less common in interviews
with the current age group of mothers in comparison to those in other age groups. It is likely that
because daughters were either away at school or living in their mothers’ houses, “being there”
physically was less distinctive as a form of support than in other dyads. Nevertheless, mothers and daughters did mention this as a form of emotional support that always functioned adaptively in their adjustment.

As with the other groups, “being there” referred to the daughters offering to come home, being physically present with their mother, or voicing to the mother that she was “there” for her. When daughters offered to come home, mothers recalled appreciating this support but, at the same time, not wanting it. Typically, mothers explained that they wanted their daughters to stay in school. This reason seemed to connect to the perceived importance of daughters “acting normal.” Had daughters come home in the middle of college, their mothers would have been more concerned about them (e.g., falling behind in school, grades suffering, and the like).

Daughters seemed to understand their mothers’ feelings about them not coming home. When mothers discussed having their daughters physically present, this referred to being present at the hospital for surgery as well as when they shaved their hair. Mothers reportedly appreciated their daughters’ physical presence even more when they experienced especially traumatic aspects of the cancer treatment. Some mothers even recalled surprise visits from their daughters when they were in the hospital or in treatment that was debilitating. Some daughters also mentioned “hanging out” more with their mothers, when they were at home, to show their mothers they were there for them.

Mothers and daughters also felt that just saying “I am here for you” was helpful in mothers’ adjustment. As one mother said:

Just her verbalizing to me that she’s there for me. It’s not been doing laundry or anything like that. It’s just that she’s there and she’s concerned and she’s there no matter what. Yeah. And I think she appreciates the fact that I’ve made her a part of it, like taking her to do the wig thing and everything. (8a)
Daughters and mothers felt that in saying this, mothers had a stronger sense of support from their daughters and that they were not alone. One daughter discussed how valuable the support was to her adjustment because it allowed her to provide her mother support more comprehensively:

It is just being there, letting her know that anything you need or want to talk about, I am here. So just making yourself accessible to her. So I think that was definitely the big thing. Just having her aware that you are there for her because there is not one thing. I do not think there is one thing that you can do as a whole to help the situation. But as long as you, you know, your mom has your support and as long as she knows that, I think that was a big part of, that is what I would say just having her know that I was there and that she had me as a support system. (28b)

“Being there” was helpful in mothers’ adjustment because they more strongly felt their daughters’ concern for them. By their daughters’ being there, their well-being was “boosted.” Daughters appreciated their time with their mothers. It was hard to be away at school during this time when their mothers were trying to cope with their life-altering experiences. They also were aware of how much their mothers wanted to be with them. As one daughter stated, “I mean she is always happy to have more interaction with me and I felt more—I felt good being around” (39b).

Enacted Emotional Support that Functions both Adaptively and Maladaptively

The most prominent determinant of whether daughters’ behavior could function adaptively or maladaptively related to the daughters’ willingness to talk or withdrawal tendencies. Mothers and daughters seemed always to discuss these two forms of behavior in conjunction. Moreover, they (being willing to talk versus withdrawing) were the most prominently mentioned forms of influence in mothers’ adjustment to cancer or negative responses.

The mothers noted that it was important to them that their daughters show concern by their willingness to talk about their condition. Mothers recalled various signals that they were
willing to talk to their mothers about the breast cancer experience, such as calling more frequently or staying in touch more often, particularly during treatment. Mothers interpreted their daughters’ calling as more than just “checking in.” They felt it showed concern and that they wanted to be a part of their mothers’ experiences. This helped mothers to adjust. As one recounted, “She seemed to want to be involved and always asking ‘How are you?’ … I could tell she was concerned and always asking how I was doing and that sort of thing” (26a). At times, daughters showed concern by calling and leaving messages if the mothers were not accessible. Other times, they made daily phone calls or consistently called after each medical appointment. Mothers found it helpful when their daughters asked questions about how they were feeling.

In daughters enacting this type of support, mothers found themselves more easily able to adjust to cancer in healthy ways. Such supportive behavior let them know that their daughters would be there if they needed to talk. Hence, this enacted support conveyed to their mothers they were “there” for them. What was most important was that being there in this way meant mothers could talk about their experiences openly as one mother observed, “I know she’s there to talk when I need to talk to her … It’s just been the conversation. Just be able to tell her whatever and whenever” (16a). Mothers also felt daughters’ willingness to talk conveyed to them that their daughters cared about them more than before. This growth in their relational intimacy (and maturity in the daughter) was important as one mother in the cohort made clear:

She seems to be I would say more caring about me. So more sympathetic on her part for me which maybe I hadn’t noticed quite as much prior to that …That was a positive thing, where she’s more concerned about somebody else. (39a)

Some daughters indicated that being willing to talk was often the only thing they felt they could do to support their mothers because they were away at college. They felt it was important to allow their mothers to talk about anything they wanted and reported that they developed a new
appreciation for their mothers, as well as came to realize how important it was to talk to them. Many daughters felt this was a combination of their transition to college and young adulthood coupled with their mother’s diagnosis. For many daughters, it was hard to separate the two. One daughter explained this change in perspective:

Just kind of a realization that she’s not going to be here forever on my part made me want to call her and talk to her more … I think my mom needed me to be there for her and she needed at least one daughter around to be supporting her and things. And I needed to talk to her because I was scared and didn’t know what was going to happen … I’ll just call her when I’m walking home from class just to say hi and tell her about my day and see how she’s doing and stuff like that. And I would never do that before. I would never even think about it … I think it’s a combination of the experience and me growing up a little bit. Mostly I think the change is in me than in her. Because I think she always wanted this kind of relationship with me, and I’ve just never kind of been willing to give it until now. So, yeah, things have changed. (36b)

Mothers felt that when their daughters were willing to talk, they were being more mature. Mothers were happy that their daughters “didn’t back away,” particularly because they were used to that type of separation or independent behavior from their daughters. One mother recalled being reassured by such support from both daughters who were entering college:

At that point when they are getting ready for school and they’re not around much and they are kind of pulling away from you a bit. I think that that [daughters calling more] reassured me that she still cared about what was happening with me and that type of thing. And yet if I asked or needed to talk to them or anything, they both were very, very supportive. (26a)

Mothers often perceived this change in their daughter as influenced by their developmental maturity. Some, like the one below, did not feel that breast cancer effected this change in her daughter’s behavior—rather, it was a product of developmental change:

I think it was her age, you know and thinking six months before - the beginning of that school year, of tenth grade she had a different relationship then maybe we had in January and February. Her maturity and her wanting to talk to me more about things, a willingness to talk to me, I think changed our relationship. So I really don’t think it was the diagnosis. (27a)
Regardless of whether mothers felt the changes toward greater willingness to talk were
due to daughters’ age, the diagnosis, or a combination of the two, they valued them because they
revealed that their daughters were “different” now, more open, and becoming more selfless.
Daughters also reported that they felt they could now be more open with their mothers.
Consequently, mothers felt they adjusted better and, at the same time, their relationship with
their daughters evolved toward greater intimacy.

In opposition, were mothers’ and daughters’ experiences with the daughters’
withdrawing. Withdrawal was not uncommon behavior among the daughters. Many of these
young-adult daughters were in high school when their mothers were diagnosed or just beginning
college. They recalled withdrawing from their mother to protect themselves or because they felt
talking about it would make their mothers’ diagnoses an even more distressing reality. Mothers
felt daughters withdrew to protect themselves but also because they were still more self-focused
as late adolescents or emerging adults.

Daughters signaled this withdrawal by “pushing away” their mothers when they tried to
talk to them, “shutting out” their mothers, becoming very quiet, leaving the house, changing the
subject, and going to their fathers instead of their mothers. Mothers felt that this behavior
functioned maladaptively in their adjustment because it made them feel excluded and
unsupported, as well as more worried about their daughters’ well-being. One mother recalled
expecting her 16-year-old daughter to withdraw but not her older daughter, who was a senior in
high school. However, when she did, the mother realized that her daughter was still quite young
and potentially vulnerable:

An 18 year old is very self-centered. And they’re supposed to be. And you know in so
many ways she’s so mature. But in so many ways she’s still kind of supposed to be a
scared little girl … I was expecting so much with [her] and she was reverting back to
being the little girl and she was hurt. And you know it all had to do with her age and my
expectations and stuff. So there’s probably lots of things she could have done that would have supported me a lot more but I think the biggest problem is that she didn’t have the support. She was so scared. She was pushing away every single person: her sister, her boyfriend, to a certain extent her dad. So she didn’t have the support either. So that’s hard. (16a)

Another mother recalled her daughters withdrawing and not letting her talk. She felt that the withdrawal was for different reasons. More important, however, because her daughters did not let her talk, she felt unsupported.

I don’t think they realize it sometimes, but I think allowing me to talk. I wish sometimes they’d allow me to talk more than they do but they probably don’t …The younger one that’s more outgoing, she would allow me to talk more if her own life isn’t there. But she’s interested in her own things. And I don’t’ think she’d see why it was important to talk. But definitely [the other daughter] is not, doesn’t want to hear it really. She’ll deal with it when she needs to deal with it. (20a)

When mothers had two daughters, they often indicated having one daughter withdraw and the other not. Sometimes they felt that was normal for the daughter who withdrew. Nevertheless, sometimes mothers were surprised and worried about their daughters’ behavior. When daughters did not talk or allow their mothers to talk, mothers saw the behavior functioning maladaptively in their adjustment. It made them feel that their daughters were not coping well:

I think if she talked to me more when I was having surgery would’ve been helpful because I was really worried about her. Like coming to the hospital. I mean she would just like look at me. I mean I’m sure I looked horrible. But you know just for her to come over and say “Mom, are you okay?” or “What can I do?” or “How are things going? How are you feeling?” … [One daughter] did that. [This daughter] didn’t. So I was more worried for her. (28a)

Daughters also recalled that they withdrew and often were unwilling to talk with their mothers. They admitted they would “avoid talking,” “get out of the house,” “go out and get away from things,” and sometimes even tell their mothers that they did not want to talk. Upon reflection and once their mothers were in remission, many daughters were remorseful and felt guilty they had acted this way. As one stated, “I think I probably should have called her more
and stuff and I think if I would have I think it probably would have helped her” (6bb). Many daughters felt that they mentally could not handle talking to their mothers about their cancer. Withdrawing enabled them to cope. Many mothers, however, did not feel this behavior was healthy, either for their daughters or them. Some mothers even intervened and made their daughters talk. Others sent their daughters to therapists to help them cope. At the same time, some mothers felt it best to let their daughters be. These mothers felt that they would come around in their own time.

Later-Life Diagnosed Mothers’ Experiences of Enacted Support with Their Daughters

The following findings are based on interviews with 11 later-adulthood mother-daughter dyads (1 dyad with 2 daughters) and 1 single diagnosed mother (N = 24). When diagnosed in later adulthood mothers talked about how their daughters supported them, they tended to describe these interactions as mostly functioning in adaptive ways. As with the midlife-diagnosed mothers, these women often noted that their daughters’ support was always helpful in their ability to adjust to cancer. Rarely did mothers admit that their daughters’ behavior was not helpful. When they did mention unhelpful forms of support, they typically did so in an indirect manner (e.g., referred to communication their daughters did not engage in). In addition, they seldom described unhelpful interactions in detail but instead focused more on what their daughters did to help them. Hence, the findings are more heavily focused on adaptive enacted support than maladaptive communication.

Adaptive Enacted Emotional Support

Six types of enacted support communication that always seemed to function in an adaptive manner emerged: listening, showing affection, being humorous, doing things to cheer me up, giving compliments, and being there (see Table 3.2). All of these recurrently identified
types of support surfaced in interviews involving the other age groups. However, later-life women’s experiences with these categories varied somewhat.

*Listening.* As in the younger cohorts, any instance of daughters listening to their mothers talk about their cancer-related experiences and concerns was reportedly helpful in mothers’ adjustment. Daughters listened to their mothers update them on medical tests and procedures as well as when they began new treatment. As one mother stated, “She listens to everything I have to say” (23a). Mothers often mentioned how consistently their daughters displayed this form of emotional support. One mother felt her daughter was “willing to listen and eager to hear things” (32a).

The importance of daughters’ listening to their mothers seemed to be connected to mothers’ gratitude for their daughters being patient, understanding, and generous of their time. Mothers were appreciative of their daughters’ willingness to listen. Daughters’ listening helped in the adjustment to cancer. When asked about what supportive behavior had been most helpful to her, one mother responded:

I think being able to share what’s going on is sort of therapeutic and they [her two daughters] were willing to listen. It wasn’t like they didn’t have time for me … They just listened patiently. They were understanding. (42a)

Both mothers and daughters also made reference to “sympathetic listening” as helpful in the mothers’ adjustment. One mother found this type of listening to be especially important when she shared information with her daughter about the difficult side effects (e.g., mood swings) she experienced from chemotherapy. Unlike the daughters of midlife-diagnosed women who often sympathized by saying “I’m sorry,” these daughters’ responses were more complex. They responded sympathetically but also in a manner that also validated their mothers’ feelings. One
mother recalled that it was helpful when her daughter responded by saying things like, “Well that’s really hard” (9a).

Daughters also recognized the importance of listening to their mothers’ disclosures. They believed it important to let their mothers talk, sympathize, and to not interrupt them. As many daughters said, “I just listened.” Daughters felt listening was particularly important when mothers were describing side effects from treatment, as well as beginning new ones. As one daughter noted, this type of support helped her mother adjust to the many transitions related to changes in her care:

It becomes very relevant for her towards the end of treatment and when we’re headed into a somewhat unknown time period … Like when we change chemo or when we’re about to have surgery or when we were finishing up the post-surgical thing and heading into radiation. All of those things were the unknown. In those particular times, it was really important for her to have somebody, just to be able to say “Okay, this makes me nervous. I’m scared about this. I don’t know what I’m thinking here.” … There’s a lot of trepidation … So just listening to her saying “Okay, well, I’m really nervous about this” or whatever. Those times were very important to her. (41b)

As true of the younger mother-daughter dyads, those in this age group felt that listening was helpful in women’s adjustment to cancer. However, they focused more on daughters’ listening when mothers talked about procedures and treatment side effects rather than on emotional concerns, a topic frequently in evidence in young-adult diagnosed daughter-mother dyads’ interviews.

*Showing affection. As reported in respect to the younger dyads, showing affection always helped mothers’ adjustment to cancer. Women recalled numerous instances when their daughters’ affection was both welcome and helpful to them. Although showing affection consisted primarily of daughters giving their mothers hugs, they stressed the importance of other affectionate behavior, including smiling, holding hands, kisses, and engaging in more cuddling or “snuggle time.” Some diagnosed mothers recalled that their daughters gave them comforting
hugs when they were having “off” days or generally displayed more affection throughout the cancer experience. As one mother observed, “When we’re together we’re not afraid to touch each other or hug or hold a hand or something. And that’s good” (4a). When daughters showed affection, mothers reported feeling comforted, loved, reassured, and/or encouraged.

Unlike those in the younger cohorts, several diagnosed mothers also mentioned their daughters’ showing affection in respect to their heads after hair loss. Although mention was infrequent with both daughters and their later-life mothers, they saw the value of this behavior as significant. Daughters talked about rubbing their mothers’ bald heads often. In this connection, one mother observed:

She is always thinking about giving me that extra something—just extra warmth … She just had a way of handling my head nonverbally that was just so loving, reassuring, and fun. That was pretty neat. (9a)

It is noteworthy that although middle-adulthood daughters did not undergo chemotherapy (and, hence, did not lose their hair) all of the young-adult daughters did, but did not report this type of affectionate behavior from their mothers.

Being humorous. Daughters used humor to support their mothers throughout the cancer transition and portrayed it as something that “gets you through” tough experiences (32a). One mother felt humor was important to her adjustment to cancer because it lightened up dark moments and distressful experiences. A mother described humor functioning adaptively after her mastectomy in this way:

The girls still laugh about the fact that when I came out of surgery, one of the first things I said to them and I knew that I said it because I can hear myself saying it now was, “She only took one, right?” I looked at both of them and I said “She only took one off right?” … We all have that sense of humor and take life as lightly as you can. You know in a grave situation like this, you just can’t dwell on it in that manner. You have to make light of it and just keep going on. (41a)
Daughters seemed to share this perspective with their mothers. As one stated, “If we didn’t laugh, sometimes I think we’d just cry all the time” (17b).

Later-life mothers’ and their daughters’ experiences were similar to those in the previous age group’s dyads. Both saw humor as critical to mothers’ adjustments because it was instrumental in making cancer-related situations or experiences silly or fun. They mentioned using humor particularly in regard to treatment-related procedures. For instance, one mother described how she and her daughter joked about measuring fluid after surgery because having bags/drains was simply silly looking. Other mothers and daughters made reference to laughing and joking together about treatment side effects, such as nail damage and hair loss. For example, some women used humor to make wig shopping fun. They recalled laughing while trying on outrageous wigs and experimenting with different hair colors and lengths, such as being a “redhead” or “blonde.” After hair loss, daughters sometimes gave their mothers funny nicknames like “Bald Eagle” or “Michael Jordan.”

Unlike the younger dyads, the daughters of women diagnosed in later adulthood noted that they had to be careful about their humor. One daughter recalled how she and her sister joked with her mother about getting manicures (after the chemotherapy severely darkened her nails for an extended period of time) and teasing her after she lost her hair and eyebrows from chemotherapy, but in a way that was free of hurt:

We were routinely making fun of her and razzing her about the fact that she can’t draw an eyebrow on to save her life … I’d be looking at her eyebrows, way down below the line of her glasses, and I’m like “Mom, did you look in the goddamned mirror when you drew that on this morning?” She would just be like, “Oh, shut up! I can’t see because I don’t have my glasses on!” We made a lot of jokes about very bad eyebrows … She was fairly sensitive about losing her hair so my sister and I tried to make jokes about that. It was sort of a touchy subject with her so we tried to make little jokes and pet her little bald head every once in awhile but she was fairly sensitive about that kind of stuff so we did it a little more lightly on that kind of stuff … I always tried to interject some sort of light-hearted comments so that she would at least chuckle to herself. Sometimes she laughed
out loud … I think that was a huge way for her to cope because I forced her into laughing even though she’s not really prepared to laugh at that point. (41b)

Doing things to cheer me up. Like young-adult daughter-mother dyads, those in later-adulthood dyads talked about what they did to cheer the diagnosed women up. This type of emotional support was somewhat different from the younger cohorts, however, in that it primarily consisted of daughters giving or sending their mothers cards and sometimes gifts. Gifts or cards often went to the mothers after surgery and during treatment. As many daughters lived some distance away, this type of enacted emotional support was especially characteristic of daughters who could not be physically present with their mothers. Mothers recalled receiving flowers, sentimental and silly cards, and gifts. For instance, daughters sent their mothers sentimental cards expressing how much they meant to them. They also bought their mothers things to help them during treatment, such as yoga equipment or new clothes when they lost weight following chemotherapy. The mothers described instances in which they received gifts from their daughters that were related to their favorite things, hobbies, or interests (e.g., one mother mentioned her daughters buying her a lot of Halloween décor because she loved that holiday). Sometimes, this type of support was frequently in evidence throughout mothers’ cancer experience. One daughter recalled supporting her mother in this way. She left her mother small notes around the house throughout her cancer experience: “[I’d] just write like ‘Have a good day! Thinking of you.’ Or something like that because I know those things make her smile. So just to make sure to try to cheer her up” (17b). Another daughter made reference to this type of support as a conscious effort on her part to help her mother adjust:

[I’d] occasionally send a card, having flowers show up at her house, kind of thing. It’s just little small things like that. I’ve always sort of been very aware of how can I put a smile on my mom’s face kind of thing … I’ll stop by and I’ll just leave a quick note at her house. When she gets home she’ll see it and she’ll laugh. Little things like that. I’m trying to make a conscious effort to do that whenever I can. (41b)
Mothers reportedly found such support as uplifting and motivating. It made them feel that their daughters cared for them and were thinking of them. One mother stressed how important this type of support was when she returned home from the hospital:

When I got home from the hospital there were flowers here and the night before I went to the hospital [my daughter] bought me this lovely gift then left it here with a card. You know, that was very inspiring. (41a)

As in the case of the younger dyads, efforts to cheer them up were instrumental in keeping diagnosed women’s spirits high. However, the actual communicative acts in this age group consisted more of special notes or cards daughters wrote to their mothers rather than celebratory times together or care packages.

*Giving compliments.* Mothers seemed to be especially appreciative when their daughters paid them compliments. Daughters often complimented their mothers in regard to how strong they were, how beautiful they looked, how brave they were, and how wonderful mothers they were to them. This form of emotional support emerged in reports of other dyads’ experiences but primarily in relation to keeping things positive or cheering the diagnosed women up. In this group of dyads’ experiences, however, giving compliments most often reflected emotional support mothers received in relation to coping with their appearance.

Mothers seemed to value compliments from their daughter about how they looked after their hair loss more than in other types. As one mother stated, “No matter what I looked like [my daughter would say] ‘You know, you are so beautiful’” (32a). Daughters often reassured their mothers that they “looked good” or “beautiful” when they wore scarves, hats, or wigs. For instance, one mother noted how good her daughter’s compliments made her feel after she lost her hair: “I mean she was just so sure I looked really cute bald. She didn’t think I needed to wear that wig or scarf so she was really complimentary” (9a).
The daughters seemed to understand that their mothers needed to hear these compliments about their appearance during chemotherapy. One recognized that this aided her mother in adjusting to her new appearance and helped her to feel that she looked okay. This support seemed important in enhancing her mother’s self-image and self-esteem:

She loves when people tell her she looks good, she looks, you know healthy. She loves when people tell her that kind of stuff. That makes her feel really good. So it’s just—you know—kind of a—what’s the word I’m looking for—a validation to her that she seems well, she looks well, you know, those kind of things are important to her. (19b)

Some daughters sensed that their compliments helped their mothers adjust in other respects. Other daughters recalled their mothers confirming this. One reported her mother confirming this directly to her:

I definitely found myself praising her a lot. I genuinely was impressed by how brave she was and how she was able to, for the most part, really maintain a positive attitude. So I found myself praising that. When she lost her hair, she told me she was made 100 times more comfortable about it because I thought she looked really cute and I told her that a lot. And when she would come see me, I would say, “I like you bald the best. I think it’s really cute” … If I thought of a compliment, I’d give it to her and I think that made her a lot more comfortable, especially in terms of appearance things. Once she was losing her hair, she was initially really nervous and self-conscious about it. (9b)

The importance of compliments for later-life women related most directly to their feelings concerning hair loss. These women were self-conscious about their appearance because of this side effect, and their daughters were aware of their mothers’ struggles with this aspect of the cancer experience. Although other women, particularly those in young adulthood, experienced hair loss from chemotherapy, this was the first group of dyads to note the significance of receiving compliments in helping them cope with this difficult physical change.

Being there. Like those in the middle-adulthood daughter-mother dyads, later-adulthood diagnosed mothers often indicated that their daughters’ presence or “being there” was helpful in their adjustment to cancer. Unlike young-adult dyads (and like middle-adulthood dyads), these
women perceived this type of support as always adaptive. They frequently characterized this type of emotional support as “just being there,” “knowing that she was there,” or her “physical presence.” Mothers appreciated their daughters enacting this type of emotional support in such cases as being with them for appointments, shopping for wigs, celebrating events, and helping at home. Many of the mothers also noted that they wanted their daughters’ company. They felt that by her “just being there” or by “knowing she was there,” they were more at peace. Additionally, daughters’ keeping their mothers company, gave them a sense that they were not alone and that they could rely or count on their daughters for support. This increased their comfort level. One mother recalled how her daughter came home to be with her:

She dropped everything she was doing and came home. Which I didn’t anticipate her doing that but it was great for me. You know, she gave up everything … She gave things up. And she was there all the way. I mean she came home and actually lived here. So she was right with me the whole way. Very positive influence. I mean I was glad she was here. Cause, you know, you do need that. (4a)

“Being there” was especially important in helping mothers adjust to hair loss. One mother recalled her daughter being with her when she shopped for wigs, lost her hair, adjusted to wearing the wig, and adjusted to taking the wig off once her hair began to come in. She stated, “I rely on her to be involved in that way” (19a).

Daughters also frequently indicated that “being there” was the best thing they could do to help their mothers adjust. One even had moved home shortly before her mother’s diagnosis:

It’s very weird, but I think it was a good thing that I moved home when I did, before that happened to her … With me being back home with her is probably the best thing I could’ve done. Because otherwise I wouldn’t have been living with her and I couldn’t, you know, just be her sounding board or whatever she wanted me to be if I wasn’t here all the time. So I think that was probably the best thing … I think I needed her as much as she needed me to be there. Just that I knew she’d be okay. (17b)

Many daughters felt that “being there” for their mothers not only helped their mother adjust but it also helped them cope themselves. One daughter noted the importance of this sort of
emotional support when accompanying her mother to her treatment appointments, both for her mother and herself:

There’s a huge level of emotional support just being able to go there … There’s a huge emotional draw for me to be there supporting her because I know that that level of support, number one, she’s only going to get from me. And number two, she definitely counts on it. I wouldn’t have it any other way. I wouldn’t have not been there to support her. (41b)

Enacted Emotional Support that Functions both Adaptively and Maladaptively

Although mothers in this cohort tended to concentrate on how helpful their daughters’ support was to their adjustment to cancer and rarely mentioned unhelpful actions, at times, they did discuss maladaptive support that proved to be maladaptive in a less direct and less detailed manner. The following types of enacted support communication emerged in the data as resulting in both adaptive and maladaptive outcomes: daughter making an effort, staying normal, offering suggestions, and staying positive (see Table 3.2). Some of these categories of supportive behavior (staying normal and staying positive) reflect emotional support communication enacted in the younger dyads. However, the list includes as new daughters making an effort and offering suggestions.

Daughters making an effort. This first type of supportive communication identified in the data addressed a notable change mothers witnessed in their daughters’ communicative behavior—a change that showed new communicative and relational sides to the daughter. Mothers frequently described two similar changes in communicative behavior that were also ways daughters emotionally supported them. They consistently discussed these in relation to their recognition that their daughters were making an effort to help them adjust. The pattern of communication required two sub-types to capture the two similar but distinct communicative changes mothers felt daughters made in supporting them: spending more time together and
calling/talking more. These were not only important to mothers’ adjustment but also in redefining the nature of their mother-daughter bond.

**Spending more time together**

It was important to mothers that their daughters make an effort to spend time together. Daughters often talked about wanting to be around their mothers more and taking corresponding steps to do so. Daughters described this motivation in relation to a new-found understanding that their time together could be limited. As one daughter stated, “We have created a new sense of we really need to be together as much as we can … Whereas maybe before, it was sort of taken for granted” (41b). Daughters who lived at a long distance attempted to spend as much time with their mothers as they could. One daughter reported making quite a few surprise long-distance visits to see her mother after the diagnosis and throughout treatment:

> I think there was a big realization of what we had and how special it was … I really made an effort to get home or to have plans for her to come to [my home] … it was just really hard for me not to be there. (9b)

The adaptive nature and importance of this communication to later-life mothers specifically focused on the meaning of daughters’ effort versus her actual physical presence or companionship. Mothers receiving this type of enacted support always discussed it in relation to noticing how much of an effort their daughters made to see them more often. Mothers recognized that before the diagnosis, daughters chose to spend more time with their own children, families, or friends rather than with them. It was their daughters’ extra effort (or being “careful” to be coming home) that was critical to mothers’ estimation of the value of this type of communicative support. One mother described this change in her daughter saying:

> My daughters didn’t always come to see [me]. The kids are in school or there was always a reason … We were visiting them more often. But once I was diagnosed, they all made an effort to come and see me. (12a)
Many of the diagnosed women in this age group felt that by coming home more and making time to be together, daughters were helping them adjust to the cancer. One mother stressed how important this was to her:

I feel we try to do as much together and it’s obvious when she comes home that she likes to make sure she spends time with me. I don’t think that would happen otherwise. She’d be in her busy way … Which is nice. (4a)

When mothers explained why they felt this behavior was supportive and helpful, they uniformly referred to how important their daughters’ effort was rather than how they spent their time together, their daughter’s presence, or having companionship. This type of communication may have been especially important to these mothers as all but one daughter was in young adulthood. Thus, they were very close to the developmental period in which women tend to separate from their mothers and not want to spend time with them.

Daughters made an effort to see their mothers and spend time together in such ways as stopping by the mothers’ house unexpectedly, making surprise long-distance visits, arranging mother-daughter activities (e.g., going to the spa, watching *Sex and the City*, candle-making), taking trips together, spontaneously going shopping together, arranging larger family shared time or activities (e.g., planning a cookout or picnic), and bringing over grandchildren (i.e., the daughters’ children). Not all of daughters’ enacted support in spending time with their mothers related to cancer (e.g., treatment and appointments). Hence, this type of support again differed from “being there” as their shared time was not health-specific. Mothers perceived this form of emotional support as daughters wanting to spend time with them—something that conveyed to them their daughters’ love and appreciation. This was not about “being there” as a supportive presence in the health setting, as a caregiver, cancer partner, or companion, but instead efforts to enhance mothers’ emotional well-being in general.
Daughters often mentioned making an effort to spend time together in an effort to boost their mothers’ emotions on down days, to ensure they were not lonely, to engage them in fun activities or make them laugh, to make sure they were staying busy (i.e., as a distraction), and to make sure they felt loved. One daughter recalled her mother sharing time together when she did not feel well. When she asked her mother what she needed, she always replied that she wanted a visit from her and/or with the grandkids.

I just try [when] I know she’s feeling down, I’ll just get her out shopping. I’ll take the kids down. They always seem to, you know, make her laugh … We’ll just go do something just to perk her up … I take her out to lunch a lot or to the mall … just to get her thinking about other things. And usually, that does the trick … you know, keeping her busy with the grandkids, keep getting her away from the house, anything that’s getting her out of her environment and, you know, just distracting her. (19b)

This type of support had reciprocal adaptive effects. Daughters admitted by spending more time together, they could make sure their mother was doing okay, which, in turn, brought them comfort.

This form of support always functioned adaptively. The only instance in which mothers referred it as maladaptive was to say that they wanted more of it. They would have liked to have had more time with their daughters. Doing so would have been even more helpful to their adjustment to cancer as one mother said: “I think I would have liked to have seen them [her daughters] more, but you know that wasn’t even possible either way. To me that would have been more helpful” (12a). Like this mother, others were very understanding of daughters’ limitations in being able to visit all the time as daughters often had children themselves, worked full time, or lived a notable geographic distance away. Interestingly, daughters often wished they could spend more time with their mothers throughout this experience. Many of these mentioned how hard it was not to be together.
**Calling/talking more.**

Mothers and daughters reported talking more with one another throughout the cancer experience. However, again, like “spending more time together,” mothers characterized this support as helpful in relation to daughters making a notable effort to talk to their mothers frequently. Often, the support consisted of daughters calling more to check in on their mothers to see how they were doing. The calling was often associated with how mothers were feeling after cancer treatment and appointments. For mothers, it was their daughters’ effort that was important to them in their adjustment because it made them feel that their daughters cared, were concerned about them, and interested in their well-being. Mothers also felt that this type of enacted support was helpful because they wanted to hear from their daughters.

The mothers spoke of this support as the daughters’ initiative to stay in touch. Some found this was “bizarre,” as it was not typical of their daughter. Nonetheless, these women felt this support was instrumental in their adjustment. One said:

> They always called and I think that was just the biggest support, just knowing that they cared … Just calling more often … because it was good just to hear from them. It just meant a lot to hear from them. (12a)

Like the young-adult daughters of midlife-diagnosed mothers, daughters in the current age group wanted to talk with their mothers more. One daughter volunteered, “I would feel bad if I didn’t talk to her for the day” (32b). Daughters admitted that they consciously called and talked with their mothers with greater frequency, often to check in on them. When daughters were at a long distance, this enacted support seemed particularly helpful for both mothers and daughters. As one daughter recalled:

> I [was] making it an important part of my day, making that a priority to know what’s going on with her. Whereas before, even though we’re really close, I may have just checked on her a couple times a week … It’s become total priority for me to know what’s going on with her at this point. (41b)
Interestingly, these communicative acts are similar to previous dyads’ experiences with “mothering,” as well as “being willing to talk.” Yet, the mothers did not refer to this behavior in a maternal way. Moreover, mothers did not discuss daughters’ calling in relation to their willingness to talk. Instead, women related calling/talking more to their daughters’ making an effort to stay in touch—an effort that they found previously uncharacteristic of their daughters’ behavior. Although this type of emotionally supportive communication could be conceived as mutual mothering or mothering support, neither mothers nor daughters conceived of it in those terms. Moreover, a notable characteristic of mothering support described by diagnosed daughters and their mothers was its maladaptive properties such that this communication often became overbearing. In contrast, later-adulthood mothers never mentioned feeling that their daughters were overdoing it or becoming overbearing when discussing their efforts to calling and staying in touch.

The only instance in which mothers referred to this type of support as maladaptive related to daughters not believing them. This sometimes occurred when daughters called to check in on how their mothers were doing. Mothers said that they were fine, but their daughters did not always believe them. For mothers, it was important their daughters trust what they said and not question them in manner that conveyed distrust. For instance, one mother said:

I liked that fact that she cared and wanted to know things. Sometimes when I would just say things, she’d say “Well, are you sure?” and I would say, “Yeah.” That was the annoying [thing] that [she] believe me that I was okay and everything. (32a)

*Staying normal.* Many women recalled that the most helpful thing their daughters did was “keeping things normal.” Like diagnosed-midlife mothers, later-life diagnosed mothers felt that certain communicative acts were key in conveying to them that life remained normal. This support was important to mothers’ adjustment because they did not want their condition to
transform their daughters’ (or their) lives. They did realize that cancer inevitably altered their
lives. Nonetheless, it was still important to them that their daughters act as normally as possible
because that led them to feel that everything was okay. Pertinent communication included
sharing their personal lives with their mother, engaging in mundane talk, and not showing any
emotion in their mothers’ presence about the diagnosis.

Mothers wanted their daughters to share with them details about their personal lives and
to learn about their daily activities, as well as their grandchildren’s well-being. By hearing about
their daughters’ lives, the mothers reportedly adjusted better. At times, this behavior helped
because it made mothers still feel needed as a mom. As one mother explained:

It made me feel like she needed me as a mom … That gave me a reason to live. It gave
me another reason, something to hold on to, to keep me going and I felt like I was
needed. (12a)

Similar to midlife mothers, these mothers also noted that when daughters shared details of their
lives with them, they worried less about how they were coping. Hearing about their lives helped
mothers feel that their daughters were doing well, which therefore, lessened their distress and
worry for their daughters. This form of emotional support also kept mothers from thinking about
the condition constantly. In effect, this type of support made things feel more normal.

When daughters recognized their mothers’ desire for this support, they were willing to
talk about their own lives more often. However, they often mentioned struggling with whether or
not to engage in this type of communication. Some daughters, at first, did not perceive that
staying normal in this way could function supportively. One daughter described the dilemma:

At first my reaction was definitely oh, I don’t want to be a burden. I don’t want to load
her with little things that are bothering me. That was only for probably a month or so
after the diagnosis and after that, I realized she actually liked hearing about all of that
stuff and helping me figure it out … She really enjoys being a part of my life … That
means not just hearing about all the good things that I was doing but hearing about the
stress and the crazy times too. (9b)
Some mothers also perceived engaging in mundane talk with their daughters as supportive. They considered it emotionally supportive because it provided a distraction from cancer and made them feel that life was still normal. One described this enacted support functioning adaptively in this way:

We would talk every day and talk about things and people and you know, what was going on. So yeah, this does take your mind off of it and just keeps you more involved in everyday life you know, in getting through. So that’s—I think that’s good because you don’t want to dwell on it too much … You know I found that if you are just home and by yourself, you would think of it [cancer] constantly. (32a)

Finally, mothers stated that not seeing their daughters become emotional about their cancer kept life nearly normal. Many women felt that by not showing emotion, ironically, daughters emotionally supported them. Some mothers even told their daughters not to cry in front of them. This reportedly functioned adaptively in that it helped them worry less about how their daughters were coping. In not seeing their emotion, they knew their daughters were handling it okay. They felt that if their daughters were to show distress about the diagnosis, it would “break” them or make them worry. Some mothers recognized that although their daughters withheld emotion in front of them, they may not have done so in their own personal time or when talking with their husbands, fathers, sisters, or friends. Diagnosed women in other age groups also mentioned not wanting to see their mothers’/daughters’ emotion. However, these women also did not discuss this in relation to keeping things normal.

Interestingly, not showing emotion and talking about the daughters’ personal lives could also function maladaptively. Although mothers did not heavily focus on this, some did briefly mention it. For instance, one mother felt that she did not want her daughter to share her problems with her because she would, in fact, feel burdened. This mother’s experience differed from that of the other mothers who seemed to want their daughters to disclose their problems for the
aforemost reasons. However, this particular mother and daughter were dealing with more serious, long-term problems in the daughter’s life (e.g., problematic behaviors such as addiction or recklessness) rather than day-to-day stresses. Hence, the intensity of the daughters’ problems that they disclosed likely affected whether the behavior was helpful or not to mothers’ adjustment.

Additionally, although most mothers reported not wanting to see their daughters’ negative emotional reactions to the disease, one mother offered a different perspective:

I didn’t want her more upset than me, you know. The fact that you worry about your daughter when you are like going through this … You worry about the effects [of this on her] … But it’s funny. I mean if they weren’t upset you felt like they didn’t care … I think a little bit you needed to know that this affected [her]. (32a)

Offering suggestions. Women in this cohort also were appreciative of daughters’ suggestions they felt were helpful in positively enhancing their adjustment to cancer. This type of emotional support had rarely been mentioned by younger cohorts. Suggestions related to treatment side effects, finding new clothes during treatment, buying and styling wigs, styling hair after chemotherapy, and how to stay active during treatment (e.g., taking walks and doing yoga). This type of support seemed to be most helpful to mothers when they perceived it as encouraging or insightful. Often, the suggestions were primarily informational in nature. However, mothers more frequently discussed this form of support in relation to helping them feel better.

Suggestions frequently addressed mothers’ adjustment to their new hair growth after chemotherapy. One mother talked about her daughter helping her in this way once her hair began to grow back after chemotherapy treatment ended.

She was the one that encouraged me to go with this shorter hair style. And she was the one that would get to the point: “Okay Mom. It’s time to take the wig off. You got a little bit of hair. That’s as good as style!” And so forth and so on. I mean, these [comments] are what I mean. She’s so encouraging … And so we went to this girl. I couldn’t quite explain what to do because I have always had long hair. (9a)
Mothers also seemed to feel that their daughters’ suggestions were helpful when they perceived their daughters had specialized knowledge about a particular issue, particularly during interactions about side effects. One mother recalled not being able to drink water after her taste buds changed. She expressed her concern to her daughter about staying hydrated. Her daughter, who was active in sports, suggested various sports drinks for her mother to try. The mother appreciated her daughter’s suggestion and found it to be helpful. Another mother talked about her experiences with various medications her daughter also had taken at one time. She described to her daughter the related side effects of these medications (e.g., tingling sensation in the legs) and noted in the interview how valuable her daughter’s suggestions were in helping her manage the uncomfortable effects.

The only circumstance in which this type of enacted support seemed not to function adaptively was when the suggestions concerned hair loss. Women diagnosed in later adulthood were particularly self-conscious of their appearance after losing their hair during chemotherapy. Both mothers and daughters talked about the trauma associated with this loss, as well as the drastic manner in which mothers’ hair fell out (e.g., in clumps). To help mothers cope, daughters often suggested they shave their hair once the hair began to fall out rather than watch it all fall out. However, this was not a suggestion that many mothers received well. Once women lost their hair or when their hair started to grow back, daughters often suggested to their mothers that they not wear their wigs. Again, mothers seemed particularly sensitive and resistant to such suggestions. One daughter discussed her experience with this:

My sister and I both tried to get her to shave her head and go bald and she flipped out about that. We didn’t really visit that a lot … Once her hair starting growing back in, then it became the kind of thing where we continued. “Okay, you hair is growing in. It looks cute. It’s a really short hair style. You should turf the wig.” She wasn’t comfortable and would get pissed off and irritated with us continuing to bother her so we just let it go. (41b)
In the previous examples of daughters’ emotional support in the form of compliments, it was evident that that mothers diagnosed in later adulthood were especially challenged in adjusting to hair loss. Mothers’ experiences with daughters’ suggestions further demonstrate that this physical change is an especially difficult one for mothers to adjust to. As such, daughters’ suggestions about how mothers wear their hair needed to be carefully communicated if they were to be perceived as helpful.

**Staying positive.** In line with most of the dyads in the younger age groups, mothers in later adulthood felt that daughters talking to them positively helped them adjust in a healthy manner. Staying positive involved daughters reassuring their mothers about cancer-related distresses they shared, encouraging them to keep fighting the disease, and making sure that an upbeat outlook had high priority during difficult times. Mothers felt that this type of enacted communication was most helpful in making them feel better, particularly on down days, and in motivating them to stay strong and beat cancer. For instance, mothers referred to daughters’ positive communication in such terms as it “picks me up,” makes one “upbeat,” or “makes me feel better.” They also felt this behavior motivated them to persist. In the words of one mother:

She’ll just tell me to think positively. If I say something negative, she says, “No, you can’t say that.” You know, “I don’t want to hear that.” But in a good way—not a bad way. She’s a positive motivator … She’s very in tune to how I feel. Picks me up, you know? (4a)

Many mothers indicated that they could not recall an instance in which their daughters were not positive with them. These women also seemed to feel that it was important for them to remain positive for their daughters’ well-being, as well as the rest of the family’s. Several mothers saw this behavior as stemming from a view of life they used to help each other adjust. One mother characterized the reciprocal nature of this enacted support with her daughter and the
rest of her family in the following way: “I was positive about it. That made them feel positive about it. Or maybe I felt so positive about it because they talk positively about it” (43a).

Daughters often discussed providing support for their mothers by talking positively to them. For instance, one daughter mentioned reading from a daily affirmation book with her mother. She felt that this form of positive interactive activity was instrumental to their adjustment: “It kind of helped us wake up and at least think ‘Okay! Today’s going to be better’” (17b). Daughters also talked about reassuring their mothers that they were “doing so well.” Many women tried to help their mothers see that “things could be worse.” Several daughters felt that this type of support was very helpful in motivating their mothers to remain strong. For instance, one said:

I think that when something like this happens, if you’re not positive everybody suffers. You know, like the person who has it suffers because you’re not really supporting them because all you’re doing is talking negative. You know? That doesn’t make them feel better and it makes them feel worse about themselves. If you’re positive, they have a better outlook on it, like, “Okay—You’re right. I am almost done [with treatment].” You know? They want to get it done. They want to get it done and they want to be fine when it’s done. (32b)

Some daughters admitted that they felt their mothers were struggling with extreme sadness and depression and that the positive talk was the only way to help them manage their emotional distress.

Although mothers rarely talked about this behavior as anything but helpful, a couple did refer to times when their daughters used positive communication to prevent them from speaking negatively. These women felt that their daughters would not allow them to talk ever about their cancer in any way but positively. One mother asserted that “negative talk” was just not in her daughter’s vocabulary. Although mothers seemed to appreciate the consistency of their
daughters’ positive nature, some women also talked about wanting to just vent. According to one mother:

If someone would ask me how I felt or whatever and if I would talk about it in a negative way, she would not be happy about that. She wants that positive attitude. She would say, “Don’t dwell on the negative.” She still tells me if I start being negative. (19a)

When asked whether she felt as if she still wanted to talk (negatively), the mother replied affirmatively but nevertheless defended her daughter’s behavior:

Yeah, I think so. Let me get it out of my system, kind of thing. [But] She is just being positive.

Other mothers felt their daughters’ positive talk sometimes blocked their ability to vent. Similar to those in other age groups, these diagnosed women perceived that positive communication was not always helpful. However, these women described this in relation to having their communication censored, as opposed to not having their feelings validated (young- and middle-adult daughters’ experiences). Hence, for later-adult diagnosed mothers, daughters’ positive talk did not help them adjust when it prevented them from having an outlet to just vent or expel their distress.
Table 3.2

Mothers’ and Daughters’ Experiences of Enacted Emotional Support

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<th>Dyad</th>
<th>Consistently Adaptive Enacted Support Communication</th>
<th>Adaptive or Maladaptive Enacted Support Communication</th>
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<tr>
<td>Young-adulthood</td>
<td>Listening</td>
<td>Being there</td>
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<tr>
<td>diagnosed daughter-</td>
<td>Showing affection</td>
<td>Mothering</td>
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<tr>
<td>mother bonds</td>
<td>Being humorous</td>
<td>Staying positive</td>
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<td>Doing things to cheer me up</td>
<td>Validating decisions</td>
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<tr>
<td>Middle-adulthood</td>
<td>Listening</td>
<td>Mothering</td>
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<tr>
<td>diagnosed daughter-</td>
<td>Being humorous</td>
<td>Staying positive</td>
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<td>mother bonds</td>
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<tr>
<td>Middle-adulthood</td>
<td>Listening</td>
<td>Talking versus withdrawing</td>
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<tr>
<td>diagnosed mother-daughter</td>
<td>Showing affection</td>
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<td>bonds</td>
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<td>Being there</td>
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<tr>
<td>Later-adulthood</td>
<td>Listening</td>
<td>Daughters making an effort</td>
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<td>diagnosed mother-daughter</td>
<td>Showing affection</td>
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<tr>
<td>bonds</td>
<td>Being humorous</td>
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Analyses from the diary case studies depict the nature of mother-daughter openness, avoidance, and emotional support during specific phases of the cancer experience—specifically when diagnosed women are receiving cancer treatment of chemotherapy or radiation. These analyses are compared with findings from the in-depth interviews. As previously noted, Yin’s (2003) single case study embedded design underlay this part of the investigation. One case study reviews the data for each dyad’s age group (two for later-life diagnosed women’s mother-daughter dyads) (see footnote 4 in Chapter 2).

At times women’s mother-daughter communication noted in diaries during treatment differed somewhat from women’s reports in interviews. At other times, the diaries were congruent reports in interviews. The reports follow Creswell’s (2007) 33-33-33 pattern of organization: description of setting (contextual background), themes (see Table 3.3), and interpretation of results. Pseudonyms for the diary authors appear in place of actual women’s names to assure confidentiality.

Diary Case Study of Young-Adult Daughter and Her Mother

Contextual Background

Ana was 36 years old and portrayed herself as happily married. She and her husband had three young children. She worked as a registered nurse and was in an online graduate program. Both of her parents were living and married. She had a younger sister, whom she referred to as her “best friend.” Her parents and sister lived a few hours away.

Ana was first diagnosed with stage 2 breast cancer at the age of 33. Nearly three years later, she was told she had a recurrence. The cancer had advanced to stage 4. At the time of her first diagnosis, Ana underwent a bilateral mastectomy, reconstruction, and chemotherapy for
about four months. She also tested positive for a breast cancer gene and, in an effort to prevent a recurrence, had her ovaries removed. After the second diagnosis, she underwent three months of traditional chemotherapy and, thus, lost her hair for the second time. At the time of the study, she was in a clinical trial with another chemotherapy drug. She was receiving the chemotherapy treatment for three weeks straight followed by one week off. She had been told that there was no end date for the treatment and that it would remain continuous.

Lily was Ana’s mother. She was 58 years old and felt very close to Ana, as well as her other daughter. Lily struggled with anxiety. She had anxiety-related mental wellness concerns for years but feels her anxiety may have increased since her daughter was diagnosed. Lily disclosed that she sometimes feels very alone in her concern for Ana. She found her husband (Ana’s father) not very supportive but did not want to burden Ana with her concerns. She often sought her other daughter’s support to cope with her anxiety. She felt close to Ana and believed she “knew” something was wrong even before she was diagnosed both times. During Ana’s recovery from the first diagnosis, Lily came and stayed with her for awhile. Ana found her mother to be very helpful in assisting her with caring for her children.

Lily and Ana have a close relationship that is not without difficulties. They talk via telephone every day and update each other on how they are doing and their daily schedule. These conversations usually consist of mundane talk. Ana describes her mother as “always there” and caring but notes that she can sometimes be overbearing. She often seeks her sister’s support during such times. However, Ana did disclose that since her diagnosis, little things her mother did that used to bother her, now affect her much less.

During the two weeks Ana and Lily kept diaries, communication between them was long distance. The conversations ranged from 5-20 minutes, with most calls lasting about 10 minutes.
Both women initiated calls. However, most of the time Ana would call her mother back when she had some time to talk. Ana wrote about 10 interactions and Lily wrote about 12. Only Lily wrote entries (10) in which she mentioned thinking about cancer or cancer-related experiences that she did not share with her daughter for various reasons. Lily’s diary entries were much more in-depth and extensive in comparison to her daughter’s. Ana typically only wrote a sentence or two. Only Ana participated in a diary-interview.

Openness During Treatment - Disclosed Cancer-Related Topics and Reasons for Openness

Most of Ana and Lily’s conversations were general updates of how each other was doing and what their plans entailed. Ana’s talk focused mostly on updating her mother concerning how her children were doing and what activities they were engaged in. For instance, Ana was busy planning a birthday party for one of her children. She also shared with her mother her graduate school-related stress (e.g., writing a paper about her cancer experience).

Although their talk was mostly mundane conversation, Ana did talk openly with her mother about a few cancer-related topics. Specifically, she communicated about her concerns regarding *medical decisions* as well as *diagnostic testing and results*. She told her mother about her uncertainty about when to get a flu shot and also her anxiety about an upcoming bone scan. She explained that she was nervous about having a flu shot when she also had a cold and allergies due to the poor weather. She also was further concerned she might receive negative results from an upcoming bone scan. When she received the test results, she shared them with her mother.

Ana also openly talked with her mother about some *treatment side effects* she recently encountered. For instance, she discussed about her hair and eyebrows growing in (which she had lost during chemotherapy). Ana also disclosed more emotional side effects. She shared with her
mother that she was feeling fatigued. She went further in her disclosure in noting that she felt there was just too much going on in her life. She told her mother that she felt that she just wanted to take a day off and “chill.” Lily wrote about her concerns in her diary that Ana was “working too hard”: “I just don’t want her to take on too much.” However, Lily also felt that at times, being busy was helpful to Ana’s adjustment to cancer because it “keeps her mind busy.”

In her diary, Lily noted waiting for Ana to bring up issues related to cancer because she did not want to express her concern. In commenting about this, she wrote, “Why borrow trouble?” Lily also agonized over all that her daughter had to worry about at such a young age. She seemed to be aware of her daughter’s need to discuss her worries. Yet, she also seemed to appreciate her daughter’s need to talk with other individuals. After giving her daughter advice about the flu shot, she wrote, “So many anxious things for her to worry about at 36. I felt better because she was going to her breast cancer support meeting.”

Ana indicated that her reason for talking about these matters was to *share good news* (about test results), as well as to *seek her mother’s support*. For instance, Ana felt that it was important to tell her mother about good test results because it was “sharing good news” together. This reason tied to her desire to *protect her mother* from worry. When asked in the diary-interview why she shared the test results with her mother, she responded:

> It was probably me [wanting to spread] the good news … And I know she worries so I was calling to let her be relieved and not be tensed up thinking “Oh my gosh, oh my gosh! How’s her results?” So it was kind of like for both of us in a sense.

Ana further explained that she openly communicated about these issues because she values her mother’s opinion. She wanted her support. Specifically, she wanted her mother’s reassurance that her future test results would be okay. Ana shared her feelings about why shefreely shared her thoughts on upcoming diagnostic testing:
I was really nervous about the bone scan … I always go “Mom, do you have any bad feelings?” She’s pretty on the money with that stuff. You know it’s just like a mother’s intuition. She’s like, “Honey, I think everything is gonna be fine. Don’t worry.” And that just kind of like gives me that little reassurance that okay. She thinks everything is okay and even if she is lying to me it gave me that all sense of hope that I didn’t worry as much … That kind of soothes me in a sense because she’s okay with it.

This experience highlights the interactive nature of open communication and emotional support. As Ana discloses her concerns about test results to seek support, Lily offers Ana reassurance by staying positive and saying everything will be okay. The interview findings showed that seeking support was one reason young-adult women diagnosed with breast cancer disclosed their cancer-related experiences to their mothers. However, the diary and diary-interview reveal the importance of this interdependent dynamic between openness and emotional support communication.

The results of the diary and diary-interview mirror the findings from the interviews in that Ana’s openness was more medically focused and, yet, at times she addressed her emotions. The reasons for openness also matched. Ana was open as a means of seeking support. However, a new reason for open communication emerged: to share good news. This motive for openness may be particularly critical when women are in treatment. During this phase of cancer, women frequently receive a multitude of tests to assess the efficacy of the treatment in fighting the disease. It is also important to note that mundane talk was a much more prominent feature of their mother-daughter talk. Although women were to include references to noncancer-related talk in their diaries, Ana and Lily seemed to keep their conversations sharply focused on their daily issues rather than Ana’s cancer.

Avoidance During Treatment - Avoided Cancer-Related Topics and Reasons for Avoidance

Ana admitted that the only matters she strenuously avoided in interactions with her mother was her mother’s problems, concerns, or complaints. She avoided talk about these
altogether and changed the subject when her mother brought up any complaints. Ana stated that her reason for avoiding such talk was that she found it too distressful. She admitted feeling stressed when her mother talked about her own personal worries, gripes, or concerns. Her motive for avoiding such discussions was likely to protect herself. However, Ana also stated that she was really trying to respect the possibility that her mother might need support too and, therefore, to be more understanding and reflective of her positive features.

Ana’s diary and diary-interview revealed that she avoided distressful topics. She was motivated to avoid this communication to protect herself. Again, these findings validate patterns of communication that emerged in the in-depth interview data. Young-adult daughters noted that they avoided topics that upset them in an effort to protect themselves from unnecessary distress. Interestingly, Lily felt that she avoided disclosing her personal concerns quite often. As previously noted, she had 10 entries in which she wrote about distresses she did not share with Ana and often mentioned disclosing to other people (e.g., her other daughter as well as her own mother) about these matters. She admitted that sometimes she needed to hear that “everything would be okay.” Due to Lily’s self-described heightened anxiety, she may have voiced more distresses to Ana than she typically would when feeling less anxious. Yet, Ana and Lily jointly described Lily as a pessimist. Regardless, this finding indicates that this mother-daughter communication dynamic is not helpful in Ana’s adjustment to cancer. Thus, her avoidance of distressful topics likely functioned adaptively in her adjustment to the disease.

Enacted Emotional Support during Treatment

Lily enacted various types of emotionally supportive communicative behaviors with her daughter during treatment: being humorous, staying positive, (reassurance, sharing survivor’s stories), validating decisions, as well as having mundane conversation. For instance, to
encourage Ana, Lily shared survivors’ stories from a book she was reading as well as what she had heard about Farah Fawcett’s (the actress) experience with remission.

All of these forms of behavior contributed to Ana’s adjustment to cancer, but several were particularly helpful to Ana. Ana reportedly appreciated her mother’s positive talk, which Lily enacted when her daughter expressed her anxiety about upcoming test results. Ana also felt that her mother’s positive talk, which was in the form of reassurance, was instrumental in giving her faith and hope. She further indicated that she valued her mother’s opinion and her maternal intuition. Ana was grateful when Lily validated her medical decisions and reassured her that the tests would turn out okay. These findings are consistent with those that emerged from daughters’ interviews.

Unlike women’s experiences surfacing in the in-depth interviews, mundane talk was a salient presence. Even though women were asked to include this aspect of their interactions in their diary entries, the striking presence of this type of talk is noteworthy. In her diary entries Ana wrote about her mundane talk with her mother in positive ways. Lily referred to this talk as “our usual morning talk about what we were going to do the rest of the day.” Often, these interactions were pleasant, joyful, or fun. For instance, Ana liked talking to her mother about her children’s activities. In turn, her mother liked hearing about her grandchildren. When Ana wrote about mundane conversations involving such topics, reported she usually also described having positive feelings (e.g., she wrote “nice conversation” or that they laughed together). Mundane talk did not emerge in the interview data prominently in this age group. In middle-adult and later life-diagnosed mothers’ experiences (from interviews), participants reported that mundane conversation was a form of emotional support. However, this type of talk in that age group conveyed “staying normal.” During treatment, mundane talk may be particularly important as
daughters adjust during treatment—a time at which cancer can literally be a pressing daily issue. Although Ana and Lily did not mention mundane talk as helping them “stay normal,” it is likely that this communication dynamic functioned in this manner.

*Diary Case Study of Midlife Daughter and Her Mother*

**Contextual Background**

Carrie was 44 years old. She described herself as happily married with two children in their early or pre-teens. She also worked in the technology field full time, was an avid runner, and felt she had a supportive group of girlfriends. She was diagnosed with stage 2 breast cancer in early 2006. She first underwent traditional chemotherapy treatment, then a mastectomy, and finally reconstruction. At the time of the study, she was undergoing a chemotherapy treatment called Herceptin, which is a form that has fewer side effects than conventional chemotherapy. As Carrie noted, “It doesn’t make you sick or make you lose your hair so people tend to think of it in different terms.” She underwent the Herceptin treatment each week and had about 3 months left at the time.

Her mother Lorraine was 64 and lived on the other side of the United States. She maintained an active lifestyle and lived with her ailing husband, Carrie’s father. Lorraine was also the caregiver for Carrie’s father suffering from Parkinson’s Disease. Carrie had lived away from her daughter for more than 10 years. Carrie and Lorraine had a family history of breast cancer. Although Lorraine herself had never been diagnosed with it, her mother was a survivor, and her sister and great-grandmother had both died from the disease.

Carrie did not feel her relationship with her mother changed much following the diagnosis. However, Lorraine felt they were closer. Carrie described their relationship as a “typical” mother-daughter bond prior to the diagnosis. She did not portray her mother as a
significant source of support before the diagnosis but did say she may vent to her from time to
time. Her mother characterized their bond as open. Carrie and Lorraine see each other a few
times a year. However, they talk at least once a week via telephone. Carrie said that she initiates
most calls because she is busier and would call when she had free time. Carrie had just been out
to visit her mother a few weeks prior to the diary study.

During the two-weeks of keeping a diary, Carrie and Lorraine communicated exclusively
via telephone. Carrie called her mother twice a week. Their conversations lasted on average 24
minutes but reportedly ranged from 10-40 minutes. Carrie and Lorraine both wrote about 3
interactions occurring during the 2 weeks. Both women also indicated in the diary that they
thought about cancer or cancer-related experiences that they did not share with each other for
various reasons (Carrie had 6 entries and Lorraine 11). Carrie’s diary entries were more in-depth
and extensive in comparison to her mother’s. Both participated in a diary-interview.

*Openness During Treatment - Disclosed Cancer-Related Topics and Reasons for Openness*

Carrie and Lorraine mostly communicated about various topics unrelated to cancer: car
trouble, Carrie’s father’s health, her mother’s hobbies, Carrie’s children, and other family
members’ activities. Carrie did discuss with her mother two cancer-related topics: *treatment side
effects* and *diagnostic testing*. Her reasons for doing so were to *seek support* and *share good
news*.

Carrie shared with her mother her experience with menopause-like symptoms. In her
diary, she indicated that she talked about her concern that the symptoms might be a result of the
traditional chemotherapy she received the previous year. She admitted that her reason for
disclosing this side effect was to attain her mother’s support. She was also hoping her mother
would share her experience with menopause. She thought that if her mother did this, she could
develop greater insight into her own experience. However, her mother did not respond as Carrie had hoped. Rather, she told her daughter that “for some people it’s like that” (Carrie’s diary). Carrie did not ask her mother directly about her experiences with menopause and seemed to excuse her mother for not disclosing when she wrote, “If the doctor can’t tell me if it’s the cancer treatments or menopause, I don’t know why I’d expect my mother to be able to!” Her mother did not write about this matter in her diary.

Carrie also shared with her mother experiences with medical testing. She talked to her mother about receiving genetic testing because of their family history of breast cancer. In addition, when she received a clear mammogram result, her first in two years, she immediately called her mother. She wrote that she wanted to “share the good news.” When she finally did reach her mother, Carrie wrote that her mother “seemed relieved” when she told her the news. In the diary-interview, Carrie explained that her mother’s tone indicated to her she was relieved and that her mother said something like “That’s good.” Interestingly, Lorraine mentioned that conversation in her diary in saying “We were both rejoicing together over the good mammogram results.” Yet, in her interview, Lorraine recalled saying something like, “Oh great,” with some enthusiasm, and then moving on to other topics.

In the diary-interview, Carrie spoke in more detail about her feelings regarding her mother’s response to her disclosure. Carrie admitted feeling a need to be allowed to be more open. She mentioned that her mother never brings up her cancer and does not talk about it much even when Carrie does. She noted that her mother “doesn’t like to talk about it at length.” Carrie admitted that she did not care if her mother brought the subject up but did not necessarily want her to. However, she did not understand her mother’s response. She was not sure whether her mother did not like talking about the cancer or whether she was worried that talking about it
upset her, but it did not bother her to talk about it. In fact, Carrie felt that if she herself brought the subject up in conversation, that it signaled that she did not necessarily want to move on, even if her mother did. Carrie reported that her mother often changed the subject when she initiated a conversation about her cancer.

She wants to end that part of the conversation probably quicker than I would like … If I bring it up, there’s usually something I really want to get off my chest—how I’m feeling about it … When I start talking about it, I don’t necessarily want to move on in the conversation—you know—[I want to] finish saying everything.

Carrie also referred to her mother’s generally closed behavior in respect to health throughout her diary. She wrote that this behavior was how her family was. She had to “pull” information about health out of her mother and father. In fact, it was not until their conversation about genetic testing (described in the diary) that Carrie learned her great-grandmother had died of breast cancer.

Lorraine did not share this view. She felt they discussed Carrie’s cancer openly saying: “We cover it pretty thoroughly before we move on to something else … That’s a mutual [effort].” She also described wanting her daughter to talk about the subject. She mentioned not having open communication with her mother or her sister after their diagnoses and even recalled her distress in having to “drag things out” of her sister. Lorraine felt her daughter knew to talk about her condition because she had complained to her about her sister’s not sharing with her.

Although the diaries in general seemed to mirror the interview data, in that topics involve medical matters like treatment side effects and diagnostic testing, two new reasons for disclosure emerged from the diary (seek support and share good news). One of these reasons (share good news) had not yet emerged in any other age group’s experiences in the interviews but had been a motive in the young-adult dyad diary. The first motive (seek support) did surface in young-adult
daughters’ accounts reported in their in-depth interviews but not in those of middle-adult diagnosed daughters’.

The diary findings highlight the complexity of open communication. Although Carrie wanted to talk more openly about her cancer (and in more depth) she was understanding of her mother’s closed and avoidant behavior. Carrie also wanted more openness from her mother. Interestingly, her mother did not see herself as closed, nor did she feel they did not talk about her daughter’s cancer in depth. Generational differences in how they characterized (and need) openness seem to pervade in this dyad’s accounts of their interactions. Lorraine was satisfied with just updates and described her daughter as being more open than her sister or mother. However, she did not seem to understand that Carrie wanted and needed even more openness and depth in discussions.

A key aspect of open communication emerged that seemed to indicate moments when daughters want to openly talk about their breast cancer with their mothers (when they themselves initiate the discussion). To Carrie, such behavior should signal a desire and need for her mother to allow her to talk freely about her experience. It is also important to note that in the previous dyad’s (Ana and Lily) experiences, like Lorraine, the mother (Lily) had mentioned not bringing up cancer because she was concerned it would upset her daughter. She allowed Ana to bring it up. Ana did not report being dissatisfied with her ability to disclose freely with her mother. This difference may indicate that Lily interacted with her daughter more when she did bring up the topic.

Avoidance During Treatment - Avoided Cancer-Related Topics and Reasons for Avoidance

Carrie did not mention avoiding any cancer-related talk except for one issue: an upcoming medical test (a mammogram). She did not inform her mother that the test had been
scheduled. Her reason was that she felt that her mother had already been through enough. Hence, she avoided this topic to protect her mother. She did not want to distress her. Carrie also wrote in her diary that she talked openly about her experiences with a woman she met at her weekly Herceptin treatment. She talked openly with this woman about her feelings regarding treatment. When asked during the diary-interview why she openly communicated with this woman, Carrie stated that it was easier to talk to people who have been through cancer because they could understand her feelings better. This experience suggests Carrie may have avoided disclosing to her mother, in part, because she talked to others. Both of these reasons (protect mother and talk to others) were in evidence in the interview data. However, in the interview data, “others” typically referred to loved ones, not less intimate acquaintances. This experience indicates that talking to other patients or survivors is something those with cancer want because of what they have in common. As women are in treatment they also have more interaction with other patients. This shared experience likely connects women, even strangers, on an immediately intimate level. Thus, the diary findings validate the interview results but also further illuminate the motivation behind daughters’ avoidant behavior.

Enacted Emotional Support During Treatment

Lorraine engaged in various types of emotional support during her daughter’s treatment. She recalled being humorous and also validating decisions concerning genetic testing. Carrie described her mother staying positive to support her when she shared information about her medical tests. Such accounts were congruent with the interview findings within and outside this age group. Validating decisions did not emerge in this age group’s interviews but frequently did in those involving diagnosed women in young adulthood, as well as the diary case study for that age group.
Positive talk was the only behavior described in both adaptive and maladaptive terms. In the diary-interview, Carrie indicated her mother always responded to her in a positive manner. When asked whether this was always helpful she said that it was not. She recalled when she told her mother she had breast cancer. Her mother responded saying that the cancer would not be a big deal and it would probably involve nothing more than a lumpectomy. Carrie would have preferred a more emotional reaction in sync with her own. In a way, she seemed to want validation of her own emotions. Her mother’s positive talk did not seem to make sense in light of the seriousness of the diagnosis. Carrie said that she was feeling sad about the diagnosis but her mother’s response indicated to her that she was not.

Although Carrie was reflecting on a past experience that did not occur during treatment, this account was consistent with the interview data. It also indicates an important detail in which mothers’ positivity can be misinterpreted and even come across as hurtful. In this way, the findings extend the interview results and enhance our understanding of the context in which supportive communication can function maladaptively.

*Diary Case Study of Midlife Mother and Her Daughter*

*Contextual Background*

Ellen was 50 years old and had two teenage daughters. Her youngest was still in high school. Her oldest, Holly, was 18 and transitioning to college at the time of the study. Ellen felt they were very different girls but close to both of them. She described herself as happily married. She and her husband ran a family business. Ellen was diagnosed with breast cancer (stage 3) about 8 months prior to being interviewed. Since the diagnosis, her husband had worked later hours and, thus, was not home very often. Ellen had already undergone a mastectomy and was
currently undergoing chemotherapy. She was nearing the end of treatment at the time of her
diary entries.

Holly was a very active young-adult woman. At the time of the study, she was beginning
her freshman year of college. She mentioned in the interview that she was very close to her
mother but had a very hard time with the diagnosis in the beginning. After her mother’s
diagnosis, she and her mother both described her withdrawing from her mother. Holly admitted
she had a hard time dealing with her mother’s diagnosis but after professional help, both women
felt Holly was doing better. She felt that she both emotionally and instrumentally supported her
mother in adjusting to breast cancer. She also shared that because her mother struggles with
depression and runs a family business, she had always provided this type of social support to her
mother. Her mother, however, indicated that Holly had not emotionally supported her in
adjusting to cancer as much as her younger daughter. She found Holly to be more involved in
instrumentally supporting her and was very helpful in doing so.

Holly was moving to a dorm. Both Holly and Ellen seemed to be struggling with this new
transition and their separation from each other. According to Ellen, Holly was very nervous
about starting college. Yet, from Holly’s perspective, her mother was distressed about her
leaving the house. From their diary entries, it appears that most of their interactions were face-to-
face in their home. Only some communication took place by telephone. Holly initiated the
communication more often. Their interactions lasted about 15 minutes on average when on the
telephone and several hours when face-to-face. The communication time-span ranged from a few
minutes to half the day. Ellen wrote about 9 interactions with her daughter. Holly wrote about
14. Both also made entries in which they reported thinking about cancer or having cancer-related
experiences that they did not share with each other for various reasons (each had 3 such entries.).
At times, Holly’s entries were slightly more detailed than her mother’s. However, she rarely addressed emotion or how she was feeling whereas Ellen did. Only Holly participated in a diary-interview.

Openness during Treatment - Disclosed Cancer-Related Topics and Reasons for Openness

Many of Ellen and Holly’s interactions took place at their home. Some communication also occurred at their family business, as Holly often helped Ellen with work. Like those in other dyads, most of their talk centered on topics unrelated to cancer. When Ellen mentioned cancer it was in relation to treatment side effects. For instance, she shared with Holly that her neck was sore because of the chemotherapy. Thus, as in the interview data, openness about treatment side effects emerged as a cancer-related topic of discussion, their talk was related only to this topic. Ellen also gave no reason for disclosing this matter. However, she did write about how much Holly’s support meant to her.

Interactions centered mostly on Holly’s life. A primary topic in Holly’s and Ellen’s diaries was Holly’s transition to college. The diary entries were recorded during the same weeks Holly was moving into a college dorm and beginning her freshman year. The pair was experiencing a notable transition in the daughter’s life that was unrelated to her mother’s cancer, but that was nonetheless important to both.

Avoidance During Treatment - Avoided Cancer-Related Topics and Reasons for Avoidance

Holly and Ellen both actively avoided talking about cancer. As noted, they both had entries about their cancer-related thoughts that they consciously chose not to share with one another. Ellen wrote about her emotional distress or negative affect, which she hid from her daughter. For instance, she did not share with her daughter her emotional distress regarding a side effect from treatment (chemo brain/fog). In this instance, she and Holly were working
together at the family business. Ellen was struggling with remembering things (because of the chemo fog) and was becoming distressed. Holly did not seem to understand what was wrong with her mother and was becoming impatient. Rather than explain to Holly what was wrong, Ellen tried to manage her distress on her own. In a similar diary entry, Ellen recalled being emotionally frustrated with still having to endure chemotherapy. She wrote: “Tomorrow I have my next to last chemo—I’m getting so tired of this! I didn’t tell anyone because they need me to be strong. I cried in my room.” Ellen also wrote about being concerned that she could not be more helpful to her daughter in her move to the dorm. She reported feeling fatigued and frustrated with her itchy wig in the summer heat. She also felt guilty that her cancer was impeding on her daughter’s life transition to college.

I feel bad that she has to do so much on her own. My husband had to work late and I can’t lift much so she had to load the car by herself. I felt like I let her down today because I couldn’t be more helpful.

Ellen further noted becoming emotional during the move because she was so hot and frustrated with her physical limitations. However, she did not disclose to her daughter why she was upset. As a result, Holly seemed to misinterpret her mother’s behavior again (as she did at the family business):

We didn’t talk much about my cancer but during move-in, I got overheated, tired, and cranky. This wig is horribly hot and it’s 98 degrees outside! Holly got angry that I was cranky.

Like mothers in the interviews, Ellen avoided talking about the emotions she experienced that were related to cancer. She reportedly concealed these feelings because “they need me to be strong” and because she did not want Holly to worry. Hence, she avoided topics to protect Holly. Most of the time, this avoidance seemed to function maladaptively for both women. Ellen noted
feeling emotionally overwhelmed and, at times, alone, whereas Holly became agitated because she misinterpreted her mother’s behavior.

Interestingly, Holly often wrote about her cancer-related thoughts and her reasons for keeping them to herself. For example:

I try not to mention much about my mom’s illness because I don’t want to make her think about it any more than she already has to. I just try to live the life we had before she was diagnosed or as close to it as possible.

The pattern was evident in others’ diaries. Like the mothers of diagnosed daughters, Holly did not bring up any cancer-related matters with her mother because she was concerned that talking about cancer would only upset her.

*Enacted Emotional Support During Treatment*

The preceding quotation above reflects a way Holly emotionally supported her mother: *staying normal*. As was evident in the interview data, keeping things normal was important in mother-daughter dyads in this age group. In this diary case, much of their interactions focused on Holly’s transition to college. The two went shopping for everything Holly needed and also had talks about Holly’s fears. Ellen indicated how these interactions helped her adjust to the disease. She felt needed by Holly and, at the same time, *wanted* to mother her. This aspect of interaction emerged in the interview data as an important communicative pattern that mothers perceived as emotionally supportive. Mothers wanted to be kept in their daughters’ lives, and they wanted their daughters to continue their lives as normal.

Consistent with reports in interviews, Holly also attempted to be supportive by *staying positive* (e.g., reassurance), *showing affection* (e.g., hugs and massages), and *being there* (e.g., telling her moms she could count on her). Much of Holly’s support was also instrumental. She drove her younger sister to her activities, did laundry, cooked dinner, and helped her mother
manage the family business. Ellen wrote about the significance of this support as being emotionally helpful to her: “I told her how thankful I am to have her.”

*Diary Case Studies of Later-Life Mother and Her Daughter*

*Case Study 1 - Contextual Background*

Sally was 57 at the time of the diary. She noted she was happily married and lived with her husband on the East Coast. Her two children were both grown adults. Her son had recently married and lived several hours away. Her daughter, Marie, also lived at a distance and was in a long-term relationship. Sally currently worked part-time at a health clinic in finance but had previously run a family business passed down to her from her family. After her first diagnosis, she and her family decided to sell the business because it required too much time and energy to run. She had first been diagnosed with breast cancer in 2004, stage 2, and had undergone a mastectomy, chemotherapy, and radiation. In late 2006, she had learned of recurrence (stage 4) and that the cancer had metastasized to her lungs. She was currently in continuous chemotherapy treatment, for which there was no end date for the treatment.

Sally’s daughter, Marie, was 30 years old at the time of the interview. She was finishing graduate school and in the process of moving to a state closer to her mother’s home. Although she lived several hours away from her mother, Marie often visited on weekends. The two talked almost daily on the phone. When her mother was diagnosed the first time, Marie was in another country. She immediately returned, moved back in with her parents, and began caring for her mother. After the recurrence, Marie returned home more frequently and developed great concern for her mother’s well-being. She admitted being worried about their not having much time left together. Sally described Marie as an unconditional, primary form of support for her. Marie seemed to be aware that she was very important to her mother. Although they had their ups and
downs during Marie’s teen and college years, both Marie and Sally felt that they had become more tolerant of each other and extremely close.

Marie was visiting her mother during the first week they kept the diary. Hence, most of their interactions were face-to-face. A limited number occurred via telephone. They each initiated calls to each other with the same frequencies. Interactions lasted about 10 minutes on average but ranged from a few minutes to several hours. Sally wrote about 9 interactions with her daughter, whereas Marie wrote about 5. This dyad did not include entries about everyday interactions or thoughts ostensibly as a result of time constraints. Both Sally and Marie’s diary entries were comparable in terms of their depth and details. However, at times, Marie’s were slightly more detailed. Both women also participated in a diary-interview.

*Openness During Treatment - Disclosed Cancer-Related Topics and Reasons for Openness*

In comparison to what those in other diary case studies reported, Sally and Marie talked more about cancer. For the most part, Sally and Marie’s interactions focused on how Sally was feeling. Sally openly talked about her *treatment side effects* with Marie. She shared her experiences with problems with indigestion, edema, hair loss, and fatigue. She admitted that she disclosed these topics with her daughter because she was seeking her support, particularly her “positive thoughts.”

Marie also recognized that her mother did not always feel well and that she was concerned for her well-being. She often asked her mother how she was feeling to make sure she was okay. One side effect that Marie wrote about was her concern about her mother’s self-consciousness about her appearance because of the hair loss. She and her mother both indicated talking about a negative interaction Sally experienced with a family friend she saw in public. Sally told Marie how this friend stared at her strangely and ignored her, which she attributed to
her hair loss. It made Sally uncomfortable, and she disclosed this to Marie to elicit her support.

In her diary, Sally wrote about this experience in the following way:

I feel like I stand out in a crowd. Although I like my short hair! … Marie said I should ask them why they are looking so strangely at me and say a “few choice” comments! Bottom line—I sometimes feel uncomfortable in a room of “healthy” people.

This experience mirrors the interview data. Mothers disclosed their treatment side effects to their daughters. However, this diary entry also reveals more emotional aspects of hair loss. Women’s experiences reported during interviews indicate that later-life diagnosed women struggle emotionally with hair loss, but Sally’s and Marie’s diary entries reveal that hair loss can be a very salient issue. In addition, Sally’s reason for openness (seek support) did not emerge in the interview data for this age group. However, it did in the other age groups, both in interview and diary data.

Marie frequently asked her mother how she was feeling. This inquisitive communicative behavior likely linked to a reason mothers gave for openness in the interviews—that their daughters want to know. Diagnosed mothers’ openness may be a reflection of how much daughters seek their mother’s disclosures, particularly, in this case, women diagnosed in later adulthood. As Marie was in the older cohort of young-adult daughters, her maturity may be tied to her more active involvement in seeking her mother’s disclosures.

Avoidance During Treatment - Avoided Cancer-Related Topics and Reasons for Avoidance

Sally seemed to be very open with Marie about cancer-related topics. However, she did admit not disclosing about two matters with her daughter. First, she had received an upsetting test result that suggested she might need dialysis. Sally reportedly did not share this information to protect Marie. She did not want to “alarm” her. Marie, she felt, was busy finishing her thesis, and such news would distract and upset her. Hence, she was protecting Marie by not disclosing,
a reason that also emerged in the interview data for this age group. In addition, a newly identified pattern of avoidant topics (unfavorable test results) emerged. This category relates to avoiding upcoming test results (a topic that surfaced in the middle-adult daughter dyad diary case study). This topic could be considered a distressful topic, which did emerge as a topic of avoidance in the interview data. Sally was in a later stage, in continuous treatment, and dealing with a reoccurrence. Thus, the implications of such results are likely more distressing than for women dealing with a first-time or early diagnosis.

**Enacted Emotional Support During Treatment**

Sally and Marie wrote about various instances in which Marie enacted emotional support for her mother. During the time they were keeping diaries, Marie and Sally went shopping together, as well as to lunch, and hung out together around Sally’s house. Hence, the support of being there was clearly present. Marie also provided support by listening to her mother when she shared her feelings about how she felt during the interaction with the friend that ignored her. Marie gave support by offering suggestions concerning how to deal with side effects as well as her mother’s hair loss.

Additionally, being humorous occurred in relation to a side effect Sally was experiencing. When Marie and Sally were shopping, Marie joked with her mother about her runny nose, a side effect she sometimes experienced. Marie wrote in her diary about this:

Her nose was very runny yesterday which some days it is. We were shopping and she was going in and out of the store and she had to blow her nose a lot. We stopped for ice cream and I said it was like having an old dog follow me around—as a joke. She laughed so hard! It is helpful I think to use humor to talk about her problems and symptoms sometimes to make light of it … Later in the day she was telling the rest of the family what I said and how funny it was. I thought that was cute.

Marie also mentioned staying positive with her mother (in particular reassuring her). In her diary-interview, she admitted that she often did this when she did not know what else to do.
This nevertheless seemed to be important to Sally’s adjustment. Sally wrote in her diary about talking to Marie about side effects to get her “positive thoughts.” Sally also noted Marie’s showing affection when she was not feeling well and was experiencing problems with her blood pressure and edema in her feet. Sally indicated that made her feel loved: “She was very concerned, we hugged, and gave each other a kiss … I am touched by how much she cares about my well-being. She goes out of her way to make sure I am comfortable.”

The only instance in which Marie’s support appeared not to be helpful was when she offered a suggestion to her mother about her hair. Both women wrote about this interaction. Sally wrote about Marie’s asking her why she was wearing her wig. She recorded in her diary the following responses: “My head gets cold; I scare patients; My hair needs professionally cut.” Sally also wrote about her feelings when Marie asked her this:

Marie said I shouldn’t care what people think. She agreed that my hair should be cut nicer. It needs to grow longer! She can’t argue with me about the fact my head gets cold. I was a little upset because I hate people telling me how to wear my hair.

In her diary, Marie recorded that she asked her then why she was wearing her wig because her real hair looked cute as it was. She was just curious. Her mother, she noted, explained that it scared people when she did not wear it and that her head was cold without it.

Marie was aware that the interaction upset her mother and was distressed by that:

She referred to a comment that I made about how her hair would look better if she styled it. I felt bad because I thought I had hurt her feelings. I said, “Oh well, you should wear whatever makes you comfortable.”

These findings are consistent with interview results relating to emotionally supportive behavior (e.g., importance of humor, listening, being there, affection). At the same time, the entries also provide more information about how daughters’ suggestions about their mothers’ hair can upset the mothers, an issue that did emerge in this age group’s interviews. It seems that
Marie meant no harm in what she said and that she was aware of her mother’s self-consciousness concerning her hair. She also noted that she felt her mother’s hair looked great and did not require a wig. Nevertheless, as in the interview data, these suggestions were not well received by the mother. Sally seemed to understand that Marie was encouraging her not to wear the wig, but also did not want anyone—her daughter included—offering advice about her hair. This behavior may relate to women’s sense of privacy, which seemed to be prominent in the interview data for this age group of women. It is, nonetheless, indicative of a problematic issue (hair loss) and supportive behavior (offering suggestions) that may not always be helpful to mothers in later life when adjusting to the condition.

Case Study 2 - Contextual Background

Olivia was 57 years old at the time of the diary. She lived with her husband on the East Coast and was going to soon be returning to work full time in counseling. She reportedly found work stressful and was motivated to change that aspect of her career. Olivia was the mother of one child, a daughter, to whom she was very close to. Olivia was diagnosed with stage 3 breast cancer about 11 months prior to the interview and diary participation (late 2006). She had undergone a lumpectomy, finished chemotherapy, and was currently in, but nearing the end of, radiation treatment.

Cassie was Olivia’s only child. She was 21 at the time of the study and lived several states away from her mother. She recently graduated from college and was working a summer job in the art field. She was also preparing to move back to her home state to begin a new job. After this move, she would only be several hours away from her mother. Because Cassie was Olivia’s only child, Olivia felt that she had the opportunity to spend a lot of time with her while she was growing up. They both described their relationship as having consistently been that way.
They talked almost daily and were open with each other about their lives. However, Olivia admitted that she did not share intimate details about her life with Cassie relating to her father. Olivia believed that the three of them (herself, her husband, and Cassie) were very family-oriented and pointed out that they still did all of their vacations and other such activities as a family.

While keeping the diary, Olivia and her husband (Cassie’s father) traveled to visit Cassie. Cassie also surprised Olivia with a visit to their cabin when Olivia and Cassie’s father were vacationing there. Much of their interactions occurred face-to-face as these mini-vacations occurred during the first week of the diary portion of the study. Their remaining interactions took place via telephone. They were equal in respect to who initiated calls. Interactions via telephone lasted about 10 minutes on average, but up to several hours when speaking face-to-face. Interactions ranged from several minutes to 5 hours. Olivia wrote about 18 interactions with her daughter and Cassie 3. Both also had entries in which they noted thoughts about cancer or had cancer-related experiences that they did not share with each other for various reasons (Olivia had 14 entries and Cassie had 5). Olivia’s diary entries included more detail than her daughter’s. Both women participated in a diary-interview.

Openness During Treatment - Disclosed Cancer-Related Topics and Reasons for Openness

Most of Olivia and Cassie’s interactions centered on issues other than cancer. For instance, they talked a lot about Cassie’s job, upcoming move, and her friends. They also talked about Olivia’s apprehension about going back to work. The cancer-related topics Olivia talked about with Cassie centered on either her experiences with treatment procedures or the side effects she encountered. For instance, Olivia talked openly with her daughter about the soreness
she experienced near her arm and on her breast due to radiation. She explained that her reasons for disclosure were because she sought her daughter’s support.

I told her about using a sock to help soften the seat belt on my shoulder since radiation had dried and burned the skin. I sought emotional support about what I was managing. I got it with an “Oh good” kind of response.

Later in the diary, Olivia described a similar interaction and wrote that she wanted Cassie’s comfort. When asked in her interview whether this was a satisfying response, Olivia replied,

Sometimes I wished she had focused to talk more. But yeah—it was just kind of I want to make this kind of a quick little report … I think the total honest answer would be there probably have been times in the late part of radiation where it just all seemed to be very routine … I wasn’t wanting her to be thinking much about it as a mom, but probably as a, as a – she is such a supportive person it would have been nice to get more from her.

Olivia then explained that perhaps her daughter could “ask a question about it or keep the conversation going by repeating back … If I’m bringing it up, then maybe a follow-up question or more response.” Interestingly, Cassie indicated in her diary numerous times that she thought about her mother’s cancer. Sometimes, she thought about how the cancer made her family closer or how proud she was of her mother. She also, however, never brought these thoughts up or shared them with her mother.

Although these entries initially mirrored the interview data, they reveal important interactive information about the diagnosed woman’s openness that emerged in two of the other diary case studies. When a woman brings up the subject of her disease, it means she is open to discussion. It may also mean she wants more openness from her daughter/mother or that she is seeking her support.

Avoidance During Treatment - Avoided Cancer-Related Topics and Reasons for Avoidance

Although Olivia talked openly with her daughter regarding her cancer, she acknowledged also avoiding discussion about her disease in general. She stated that she avoided talking about
her health and treatment (or cancer in general) when possible. She felt she only wanted to keep Cassie updated. She shared more with her husband. Olivia’s reason for avoiding cancer talk was because she said she did not want to burden Cassie. Hence, she was protecting her daughter. However, she also chose to talk with others (her husband). Olivia wrote about avoiding cancer talk to protect her daughter:

I would say Cassie and I aren’t as involved in cancer treatment talk and worries right now. I don’t want this to be a big part of our talks together as other things are more important to me. From what she’s said about the difference during surgery, chemo time, and radiation makes me believe she is less worried about me and how I’m doing. That’s good.

In this instance, the findings match well with the interview data on multiple levels (protecting daughter, talk with others) but also suggest that avoidance may function adaptively for mothers in midlife (or mothers with young-adult daughters). It helps them feel that their daughters are coping reasonably well, which enhances their own sense of well-being.

Enacted Emotional Support During Treatment

Both Olivia and Cassie discussed various situations in which Cassie provided emotional support, including offering suggestions, complimenting her hair, listening, being humorous, and staying positive. The first week of diary entries made reference to time together, enacted support from Cassie that seemed especially helpful for Olivia. This type of support was uplifting for Olivia, particularly when Cassie surprised her and joined her parents at their new cabin. Olivia also wrote about the joy she experienced in being with her daughter, as well as in having dinner with Cassie and her friends during a visit. Olivia often mentioned admiring her daughter’s behavior and communication. She once wrote, “Pride and smiles all around,” after a face-to-face visit. She seemed to be energized by spending time with her daughter: “Being with my daughter and friend with such energy and enthusiasm is catching and energizes me.” Consistent with the
interview data, *spending time together* seemed particularly important to Olivia’s adjustment. Olivia also wrote about receiving *affection* from her daughter quite often and at one time specifically indicated how meaningful this form of support was to her: “Her hug was so wonderful. They feel different to me now—last longer, more special. I remember my feelings about hugs changed with my diagnosis.”

Another form of support about which Olivia and Cassie frequently wrote was Olivia’s wanting to hear about Cassie’s life and wanting to be involved in supporting her through her stresses of finding a new home and job. “Being there” to support her daughter seemed to function adaptively for Olivia. As she recorded, “I want to help with [Cassie’s move]. So it was kind of mutual support. I wanted to be with her as that is such a positive in my life.” Later she wrote about another time Cassie shared her personal life “I loved hearing about her day!”

These findings reinforce those in the interview showing more depth in how support in the forms mentioned proved to be helpful in mothers’ adjustment. While these findings other mirror women’s reports, they also reveal that the diagnosed women can be actively involved in eliciting emotional support. For instance, Olivia actively sought to be involved in her daughter’s life because being involved helped *her* feel needed.

*Important Conclusions from Diary Case Studies*

The diary findings mirrored and, thus, matched interview findings in each age group. However, these findings also expand knowledge of each communication phenomenon on a deeper level. For instance, openness and emotional support were clearly connected. Mothers and daughters of diagnosed women tended not to bring up the cancer. Yet, when diagnosed women did openly discuss cancer-related issues, they wanted their mothers/daughters to allow them to talk openly as they are often seeking support. Additionally, new features of communicative
adjustment also emerged. In particular, the presence of mundane talk recurrently emerged in the diary findings as a more prominent feature of mother-daughter communication during treatment than cancer-related talk. Women tended to talk most about other aspects of their lives (e.g., children, grandchildren, moving to college, etc.). The diaries and diary-interviews demonstrate that talk about women’s daily lives that is noncancer-related can be a significant aspect of their coping adjustment during treatment. Finally, the diary case studies showed the influence of human development on mother-daughter communication. For instance, the findings depict the complexity of open communication and avoidance, particularly for diagnosed women with later-life mothers or young-adult (in their twenties) daughters.
## Table 3.3

Diary Case Study Analyses: Mothers’ and Daughters’ Openness, Avoidance, and Enacted Support Communication

<table>
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<tr>
<th>Dyad</th>
<th>Open Topics</th>
<th>Openness Reasons</th>
<th>Avoided Topics</th>
<th>Avoidance Reasons</th>
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<td>Treatment side effects</td>
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<td>Being humorous</td>
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<td>Medical decisions</td>
<td>Share good news*</td>
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<td>Diagnostic testing &amp; results**</td>
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*Denotes emergent patterns in diary analyses that were not recurrent in interview data.

**Denotes emergent patterns new to that age group but emergent in another age group’s interview data.
Chapter Four

DISCUSSION

Overview of Discussion

This study was conducted in two phases and had two specific purposes. The first phase explored the importance of family communication in breast cancer patients’ adjustment to the disease. The second phase expanded knowledge of how families, in particular developmentally diverse mothers and adult daughters, communicatively adjust to this difficult transition. The results from the first phase add to existing literature in health communication by demonstrating how a breast cancer diagnosis is a time-sensitive life transition. These findings also expand our understanding of the role of family communication in a cancer context. The results from the second phase more richly depict how women communicatively adapt to breast cancer in their mother-daughter bond through open communication, avoidance, and enacted emotional support. The findings further capture how mother-daughter communication can function adaptively and maladaptively in their adjustment to cancer.

Following is an in-depth discussion of these results. This discussion begins with the significance of the findings in both phases, specifically how these theoretically and practically expand and contribute to the interdisciplinary literature on family communication, human development and aging, and health communication; the utility for improving health-care services and interventions; possibilities for future research; and the study’s limitations.

The Importance of Family Interaction in Adjusting to Cancer

The first phase of this study explored the importance of family communication to individuals’ adjustment to the breast cancer transition. Using socioemotional selectivity theory (SST) as a framework, Hypothesis 1 and Research Question 1 addressed whether a time limited
perspective, due to being closer to the end of life because of age (Hypothesis 1) or a breast
cancer diagnosis (Research Question 1), leads women to prefer family communication partners.
The results revealed that both time factors lead women to give priority to communication in kin
bonds. Healthy women in later adulthood (age 57 or older) preferred family communication
partners more so than younger healthy women. In addition, women diagnosed with later, more
life-threatening stages of breast cancer (stages 3 or 4) preferred communication in kin bonds,
regardless of age. The results relating to Hypothesis 1 and Research Question 1 have several
significant implications.

**Hypothesis 1**

The results pertaining to Hypothesis 1 extend the utility of SST. Previous studies had
only examined and confirmed that as healthy individuals age their time perspective becomes
more limited. As a result, they prefer communication in close, familiar bonds (relationships that
include both kin and friendships) (Carstensen et al., 1999; Carstensen & Frederickson, 1995;
Fredrickson & Carstensen, 2000). From the perspective of SST, this communication preference
is an important aspect of healthy older adults’ ability to adapt socially to the aging process in a
manner that maximizes quality of life. Because the methods in previous studies confounded kin
bonds with any familiar close bond, a specific preference for family communication had not yet
been determined. The present findings extend SST in revealing that as healthy women age, they
give priority to communication in family relationships (and not just familiar ones).

**Research Question 1**

The results relating to Research Question 1 were somewhat unexpected, in failing to
demonstrate that any woman facing breast cancer prioritizes communication with family partners
in a manner similar to how a healthy older adult woman does. The expectation was that women
with breast cancer would mirror older adults’ preferences because cancer leads these women to consider their own mortality and, hence, to perceive life as more limited. However, the results indicate that age differences appeared. Young diagnosed women reported communication partner preferences similar to young healthy women. Additionally middle-aged and later-life diagnosed women reported communication partner preferences similar to healthy middle-aged and later-life women. As diagnosed women vary greatly in their cancer experience, additional analyses were run to explore possible moderating influences.

Two factors that ostensibly affect women’s cancer experiences, stage at diagnosis and time since last treatment, were explored. The additional analyses revealed that a woman’s stage at diagnosis did relate to whether she developed a limited time perspective. Specifically, women diagnosed with breast cancer in later and the more life-threatening stages (i.e., 3 or 4) experienced a change in time perspective. Regardless of age, all women diagnosed with cancer in stages 3 or 4 reported giving priority to communication with family partners. In comparison, women diagnosed in earlier stages (0-2) did not exhibit a time shift and reported a lower preference for communication in kin bonds. Other analyses investigating time since last treatment failed to reveal significant changes in a woman’s time perspective.

These findings from the first phase of this dissertation add to our theoretical knowledge in several ways. First, these results reinforce the utility of SST in family communication and cancer contexts. In addition, these findings expand our understanding of the role of family communication after women are diagnosed with a late stage of breast cancer. The results from the second phase of the dissertation extend this understanding by depicting how mothers and daughters communicatively adjust to cancer in ways that maximize their well-being.
Mothers’ and Daughters’ Communicative Adaptations to Breast Cancer

The second phase of the study concerned how diagnosed women and their mothers and adult daughters communicatively adjust to breast cancer. Three aspects of communicative behavior (openness, avoidance, and enacted emotional support) were of interest. Additionally, women’s experiences were separated into groups by age at diagnosis (young-adult diagnosed daughters, middle-adult diagnosed daughters, middle-adult diagnosed mothers, and later-adult diagnosed mothers) and compared. These findings are discussed below according to each research question.

Research Questions 2-3: Openness

Research Question 2 addressed what cancer-related topics diagnosed women freely discuss with their mothers/daughters. Research Question 3 concerned women’s reasons for openness. Across ages, women showed similar patterns of openness in analyses for both research questions. These findings indicated that some of diagnosed women’s mother-daughter cancer experiences were similar across age. However, age differences also emerged. These findings highlight unique cancer-related issues mothers and daughters communicatively encounter that are influenced by age and human development. These findings also highlight the complexity of open communication as a variable of study.

Similar Open Communication Patterns Across Age

The data from Research Question 2 revealed that most of the diagnosed women’s openness with their mothers/daughters centered on medical or physical aspects of breast cancer. Diagnosed women in all age groups shared with their mothers and daughters the physical side effects they encountered during treatment. One of these groups (middle-adult diagnosed mothers) also openly discussed the treatment procedures involved, and diagnosed women in two age
groups (diagnosed middle-adult daughters and diagnosed later-life mothers) openly talked about diagnostic testing. Nearly all age groups of women also openly discussed disease prevention for the woman’s mother, daughter, or another female relative. Middle-adult diagnosed daughters were the only ones who did not report openly talking about this prevention. This topic may not be as salient an issue in mother-daughter communication in this age group. These diagnosed daughters’ mothers were in later life. If these women had daughters, they were often under the age of 18. Two of the groups of women also openly talked about their medical decisions. Both involved diagnosed daughters. Their openness typically consisted of sharing their decisions with their mothers, not seeking (or wanting) advice. In sum, across ages diagnosed women’s openness about cancer was largely medically focused.

These findings suggest that diagnosed women may feel most comfortable disclosing medical information or the physical experiences of breast cancer in their mother-daughter bond. Other studies of open communication in marital bonds have shown that talking about the medical aspects of cancer is often perceived as easier than other topics (e.g., feelings) (Lewis & Deal, 1995; Pistrang & Barker, 1992). It is important to recognize that women deal with a multitude of emotional concerns related to cancer (e.g., depression from trauma and chemotherapy, anger, emotions about relational changes, anxiety and uncertainty about the future, wanting to see their children grow up, fear of death, etc.). These issues, however, did not arise as open topic as prominently as topics related to their physical experiences.

Research Question 3 explored women’s reasons for openness. Patterns were again consistent across ages. The findings suggest diagnosed women’s openness is often driven by their mothers’/daughters’ needs. Diagnosed daughters in young adulthood described talking openly about their cancer experience to protect their mothers from negative outcomes. These
women, however, acknowledged that *not* talking or not being open could have negative effects for their mother, such as increased anxiety. Diagnosed daughters in middle adulthood noted that it was easier to openly talk about medical aspects of cancer to prevent their mothers from becoming confused. Both diagnosed mothers in middle and later adulthood felt it was necessary to be open because their daughters expressed wanting to know about their experiences. These findings revealed that diagnosed women’s disclosures could be motivated by a desire to fulfill their communication partner’s needs. Across ages, diagnosed women frequently indicated concern with about how their mothers/daughters were coping. These results showed that diagnosed women were aware that their diagnosis greatly affected their mothers/daughters and, as such, they exhibited a strong sense of concern about their mothers'/daughters’ well-being. Diagnosed women can address this concern by openly communicating about certain topics. Their openness likely contributes to a better adjustment to cancer in lessening their worry about their mothers’/daughters’ welfare.

*Age Differences and Level of Openness*

Despite similarities, diagnosed women’s *level* of openness varied. Differences were tied to age-related concerns. Typically studies examine open communication quantitatively as a binary phenomenon. Family members either perceive that they discussed a topic openly or did not. This approach only provides a snapshot of an exchange rather than a complex, multi-layered interaction (Miller, Kotchick, Dosey, Forehand, & Ham, 1998). The actual nature of openness is missing from these studies. The present findings captured more of the dense nature of mother-daughter communicative exchanges. The complexity of this variable became evident in comparisons across ages. These comparisons also indicated that the level of openness may affect the nature of the open communication, as well as their adjustment to cancer.
Both groups of diagnosed middle-adult women reported varying levels of openness tied to age-related perceptions. Daughters diagnosed in middle adulthood often mentioned having less in-depth interactions with their later-life mothers. In their interviews, these women recalled interactions that centered only on facts and that discussions tended to be brief and less detailed. Similarly, many middle-adult diagnosed mothers explicitly stated that even though they openly shared their physical experiences with their young-adult daughters, they did not go into detail. Rather, like diagnosed middle-adult daughters, these mothers’ discussions tend to be brief, factual, and lack in detail. In contrast, daughters diagnosed in young adulthood and mothers diagnosed in later life often recalled more thorough mother-daughter discussions of their cancer-related experiences. These two groups described sharing intricate details about their physical experiences. Daughters of diagnosed later-life mothers often commented about the extensive detail provided to them in their mothers’ disclosures. Even though all of these groups of women reported being open about certain cancer-related topics, the two latter mentioned groups described more intimate open discussions about the same topics.

Women explained varying levels of openness in relation to age-related concerns. Middle-adult diagnosed daughters’ mothers were in later life (Average age of mothers was 73.). Most of the daughters described their mothers as aging. Some felt their mothers had increased anxiety with age. Others felt that the complexity of cancer treatment and testing confused the mothers and, in effect, contributed to their anxiety. In findings for Research Question 3, these women reported that they were in a way that still protected their mothers from additional worry or confusion. Thus, they kept discussions brief and to the point to ensure they protected their mothers.
Their low level of depth in openness could be due to another age-related difference. It is important to recall that the mother-daughter bond is an intergenerational relationship.

Generational differences in open communication preferences have emerged in previous studies (Segrin, 2003; Zietlow & Sillars, 1989). Similar differences emerged in the present findings. The diagnosed middle-adult daughters mentioned that their mothers did not ask a lot of questions or seek details and, at times, did not allow them to talk about their cancer at length. Because of this behavior, daughters sometimes felt that their mothers did not want to talk about the cancer experience. However, their mothers often characterized their interactions as very open! This suggests that aging mothers and midlife daughters may have divergent perspectives on what open communication is. These mothers were of the generation that functions generally in a more closed socio-emotional climate. Hence, depth of openness may not be as prominent of a factor in their conceptualization of being open. On the other hand, midlife daughters may be more accustomed to an environment that encourages free expression of ideas and emotions.

Age differences in the level of openness also emerged in the group of diagnosed middle-aged mothers. These women had daughters in young adulthood (average age 20). The mothers often explained their less in-depth open talk as necessary because of their daughters’ young age. Many of their daughters were in high school or freshmen in college. They were just entering young adulthood and could even be considered late adolescents (La Sorsa & Fodor, 1990). Some mothers felt their daughters were too young to hear details. In findings relating to Research Question 3, these women described sharing their cancer experiences only if their daughters wanted to know. They allowed their daughter to determine the level of openness. Many mothers explained that they allowed this because their daughters withdrew from them and exhibited signs of distress when mothers talked about their cancer experiences. Daughters often admitted they
enacted avoidant behavior (e.g., leaving the room or home, cutting conversations short, and refusing to discuss cancer) because they were too emotionally upset to hear about their mothers’ cancer. Hence, like middle-adult diagnosed daughters, diagnosed mothers’ open communication was influenced by their daughters’ age or developmental maturity. They minimized the level of openness to protect their daughters from additional distress. These mothers often described such instances as negatively affecting their adjustment. When daughters withdrew and avoided talk about their mothers’ cancer, their mothers in turn worried. Some mothers felt that this distress prevented them from being able to focus more on their own health and well-being. Therefore, this mother-daughter communication pattern could be maladaptive in women’s adjustment.

Research Questions 4-5: Avoidance

Research Question 4 focused on what cancer-related topics diagnosed women avoid talking about with their mothers/daughters. Research Question 5 related to the reasons for avoidance. The findings complemented those pertaining to open communication. Collectively, these results enhance our understanding of how mothers’ and daughters’ openness and avoidant communicative behavior influences their adjustment to breast cancer. Like the findings involving openness, across ages, women showed similar patterns of avoidant communication following a breast cancer diagnosis. Age differences again emerged. These differences highlight the unique avoidant communication issues mothers and daughters encounter depending upon their age at diagnosis as well as their mothers’/daughters’ age.

Similar Avoidant Communication Patterns Across Age

Women in all groups tended to avoid talk about highly emotional topics, including extreme emotions resulting from treatment side effects, distress about the diagnosis, emotions concerning sexuality and body image, and uncertainty about the future. Although women
sometimes mentioned talking to their mother/daughter about their emotions (particularly diagnosed young adults), they also consistently noted that it was a rare, or at least not common, occurrence or that it was something they typically avoided. Some women expressed that it was a topic they shared in other relationships (e.g., marital, sister bond, friendship). Two groups of diagnosed mothers (middle adulthood and later adulthood) admitted they avoided disclosing any negative emotions to their daughters. Interestingly, in both groups the women were the mothers in the relationship. Emotions mothers did not share ranged from feeling “down” to being distressed about certain issues (e.g., waiting for test results). Women in all but one group reported avoiding emotional talk regarding the uncertain future, namely in respect to mortality and recurrence. Similar findings have characterized studies of marital communication. Cancer patients report reluctance in sharing distressing emotions with their spouses (Gray, Fitch, Phillips, Labrecque, & Klotz, 1999). In this study, mothers diagnosed in middle adulthood were the only group not indicating that they actively avoided the topic. However, in comparison to the other groups, most of these women were diagnosed at early, less threatening stages (0-2) and only have had surgery as treatment. Hence, due to their early diagnosis, death and related uncertainty about the future were likely less salient concerns.

Similar to women’s reasons for openness, women’s reasons for avoidance related to their mothers’/daughters’ needs. Again, similar patterns of avoidant communication emerged across ages. Findings involving Research Question 5 revealed that diagnosed women most often avoid cancer-related talk to protect their mothers/daughters. Protection is commonly a reason that women coping with HIV hide their health status from their children (Schrimshaw & Siegel, 2002). However, this motive is less well understood in the cancer context. In this study, mothers and daughters appeared to have a strong sense of responsibility to one another. In every age
group of diagnosed women, they were concerned with how their mothers or daughters were coping with the diagnosis. This theme also was evident in data relating to openness. Diagnosed women’s motivation to be open or avoidant had to do with whether the information likely would hurt their mothers/daughters. If women felt that disclosing would cause distress, they often avoided doing so.

This reason for avoidance often functioned adaptively for both diagnosed women and their mothers/daughters. However, protection sometimes had the opposite effect in dyads in which the mother was diagnosed. Mothers felt they were shielding their daughters from distress when they avoided topics or withheld information. Yet, diagnosed mothers’ avoidance ironically served to distress their daughters. Daughters described being worried when they felt something was wrong and their mothers would not tell them. They indicated that not knowing was even more upsetting than knowing. Although these daughters were in young adulthood, all were post-college, and many were in their thirties (average age was 31). Hence, they were likely more emotionally mature and able to handle more disclosures from their mothers. Their experiences were in opposition to “younger” young adult or emerging adult daughters in their early twenties, who reported more distress when their mothers’ disclosed about their cancer experiences.

Age Differences and Reasons for Avoidance

Unlike the age-related findings for open communication, the results for this part of the study indicated that both the age of the diagnosed woman and the age of her mother/daughter entered into whether she avoided cancer-related talk. Diagnosed women avoided talk when they perceived their daughters were too young so as to protect their young-adult daughters from emotional distress. Mothers diagnosed in middle adulthood often reported hiding their emotions from their young-adult daughters. This is complementary to the results for openness in this age
group. Again, the daughter’s age was a determining factor in how open or avoidant a diagnosed mother behaved. Mothers’ concern for their daughters’ well-being motivated both their open and avoidant behavior.

Additional age-related findings involving women’s avoidant patterns that also complemented the openness results revealed later-life mothers of diagnosed daughters tended to display patterns that appeared to be related to generational differences. These diagnosed mothers admitted hiding their emotions from their daughters and cited privacy as their motivation. Women in later life explained that they valued their privacy and felt that some things should be kept personal. Privacy emerged as a motive for avoidance in a study by Elal-Lawrence and Celikoglu’s (1995) showing that a small number of women with breast cancer in Istanbul, regarded their thoughts and feelings as private.

This motivation did not emerge in any of the other age groups. Later-life diagnosed mothers’ motivation may have been a product of the more closed environment in which they grew to adulthood. As previously noted, later adult women were from a generation in which they were not encouraged to be emotionally open (Segrin, 2003; Zietlow & Sillars, 1988). Consequently, they may have regarded their emotional experiences as private and, therefore, not something to share. Vangelisti’s (1994) work on family secrets may also provide insight. She and other scholars have shown that families sometimes keep things secret by avoiding topics (Paul & Berger, 2007). One commonly reported reason for secrecy is to maintain privacy. This body of work may be a bit of a stretch in understanding women’s avoidant behavior in other situations, however. Secrets involve information kept private within certain boundaries (see Communication Privacy Management Theory (CPM), Caughlin & Petronio, 2004; Petronio, 2002). Secrets are generally categorized as taboo (topics that are stigmatized), rule violations
(breaking family rules), or conventional (meaning the topic is not wrong to discuss but an individual perceives it be inappropriate). Hence, while women may avoid talking about recurrence in younger age groups, they might not necessarily perceive this emotional concern as a secret. Be that as it may, in regard to later-life diagnosed mothers’ experiences, this body of work can help inform their avoidant behavior about negative affect if one thinks of negative emotions as a form of conventional secret. These women specifically cited privacy as their reason for not disclosing their negative emotions to their daughters. They were also the only generation of women to so. For later-life women, then, their negative emotions could be considered a conventional secret because they were raised in a culture in which emotional feelings were not freely shared.

Even though mothers avoided this topic, their daughters seemed to be aware of their mothers’ emotional state. They also often mentioned being very concerned about their mothers’ mental health. Many of these daughters reportedly felt their mothers exhibited signs of depression, sadness, and anxiety. At times they talked about being frustrated that their mothers would not address the matter. Not talking about it worried the daughters even more. In addition, daughters were concerned about their mothers’ emotional distress not being addressed and professionally treated. Hence, the mothers’ avoidance may have ironically impeded their own adjustment to cancer. It almost certainly affected their daughters’. Interestingly, in the openness results, diagnosed midlife daughters also mentioned their mothers’ negative emotional states in terms of aging. According to these daughters, their mothers’ depressed or anxious mental state led them to discuss their physical experiences in less detail so as to not distress their mothers. Collectively, these findings highlight age differences for later-life women in both open and avoidant mother-daughter communication as they adjust to cancer. Moreover, the findings
highlight a notable area of concern (i.e., negative affect) that may be a more significant issue for later-life women (both diagnosed and not) in coping with breast cancer.

Research Questions 6-7: Enacted Emotional Support Communication

Research Question 6 had as its central concern how diagnosed women and their mothers/daughters adapt to breast cancer in respect to enacted emotional support communication. Research Question 7 focused on whether diagnosed women perceive such support as helpful in their adjustment. Some women found certain types of emotional support to be always helpful to their adjustment. However, other women characterized support as sometimes helpful and sometimes not. Age differences were in evidence. Context, moreover, was a key factor in whether women perceived support as helpful or not.

Similar Emotional Support Experiences Across Age

Women in all age groups consistently reported that two types of enacted emotional support communication were always helpful in their adjustment: listening (in it allowed them to freely share with their mothers/daughters their cancer-related concerns and experiences) and being humorous (typically in respect to drastic physical changes resulting from surgery and treatments).

In addition to these two forms of communication, three age groups noted that showing affection was a purely adaptive form of support that noticeably increased following a diagnosis (This was not true in the midlife group of daughters.). They felt their mothers/daughters made more of an effort to kiss, hug, or say “I love you.” For women with young-adult daughters (who were also very close to the adolescent period), this increase in affectionate communication was especially obvious. At times, hugs were comforting to diagnosed women when they felt distressed or sad. In other instances, affection was helpful in offering them encouragement and
strength to keep fighting the disease. As noted, the only age group not reporting this emotional support communication was diagnosed middle-adult daughters. This behavior may have been less of a matter worthy of issue in this group, as most of these daughters’ mothers lived a long distance geographically.

Women’s experiences with these three forms of emotional support communication highlight contextual aspects of the breast cancer experience (e.g., physical or bodily changes) in which this communication was enacted to help women adjust. The findings also reinforce previous research involving emotional support communication. Listening, being humorous, and showing affection are all forms of supportive behavior that have emerged in other studies of family coping during transitions, including how women cope with breast cancer in other bonds (Kershaw, Northouse, Kritpacha, Schafenaker, & Mood, 2004). These forms of emotional support are also consistently described as ones that help families display resilience following crises (Ell, 1996; McCubbin & Patterson, 1983). However, most studies rarely include the context in which such behavior occurs. The present study did. These behaviors help women adjust to the disease.

Age Differences and the Adaptive Functioning of Enacted Emotional Support

Diagnosed women perceived other forms of enacted support communication as sometimes helpful and at other times not helpful in their adjustment to breast cancer. In these cases, age differences emerged. There were notable age differences in perceptions of two forms of emotional support communication: being there and staying positive. First, “being there” was received differently by women. All groups of women conceived of being there as having their mother/daughter as a companion, someone to keep them company, as well as a feeling of consistency of support or presence. They mentioned this support of “presence” in various
contexts, including the health setting (e.g., going to appointments together), being present in their home, as well as just being available at any time. Only young-adult diagnosed daughters mentioned being there in an additional way in the health context. These daughters recalled their mothers being there more actively and specifically as their health advocate.

Interestingly, all groups of women found being there as helpful to their adjustment, with the exception of diagnosed young-adult daughters. These women reported this type of support as functioning maladaptively at times. It reportedly was not helpful when mothers invaded their space, were not consistently “there,” or did not negotiate with their daughters their roles as health advocates. In contrast, the other age groups of women felt that this form of support was always helpful. They found it comforting.

This difference in perception is likely influenced by young-adult daughters’ developmental place in life. These daughters were young adults. As such, they are closest to the adolescent period. This period of life in the mother-daughter bond is characterized by a dialectical tension in which daughters want to be connected emotionally with their mothers but, at the same time, actively seek independence, a separate sense of self, and separation from their mothers (Hershberg, 2006; Kaufman, 1999; La Sorsa & Fodor, 1990) This dynamic can be at the base of tension in the relationship as mothers struggle with giving their daughters independence (La Sorsa & Fodor). Even in emerging and young adulthood, women struggle for independence and a sense of self separate from their mothers. Daughters are just beginning to stand on their own. Interestingly, these diagnosed daughters made reference to this dynamic in their mother-daughter bond in commenting on the need for space. They also talked about understanding their mothers’ need to “mother” them. Yet, this understanding competed with daughters’ desire to be independent at times. The findings suggest that when mothers’ support of “being there”
encroaches on daughters’ independence, this communicative support may function maladaptively in young-adult daughters’ adjustment and highlights how human development can influence diagnosed women’s communication support preferences.

Second, “staying positive” was a form of support diagnosed women did not always perceive as helpful in their adjustment. In fact, only one group of women (diagnosed middle-adult mothers) felt this type of communicative support always functioned adaptively. Staying positive was generally described in the same manner by all groups of women as consisting of giving encouragement, maintaining a positive outlook, and offering reassurance. Diagnosed middle-adult daughters also perceived their mothers’ reframing behavior as a means of offering positive emotional support. Often this type of supportive communication surfaced when diagnosed women were distressed about upcoming test results or feeling depleted or ill from treatment side effects. However, at times, women described this communication as a consistent form of support, even a philosophy of life, their mothers/daughters manifested throughout their cancer experience.

Most women described staying positive as sometimes functioning maladaptively and pointed to interactions in which they perceived positive talk minimized or glossed over their feelings, prevented them from expressing negative emotion, or made them feel censored in what they could or could not say. Similar findings surfaced in previous research. Goldsmith’s (2004) review of research involving social support mentioned studies showing that communication that minimizes the difficulty of one’s experience is not helpful. The present study added to this discovery by capturing the specific behavior (i.e., positive communication) that can prove to be maladaptive. Additionally, studies Goldsmith cited have shown that encouragement in recovering can be received negatively. The current results are consistent with this finding.
However, they go further in identifying the context of recovery in which such negative outcomes can occur. Identifying women noted they did not necessarily like hearing positive talk during treatment recovery when they felt especially ill or tired from treatment side effects.

The only group of women reporting that being positive was always helpful consisted of diagnosed midlife mothers. Interestingly, these women also had the youngest relational partners in comparison to the other mother-daughter bonds. As previously noted, their daughters were in young adulthood. In the open and avoidant communication results, this group of daughters exhibited a notable amount of emotional distress. They even withdrew communicatively from their mothers in an effort to cope with the diagnoses. Daughters’ withdrawal and avoidant behavior greatly worried their mothers. Hence, it is likely that when daughters talked positively about the cancer to their mothers, this form of support alleviated some of the mothers’ concern about their daughters’ well-being.

Additional findings revealed another type of age difference among mother-daughter support experiences. Women reported different types of support behavior in different age groups. These findings suggest that certain types of support behavior may be more salient or more important in these age groups’ experiences. For instance, only daughters mentioned “validating decisions” as a form of emotional support from their mothers (young-adult daughters in the interviews and diaries and middle-adult daughters in the diary). For these women, it was particularly important that their mothers reinforce their medical decisions, not question them. This finding is not entirely surprising when one reflects on the developmental literature involving emerging and young adulthood as well as literature concerning mothers and daughters (Arnett, 1998, 2000, 2001; La Sorsa & Fodor, 1990). This age period for daughters is a time in which they are just beginning to become independent of their mothers and to learn how to
function on their own (Arnett, 1998, 2000, 2001). Their decision-making can be a source of tension in the relationship as young adults vie for their mothers’ respect, and mothers, in turn, worry that their daughters will make the right decisions (La Sorsa & Fodor, 1990). Breast cancer is also a time of heightened uncertainty. Thus, mothers’ validation of daughters’ decisions, especially during this developmental period, likely helps minimize this emotional distress by reassuring daughters they are making the right choices. Many daughters reported that this type of emotional support made them feel that their mothers trusted them and had faith in their coping ability.

A similar age difference finding emerged in the later-life group. Only later-life diagnosed mothers mentioned making an effort to spend more time together or calling as a significant form of supportive behavior from their daughters. Virtually all diagnosed women and their mothers and daughters noted spending more time together or calling more often. However, later-life mothers were the only women to characterize their daughters’ behavior in terms of effort. These women’s daughters were only in young adulthood, a time period in which the mother-daughter relationship is often redefined. Previous research on filial comprehending (Nydegger, 1991; Miller-Day, 2004) shows that young-adult daughters eventually see their mothers as women, not only their mothers. This change in perspective leads daughters to see their mothers in a new light. During the cancer experience, the young-adult daughters of later-life diagnosed mothers seemed to gain an appreciation for their mother in this light. They often indicated that they felt closer and more intimate with their mothers and, hence, valued their relationships more. Their mothers stated that this change in behavior was very meaningful to them. They felt supported, often for the first time, on a more equal level. These daughters’ behavior was different from that of young-adult daughters of midlife diagnosed mothers (who
were also, on average, 10 years younger). Daughters of diagnosed later-life mothers exhibited a more mature demeanor, which indicated they could emotionally support their mothers in more intimate ways. This relational communication change for later-life diagnosed mothers seemed to be particularly uplifting and helpful in their adjustment to cancer.

These findings point to the importance of age and human development in women’s breast cancer experiences. Age and development affect how women conceptualize certain emotionally supportive behavior as well as their support communication preferences. A previous study demonstrated that a diagnosed women’s age or developmental phase of life affects her breast cancer related concerns and needs (Oktay & Walter, 1991). However, age and human development are often ignored when attempting to understand communication dynamics, particularly when adjusting to transitions. The present findings confirm that age and human development are important contextual factors that not only influence how support behaviors are defined but also how they are perceived in terms of affecting women’s well-being and adjustment to the disease.

Noteworthy Scholarly and Practical Implications of the Findings

The findings discussed above make noteworthy contributions to the theoretical and practical knowledge base of the communication discipline in understanding family, aging, and health communication experiences. The most noteworthy ones are further discussed below.

Theoretical Advances in Family Communication and Health

The findings from the first phase of this dissertation enhance the utility of SST as a theory, as well as our understanding of family communication in a cancer context. SST was applied for the first time in a family communication and cancer context. The results demonstrated that cancer can function as an ending experience within the SST framework.
Hence, the utility of this theory was expanded to cancer and family communication contexts. In addition, the dissertation findings demonstrate that SST is useful in attempting to understand why individuals’ kin communication partner preferences are of greater importance with increasing age and with a diagnosis of cancer. SST is a theory that explains social behavior changes enacted to maximize survival (Carstensen et al., 1999). The present findings provide support for the view that family communication can be an adaptive mechanism in adjusting to cancer, particularly when women of any age are diagnosed in later, more life-threatening stages.

At the same time, these findings are a source of practical knowledge one can use to improve breast cancer patients’ care. The results of this study indicate that family communication gains priority among women diagnosed in later stages of breast cancer. This finding should be considered in conjunction with previous research suggesting family communication affects patients’ adjustment (Jamison et al., 1978; Kahn & Antonucci, 1980; Mallinger et al., 2006; Thotis, 1985; Zemore & Shepel, 1989). In conjunction, the findings suggest a need for health professionals to integrate family communication into breast cancer patients’ care. The findings further suggest that such interventions are particularly critical when a woman receives a diagnosis in stages 3 or 4 or the disease advances to a later stage. Many of the women in the study noted wanting their health professionals to involve family members in their care. They felt that their family was not only an integral part of their adjustment but that they too were inevitably affected by the diagnosis.

Currently, family communication is not typically an aspect of cancer care. Health professionals can integrate family communication into breast cancer patients’ care in a number of ways. For instance, practitioners could require patients to bring a family member to critical appointments (e.g., treatment decisions, test results, and first treatment appointments) or provide
support services geared to both the patient and her selected family member(s). Doing so could stimulate greater family communication for patients. Individual services could also be provided to patients and their family members to ensure their individual needs are met. Findings from the second phase of the dissertation additionally extend our understanding of the role of family interaction, specifically mother-daughter communication, when developmentally diverse women adjust to breast cancer.

*Unique Experiences in Developmentally Diverse Mother-Daughter Bonds*

The results of this study revealed the influence age and human development can have on women’s breast cancer experiences, their perceptions of communicative behavior, their communicative preferences and needs, their evaluations of communicative behavior, and their mother-daughter relationship. Previous studies have suggested that age affects communicative behavior (Nussbaum et al., 2002; Pecchioni et al., 2005), as well as the cancer experience (Oktay & Walter, 1991). However, this variable has been consistently ignored in social support literature, studies of open and avoidant communication, and research examining cancer-related communication (Goldsmith et al., in press). Hence, age and development are not fully understood as influential factors in families’ communicative adjustment to breast cancer. The findings of the present study have enlarged our understanding by highlighting the role age and development play in women’s breast cancer experiences and their mother-daughter communicative adjustment to this transition.

*Unique breast cancer related concerns.* Findings involving openness of communication and avoidance revealed that some age groups may struggle more than others with emotional distress. First, the young-adult daughters of diagnosed mothers (who were typically in midlife) often exhibited extreme signs of distress. These daughters actively refrained from certain kinds
of communication with their mothers and admitted they refused to deal with the reality because it was just too stressful. In response, their diagnosed mothers expressed considerable concern for the daughters’ well-being. Young-adult daughters of diagnosed mothers especially were emotionally distressed about their mothers’ diagnoses. Previous studies indicate that adult daughters of diagnosed mothers can mirror their mothers in psychological distress and even exhibit negative psychological effects (e.g., PTSD) and physiological changes (e.g., increased stress hormones) (Boyer et al., 2002; Cohen et al., 2002). The current findings support this research and suggest that emotional distress may be even more of a concern with young-adult daughters. The findings yielded evidence of a tell-tale mother-daughter communication dynamic (i.e., a daughter’s withdrawal behavior) that can signify to the mother her daughter is emotionally suffering.

Health professionals need to be aware of young-adult daughters’ struggles with their mothers’ diagnoses. As previously noted, family communication should be integrated into care. For diagnosed women with young-adult daughters, social support services could be offered to help daughters adjust in a healthy manner. Information could be given to mothers concerning how to talk to their daughters about the disease in ways that can alleviate or minimize daughters’ distress. Although this service may readily be viewed as only helping daughters’ adjustment, it is important to recall that mothers expressed extreme and even distracting concern about their daughters when they withdrew socially. They felt this prevented them from being able to completely focus on fighting the disease because they were too worried about their daughters. In this sample, some mothers and daughters did discuss finding a therapist for their daughters who were enacting extreme avoidant behavior. All mothers felt this service was instrumental in helping their daughters (and themselves) adjust to cancer.
In addition to this age group, women diagnosed in later life had different concerns. As noted previously, like young-adult daughters of diagnosed mothers, later-life women more frequently experienced negative affect. Later-life diagnosed mothers were especially affected by their hair loss during treatment. They described their daughters’ emotional support of giving advice, suggestions, as well as compliments about their hair as especially helpful in their adjustment to this physical change. All women experiencing chemotherapy mentioned the difficulty in adjusting to hair loss. However, this age group of diagnosed women discussed this struggle in terms of emotional trauma the most. Their daughters also noted about how their mothers were particularly self conscious about their appearance. Many of the daughters reported making efforts to reassure their mothers that they looked beautiful and, at the same time, to be sensitive to their feelings about their appearance.

In comparison, young-adult diagnosed women often talked about the hair loss but seemed to have less emotional distress in terms of adjusting to wearing a wig, scarf, or being bald in public places. Midlife-diagnosed women also discussed their hair loss but not as commonly in reference to their experience in the mother-daughter bond. At times, these women had young daughters who did not want to see their mothers’ hair loss—hence, the mothers hid it. At other times, diagnosed women’s daughters lived far away, as they were in college, as did their mothers (when midlife women were diagnosed daughters). Hence, adjustment to hair loss was less of a shared mother-daughter topic.

For later-life mothers, as noted above, the loss of hair was especially traumatic. Many of them noted always covering their heads in public with wigs so that others would not know they had cancer. Some women even refused to wear scarves for this reason. The behavior may be tied to later-life women’s need for privacy. As noted earlier, privacy was a concern that emerged
when these women discussed their avoidant behavior with their daughters about their emotions. Regardless of the reason, however, this finding reveals that hair loss may be more traumatic for women in older adulthood. This finding is important for health professionals and practitioners in caring for older breast cancer patients. Across the United States, there are a multitude of wonderful free services available to women to help them select a realistic wig, learn how to put on make-up after losing their eyelashes and eyebrows, and how to cope with their new physical appearance (see Image Recovery Centers at http://www.imagerecovery.com/). Interestingly, however, not all women in this sample were aware of these services. Women who were aware of these services accessed them with their mothers/daughters. Many of these women described these activities as a fun mother-daughter day. For later-life patients, especially, it would be helpful for health interventionists and their family members to be knowledgeable of these services. In addition, for daughters of later-life diagnosed mothers, these services offer them opportunities for communicative activity that can help their mothers adjust more easily to the traumatic change in their lives that breast cancer produces.

*Unique communicative conceptualizations, preferences, and evaluations.* The participants also displayed age differences in their communicative conceptualizations, preferences, and evaluations of communicative behavior in aiding their adjustment to cancer. For instance, as evident in the openness results, later-life women and younger women differed in their views of openness. Women in later generations grew up in more closed environments whereas young women grew up in open environments and apparently had a different understanding of what it means to be open. This difference in perception can affect whether interactions function positively or negatively in women’s adjustment to cancer. According to Goldsmith (2004), whether or not communication is considered helpful, in part, depends upon whether both partners
have shared definitions of what constitutes helpful behavior, which may, in turn, depend on how open they see one another.

Age differences also emerged for women’s preferences for emotional support communication and their evaluations of how different forms contributed to differences related to stage of social development. For example, young-adult daughters’ need for independence affected their preferences for emotional support from their mothers. For instance, when their mothers supported them by being there, they preferred this support to be conveyed in a manner that also respected their need for space. Later-life diagnosed mothers especially appreciated witnessing their daughters’ effort in their emotional support behavior. They valued this because it reflected a change in their relational bond. Also, midlife-diagnosed mothers, who often worried about their daughters’ well-being, talked about “keeping things normal” or “positive talk” as key ways their young-adult daughters contributed to their adjustment to cancer. Health interventionists, therapists, and practitioners could help mothers and daughters cope by making them more aware of such age-related tendencies and creating interventions geared to teaching them how to adjust in healthy ways. The findings of this dissertation appreciate developmental diversity in women’s needs and preferences.

_The Importance of Context and the Adaptive Nature of Communication_

Another implication of the second phase of the study is that the context of the communication experience is important to be aware of. Although the term “context” encompasses a multitude of factors, this study established that the relationship in which communication occurs affects it in significant ways. Context includes the individual’s relational role (e.g., mother or daughter), communication partners’ ages and social development, and the matter of concern (breast cancer-related experiences). Goldsmith (2004) notes that attention to
context has been consistently missing in studies of how communication affects our adjustment to difficult changes or life events. Instead, scholars have focused on aspects of supportive communication, such as the frequency of interactions or the quantity of relationships in one’s social network. The quality of the supportive communication is largely ignored.

Scholars sometimes try to assess quality by asking individuals whether or not specific supportive behaviors have been helpful or satisfying. However, global ratings tend to be inadequate for assessing the adaptive or helpful potential of emotionally supportive behavior (Goldsmith et al., in press). Understanding the actual quality of the communication is incomplete because the context in which the communication is enacted remains unexamined. Goldsmith’s (2004) synthesis of decades of work revealed, however, that context is critical to understanding the quality of adjustment to traumatic situations. Without individuals’ perceptions of quality, social support or other forms of communicative behavior cannot be linked to quality of life and well-being.

This study gives credence to Goldsmith (2004) in showing that the context of communication matters. With the qualitative approach, women could describe supportive behavior in their own words in relation to their own experiences. Moreover, they had the opportunity to explain why communication can be helpful to their adjustment or not by describing the context in which the interaction occurred. Without contextual variables like the relationship type, relational role, topic of discussion, and age of the communication partners, it is nearly impossible to ascertain how and why people see communicative behavior as helpful or unhelpful in making adaptations to changes in their lives. Without context, it is not possible to understand fully the necessary conditions for communication to be helpful in adjusting to cancer
(Goldsmith). Hence, it is also impossible to determine what can help affected parties to adjust in ways that maximize their quality of life.

This study has also shown the value of multiple methods to capture the context of mother-daughter communicative adjustment to cancer. Women’s experiences across the course of cancer (e.g., from diagnosis to post-treatment and survival) are illuminated via questionnaires, interviews, and diaries. This provided a comprehensive picture of mother-daughter communication in adjusting to cancer. The diaries and diary-interviews more fully captured how openness, avoidance, and emotional support communication function during a specific and often difficult aspect of the cancer experience—treatment. This, in turn, contributed understanding of openness, avoidance, and emotionally supportive communication under differing sets of circumstances.

Findings from both interviews and diaries might be of help to create narratives of women’s experiences across the cancer journey. Narratives are an effective way of communicating cancer-related information (Green, 2006). According to Green,

Transportation into narrative worlds, or immersion into a story, is a primary mechanism of narrative persuasion … [Narratives] facilitate the mental simulation of unknown, difficult, or frightening procedures (e.g., screening) and provide role models for behavior change (p. 163; see also Green & Brock, 2000, 2002).

Narratives are increasingly in use in medical school curricula (see Charon, 2007) to educate health professionals on their patients’ needs and experiences. Narratives are also often recommended in health communication campaigns. Campaign scholars, drawing on social cognitive theory (Bandura, 1977), see narratives as useful in providing individuals with models of behavior. Stories can inspire individuals to enact certain behaviors. According to Green (2006), “When individuals identify with characters, these characters may provide templates for ‘possible selves’” (p. 167, see also Markus & Nurius, 1986). Moreover, people gravitate toward
stories. Lance Armstrong’s stories of survival
(http://www.livestrong.org/site/c.khLXK1PxBmF/b.2662117/k.68D9/Hear_Survivor_Stories.htm), as well as other women’s breast cancer stories (e.g., Elizabeth Edwards), were ones the
women saw as inspiring and encouraging. Narratives could be just as helpful in providing future breast cancer patients and their families with models of behavior in terms of how to
communicatively adjust in healthy ways.

In the present study, women could openly discuss their breast cancer mother-daughter interactions. Because women’s stories are captured in their own words, they are an effective way to transfer knowledge to cancer patients to help them adjust. Excerpts from interviews, diaries, and diary-interviews can be used to create multiple stories of women’s experiences in each age group. With such materials, diagnosed women and their mothers/daughters can be forewarned about aspects of the breast cancer experience facing them, the communication preferences and needs of their mothers/daughters (as well as themselves), and the communication dilemmas that may arise. By having multiple narratives of experiences (that address factors of diversity), women could more easily find stories that match their experiences. Women in this study frequently mentioned not knowing what to do to help their mothers/daughters cope with cancer. They admitted that they did not know what to say or whether their behavior was even helpful. The present study illuminates experiences in ways that make such problems less likely. Studies show that by using narratives to provide individuals models for behavior, their own self-efficacy increases. They begin to believe they can enact certain types of behaviors effectively (Anderson, 2000).
Directions for Future Research

The preceding discussion suggests some possibilities for further research. The suggestions have as an aim producing applied, socially relevant research that is useful in developing interventions and changing social and health policy. To effect social change, research must be “meaningful and valuable to the scientific community, as well as the public at large” (Kelley, 2008, p. 1; see also Nussbaum, 2007).

Openness and Avoidance

Currently, researchers conceptualize openness and avoidance simplistically. Studies are needed to provide a richer conceptualization. Openness functions as a multi-dimensional variable. Women choose to disclose, but at varying levels of depth. Hence, even though a woman may share a breast cancer related topic, she may not talk openly enough about it for her mother/daughter to understand her experience fully. The level of disclosure is actually what determines how much mothers and daughters understand the breast cancer experience.

Avoidance is also a complex variable. The term has negative connotations, which may lead individuals initially to be less honest about their behavior. When women were asked which cancer-related topics they avoided in discussions, they often reported that they did not consciously avoid any talk. During interviews, many women indicated they never avoided topics until they were directly asked about specific ones (e.g., recurrence concerns). This initial response could be an outgrowth of the negative connotations of the term “avoidance.” In addition, sometimes women did not consciously avoid topics. Certain matters simply never came up. Not discussing an issue, then, does not necessarily imply that this is their desire. Finally, women sometimes admitted they avoided certain topics (e.g., mortality) with their
mothers/daughters but did share their concerns in other relationships (e.g., with their husband or a friend).

These findings suggest the importance of examining and conceptualizing openness and avoidance on a deeper, more complex level. At the same time, they seem to warrant sampling multiple supportive relationships in breast cancer patients’ social network to capture communicative adjustment to cancer more fully.

Certain methods may be especially helpful in capturing the complexity of these variables in future studies. The diary-interview method was very good for learning about women’s cancer-related thoughts in greater depth. Using it permitted better assessments of which cancer experiences those in the mother-daughter bond share. Clearly, openness and avoidance operate simultaneously in that women share some details (e.g., medical facts) and withhold others (e.g., feelings), at least they did in this study. Such “selective communication” may result in patterns of communication that are helpful or not helpful in families’ adjustment to cancer (Goldsmith et al., in press; see also Lewis & Deal, 1995). However, their interconnections are not well understood. Investigations that focus on them would be of value.

The diary-interview method allowed for a more comprehensive analysis of each of the communication phenomena of interest. By using this mixed method qualitative approach, one can examine variables in a specific context of cancer (e.g., treatment) on a deeper level. Interviewing women about their diary entries also gave them the opportunity to explain their communicative experiences in more detail. This method also illuminated the selective nature of women’s open and avoidant communication as well as the simultaneous functioning of both variables. John Gottman’s extensive work on positive and negative communication in married couples may be insightful for future scholars of openness and avoidance (Gottman, 1994). In his
work, he determines a ratio of positive and negative communication to predict marital satisfaction and even divorce. The same approach could be used with openness and avoidance. A ratio of openness and avoidance in communicative behavior may be helpful in predicting how adaptive patients’ selective communication behavior functions in their adjustment to cancer. Since these variables seem to function together, Gottman’s ratio approach could possibly reveal how they moderate women’s positive or negative adjustment to cancer.

Enacted Emotional Support

The complexity of emotionally supportive communication came to the forefront in the research for this dissertation. Various forms of communicative behavior overlapped (e.g., overlap with openness and daughters’ being willing to talk; overlap with listening and being there). Such overlap signals the interactive and dynamic nature of providing emotional support. Collecting actual recorded conversations between mothers and daughters would be an invaluable method to examine this complexity further. Wayne Beach’s work is an exemplary of how to conduct this type of research (Beach & Anderson, 2003a, 2003b). His use of recorded telephone conversations and conversational analysis has been instrumental in revealing how families cope with cancer. According to Beach and Anderson (2003b), “Conversation analysis is a methodological alternative for closely examining the detailed and patterned organization of interactions in natural settings, including oncological involvements in both clinical and home environments” (p. 1). Beach’s approach captures family conversations in context as they would occur without a recording device or a researcher observing them. To fully reveal the complexity of emotional support communication (and its value in women’s adapting to breast cancer) Beach’s approach would be invaluable. As Beach and Anderson note

During communication, participants continually reveal their orientations to and understandings of moment-by-moment interactional involvements. In the precise ways
speakers construct and respond to turns-at-talk and related embodied actions (e.g., gaze, gesture, touch, and the use of objects), they demonstrate first for one another (and subsequently for analysts’ inspections) their real-time and practical understandings of evolving conduct-in-interaction. Thus, exactly what gets achieved in communication is a result of how speakers construct and make available to one another their understandings of the local environment of which they are an integral part. (p. 2)

It would also be valuable to utilize the diary-interview method in conjunction with Beach’s approach to gather individuals’ cancer-related thoughts as well as their evaluations of interactions. Doing so could capture the topics families share with one another, what they avoid talking about, and what communicative behavior they perceive to be most helpful in their adjustment to cancer.

Limitations

This study had several limitations. First, despite effort to obtain a diverse set of participants, the sample was homogeneous. These findings apply largely to rural Caucasian women’s breast cancer experiences and their mother-daughter interactive adjustment to the disease. Mothers’ and daughters’ communicative experiences and relational expectations are influenced by ethnicity and culture (Rastogi & Wampler, 2004). As such, a culturally diverse sample of mothers and daughters would have been preferable and should be recruited in future studies.

Second, the study did not allow general claims about particular subsets’ breast cancer experiences. However, breast cancer itself is a very diverse experience. Some women were newly diagnosed, whereas other women had a recurrence. The stage at diagnosis was variable. Diversity in treatment regimen also affected women’s cancer experiences. Women sometimes only had a lumpectomy and characterized their breast cancer diagnosis as “just a surgery.” In stark contrast, other women received a mastectomy, radiation, chemotherapy, five years of hormonal prevention treatment, and sometimes additional surgeries (e.g., removal of ovaries) to
prevent a recurrence. These women described their experience as a daily emotional struggle and major life disruption lasting several years in addition to a projected five-year follow-up. Variance in treatment affected the intensity and length of women’s cancer experience. Moreover, the life span of the disease (biopsy – surgery – treatment decisions – radiation – chemotherapy – preventive five-year drugs – survivorship or end of life) is a factor influencing the breast cancer communication experience. Women talk more about cancer in their mother-daughter bond early on in the disease as opposed to after they end treatment and begin survivorship. In this study, it was not possible to control for such variations and still have an adequate sample. When possible, future studies should at least attempt to examine mother-daughter communicative adjustment in dyads with similar diagnoses and treatment regimens to capture their unique experiences.

Finally, the data are from retrospective reports, not observations of mother-daughter interactions. As a result, the findings may not provide a fully accurate picture of mother-daughter communication. Observations seemed to be inappropriate in light of the sensitive nature of this issue. Moreover, the presence of a researcher, even on the other side of two-way mirror, could influence the behavior to be observed. Still, observations could serve a validating function. On the other hand, family communication literature shows that retrospective perspectives are of value. Often, it is not simply the patterns of communication themselves but family members’ perceptions of those patterns that are at the base of healthy and unhealthy outcomes (Caughlin, 2002; Rogers, 2006). Therefore, it can be important to obtain subjective retrospective accounts of interpersonal interactions because memories of interaction can and do influence individual and relational functioning, and in the present context the parties’ mutual adjustments to cancer.
References


Edwards, B., & Clark, V. (2004). The psychological impact of a cancer diagnosis on families:
The influence of family functioning and patients’ illness characteristics on depression and anxiety. *Psycho-Oncology, 13*, 562-576.


Green, M. C., & Brock, T. C. (2002). In the mind’s eye: Transportation-imagery model of
narrative persuasion. In M. C. Green, J. J. Strange, & T. C. Brock (Eds.), *Narrative impact: Social and cognitive foundations* (pp. 315–341). Mahwah, NJ: Erlbaum.


life stress, pain and emotional adjustment to advanced breast cancer. *Psycho-Oncology, 7*, 101-111.


Manne, S. L., Dougherty, J., Veach, S., & Kless, R. (1999). Hiding worries from one’s spouse:


New York: Springer.

family systems perspective on childhood cancer survivorship. In L. Baider, C. L. Cooper,
& A. Kaplan De-Nour (Eds.), Cancer and the family (2nd ed., pp. 155-173). New York:
John Wiley & Sons.

Speech, 70, 274-287.


Erlbaum.

the literature. Journal of Psychosocial Oncology, 6, 95-118.


Psychological Science, 8, 162-166.


Segrin, C. (2003). Age moderates the relationship between social support and psychosocial


Appendix A

Phase 1 Informed Consent

Implied Informed Consent Form for Social Science Research
The Pennsylvania State University

Title of Project: Social Partner Preferences

Principal Investigator: Carla L. Fisher, ABD
PhD Candidate/NIA Predoctoral Fellow
234 Sparks Penn State Building
University Park, PA 16802
(814) 574-6434; clf196@psu.edu

Advisor: Dr. Jon F. Nussbaum
Professor, Communication Arts & Sciences
234 Sparks Penn State Building
University Park, PA 16802
(814) 863-3619; jfn5@psu.edu

1. Purpose of the Study: The purpose of this research study is to learn more about your social partner preferences and about the relationships that make up our social network.

2. Procedures to be followed: You will be asked to answer questions about who you interact with or would potentially interact with via several surveys.

3. Discomforts and Risks: There are no foreseeable discomfort or risks to participating in this study

4. Benefits: Your answers will be useful in helping professionals understand individuals’ social needs.

5. Duration/Time: Your participation should only take about 30 minutes.

6. Statement of Confidentiality: Your participation in this research is confidential. The survey does not ask for any information that would identify who the responses belong to. The following may review and copy records related to this research: The Office of Human Research Protections in the U.S. Department of Health and Human Services, the Social Science Institutional Review Board and the PSU Office for Research Protections. A master list containing a code with your name will be kept confidential in the private offices of the investigator in case there is a need to contact you. In the event of any publication or presentation resulting from the research, no personally identifiable information will be shared.
7. Right to Ask Questions: Contact Carla L. Fisher, M.A. (ABD) at (814) 574-6434 with questions, complaints or concerns about the research. You can also call this number if you feel this study has harmed you. If you have questions about your rights as a research participant, or you have concerns or general questions about the research, contact The Pennsylvania State University’s Office for Research Protections at (814) 865-1775. You may also call this number if you cannot reach the research team or wish to talk to someone else.

8. Payment for participation: If you are a CAS100A student, you receive 2 research credits.

9. Voluntary Participation: Your decision to be in this research is voluntary. You can stop at any time. You do not have to answer any questions you do not want to answer. Refusal to take part in or withdrawing from this study will involve no penalty or loss of benefits you would receive otherwise.

You must be 18 years of age or older to take part in this research study. Completion and return of the survey implies that you have read the information in this form and consent to take part in the research. Please keep this form for your records or future reference.
Appendix B

Demographic Questionnaires

Questionnaire for Women Diagnosed with Breast Cancer

1. Please note your age and whether you are reporting as a mother or daughter.
   AGE _____________  Mother/Daughter (Circle One)

2. Please note your ethnicity.
   Caucasian __     African-American __   Asian __
   Native American __   Hispanic __     Other __

3. Please note what level of education you have completed.
   Some high school ___  High school graduate ___  Some college ___
   Associate’s degree ___  Bachelor’s degree ___  Some graduate work ___
   Graduate degree ___

4. Please note your work status.
   Don’t work ___  Work part-time (20 hrs/week) ___
   Work full-time (40+hrs/week) ___  Full-time student/Don’t work ___
   Full-time student/Work part-time (20 hrs/week) ___
   Full-time student/Work full-time (40+hrs/week) ___

5. Please note your total household annual income.
   $0-$20,000 ___  $21,000-$30,000 ___  $31,000-$40,000 ___
   $41,000-$50,000 ___  $51,000-$60,000 ___  $61,000-$70,000 ___
   $71,000-$80,000 ___  $81,000-$90,000 ___  $91,000-$100,000 ___
   over $100,000 ___

6. Please note your marital status.
7. Please list your current place of residence: City/State ____________

8. When were you diagnosed with breast cancer? Date: ____________

9. What was the diagnosis? Please include the stage.
________________________________________________________________________
________________________________________________________________________

10. What is your cancer status today?
________________________________________________________________________
________________________________________________________________________

11. What type of treatment (if any) are you currently undergoing? What past treatments have you received?
________________________________________________________________________
________________________________________________________________________
Questionnaire for Mother/Daughter of Woman Diagnosed with Breast Cancer

1. Please note your age and whether you are reporting as a mother or daughter.
   AGE _____________ Mother/Daughter (Circle One)

2. Please note your ethnicity.
   Caucasian __    African-American __    Asian __
   Native American __    Hispanic __    Other __

3. Please note what level of education you have completed.
   Some high school ___    High school graduate ___    Some college ___
   Associate’s degree ___    Bachelor’s degree ___    Some graduate work ___
   Graduate degree ___

4. Please note your work status.
   Don’t work ___    Work part-time (20 hrs/week) ___
   Work full-time (40+hrs/week) ___    Full-time student/Don’t work ___
   Full-time student/Work part-time (20 hrs/week) ___
   Full-time student/Work full-time (40+hrs/week) ___

5. Please note your total household annual income.
   $0-$20,000 ___    $21,000-$30,000 ___    $31,000-$40,000 ___
   $41,000-$50,000 ___    $51,000-$60,000 ___    $61,000-$70,000 ___
   $71,000-$80,000 ___    $81,000-$90,000 ___    $91,000-$100,000 ___
   over $100,000 ___

6. Please note your marital status.
   Single ___    In long-term relationship ___    Engaged ___
   Married ___    Separated ___    Divorced ___
   Divorced/Re-married ___    Widowed ___    Widowed/Re-married ___

7. Please list your current place of residence:    City/State ____________
Questionnaire for Control Group

1. Please note your age. ______________

2. Please note your ethnicity.
   Caucasian __       African-American __    Asian __
   Native American __ Hispanic __       Other __

3. Please note what level of education you have completed.
   Some high school ___   High school graduate ___  Some college ___
   Associate’s degree ___  Bachelor’s degree ___  Some graduate work ___
   Graduate degree ___

4. Please note your work status.
   Don’t work ___        Work part-time (20 hrs/week) ___
   Work full-time (40+hrs/week) ___  Full-time student/Don’t work ___
   Full-time student/Work part-time (20 hrs/week) ___
   Full-time student/Work full-time (40+hrs/week) ___

5. Please note your total household annual income.
   $0-$20,000 ___   $21,000-$30,000 ___   $31,000-$40,000 ___
   $41,000-$50,000 ___ $51,000-$60,000 ___   $61,000-$70,000 ___
   $71,000-$80,000 ___ $81,000-$90,000 ___   $91,000-$100,000 ___
   over $100,000 ___

6. Please note your marital status.
   Single ___       In long-term relationship ___  Engaged ___
   Married ___      Separated ___         Divorced ___
   Divorced/Re-married ___ Widowed ___       Widowed/Re-married ___

7. Please list your current place of residence:  City/State _____________
8. Please note if you are currently experiencing any major life event that could be considered a life crisis such as a recent death in the family, diagnosis of a life-threatening disease, family member diagnosed with a life-threatening disease, divorce, recent return from military service overseas, etc.

_________ Yes
*If you feel comfortable disclosing this, please indicate what life transition you are currently experiencing.

____________________________________________________________
____________________________________________________________
____________________________________________________________

_________ No
Appendix C

SST Questionnaire

Potential Partners

a. Close friend of yours
b. Recent acquaintance with whom you seem to have nothing in common
c. Your doctor
d. Member of your immediate family
e. Casual acquaintance of yours
f. Person that you know but dislike
g. Attractive person that you do not know
h. Relative not in your immediate family
i. Recent acquaintance with whom you seem to have much in common
j. Sales representative
k. New neighbor
l. Author of a book you’ve read
m. Your sibling
n. Poet or artist whose work you like
o. Stranger about your age
p. Clergy member (e.g., pastor, rabbi, priest)
q. Younger relative (e.g., niece, nephew, cousin)
r. Person running for a local political position

Instructions:
Please list those individuals from the list above with whom you most like to spend your time with. Please list them in order from first to third choice.

FIRST CHOICE  SECOND CHOICE  THIRD CHOICE

_________________  ___________________  ___________________
Appendix D

Phase 2 Informed Consent

Informed Consent Form for Social Science Research
The Pennsylvania State University

Title of Project: Mothers and daughters coping with breast cancer

Principal Investigator: Carla L. Fisher, ABD
PhD Candidate/NIA Predoctoral Fellow
234 Sparks Penn State Building
University Park, PA 16802
(814) 574-6434; clf196@psu.edu

Aileen S. Galley, ACSW, LSW
Administrative Director
Penn State Cancer Institute at Mount Nittany Medical Center
1800 East Park Avenue
State College, PA 16803
(814) 234-6787; agalley@mountnittany.org

Susann E. Schetter, D.O.
Penn State, M.S. Hershey Medical Center
Department of Radiology, HS08
Section Chief, Breast Imaging
670 Cherry Drive, P.O. Box 850
Hershey, PA 17033
(717) 531-2926; sschetter@psu.edu

Advisor: Dr. Jon F. Nussbaum
Professor, Communication Arts & Sciences
234 Sparks Penn State Building
University Park, PA 16802
(814) 863-3619; jfn5@psu.edu

1. Purpose of the Study: The purpose of this research study is to learn more about how mothers’ and daughters’ communicative behavior impacts their adjustment to breast cancer. You were selected as a possible participant in this study because you are either a daughter or mother with breast cancer or a mother or daughter of a woman with breast cancer.

2. Procedures to be followed: You will be asked to answer questions in an interview about your relationship with your mother/daughter as well as your interactive experiences with her within the breast cancer experience. This interview will be audio-taped. You will also be
asked to complete short surveys. After this interview, you may also be asked to journal these experiences in a diary for two weeks and be interviewed about the experiences you recorded in your diary. You do not have to answer any questions you do not feel comfortable discussing. Your responses both in the interviews and diaries will be kept strictly confidential.

3. Discomforts and Risks: You may experience sadness and/or anxiety in recalling your (and your mother/daughter’s) experiences with breast cancer. While the psychological and social risks involved with this study are minimal, it is possible that you may experience some discomfort in this way.

4. Benefits: By sharing your experiences about breast cancer and the mother-daughter bond, you will be sharing information that will be helpful to other mothers and daughters coping with cancer. In addition, women often report having therapeutic benefits in sharing their stories by writing and talking about their experiences.

5. Duration/Time: Each interview may last as long as 2 hours. You will be asked to diary for 2 weeks.

6. Statement of Confidentiality: Your participation in this research is confidential. In the event of any publication or presentation resulting from the research, no personally identifiable information will be shared. Pseudonyms will be used. You do have the option of using your own name in any future publications if you prefer. Only the principal investigator will have access to any audio files of interviews. These will be stored on her personal computer that is password-protected. Diaries will be stored in a locked file cabinet that only the principal investigator has access to. These files will be destroyed once all analyses have been exhausted or by 2030. Please note that the investigators are obligated by ethical standards to report to the appropriate agencies any information uncovered during the course of the research pertaining to the potential for or threat of harm to self or others. The following may review and copy records related to this research: The Office of Human Research Protections in the U.S. Department of Health and Human Services, Penn State University’s Social Science Institutional Review Board, and Penn State University’s Office for Research Protections.

I prefer that you use my own name rather than a pseudonym in any publications. Yes___No ___

7. Right to Ask Questions: Please contact Carla L. Fisher, ABD at (814) 574-6434 with questions about this study. You can also call this number if you have complaints or concerns about this research or feel that you have been harmed by the research. If you have questions about your rights as a research participant, or you have concerns or general questions about the research, contact Penn State University’s Office for Research Protections at (814) 865-1775. You may also call this number if you cannot reach the research team or wish to talk to someone else.

8. Payment for participation: You will receive $25 for your participation. Your name will also be entered in a drawing for a chance to win one of three $100 gift cards. Total payments
within one calendar year that exceed $600 will require the University to report these payments to the IRS annually. This may require you to claim the compensation that you receive for participation in this study as taxable income.

9. Voluntary Participation: Your decision to be in this research is voluntary. You can stop at any time. You do not have to answer any questions you do not want to answer. Refusal to take part in or withdrawing from this study will involve no penalty or loss of benefits you would receive otherwise.

You must be 18 years of age or older to consent to take part in this research study. If you agree to take part in this research study and the information outlined above, please sign your name and indicate the date below.

You will be given a copy of this signed and dated consent form for your records.

_____________________________________________  _____________________
Participant Signature       Date

_____________________________________________  _____________________
Person Obtaining Consent      Date

Would you be willing to be contacted regarding future research studies on breast cancer?
Yes ___ No _____
Appendix E

Turning Points during the Cancer Experience

INSTRUCTIONS:
There are no right or wrong answers. Everyone who completes this graph has a unique representation of their experiences with breast cancer.

Please use this graph to plot out turning points you have experienced as they relate to cancer. These turning points are moments when you recall changes in your own emotional well-being. This graph is a chance for you to reflect on your experiences and take some time to recall them. We will use this graph to guide us during part of the interview.

Recall the period before you were diagnosed. Please draw a dot above the label "Pre-Diagnosis" to indicate your emotional state at that time. "Low emotional state" means you had negative feelings at that time and "High emotional state" means that you had positive emotions during that time. If you were dealing with something that was stressful (e.g., marital problems) or uplifting (e.g., recent birth of a child) in some way, please write one word or a brief phrase above the dot to note this. Next, please make a dot above the label “Diagnosis” to represent how your emotions changed once you were diagnosed.

Now I’d like you to make any dots on the graph when your mood changed positively or negatively since you were diagnosed. You may recall changes in your emotions due to a specific event (e.g., having surgery) or it may not be in reference to a specific event (e.g., you just recall a change in your mood for some reason). Please write a brief description of what the turning point was at that time (e.g., “ended treatment”). You may also recall turning points that didn’t specifically relate to cancer but that clearly affected your mood (e.g., death of family member, new marriage in the family, etc.). You may find these important to your experience so please feel free to plot them as well. Do this up until the present day. Once you reach the end of the graph, please rate your present mood above the label "Present Day." Finally, connect the dots that you plotted with a line.
Appendix F

Life-Span Interview Scripts

Woman Diagnosed with Cancer Version

INTRODUCTION
I’m interested in learning about how mothers and daughters experience breast cancer. I’d like to
learn more about your relationship with your mother/daughter before you were diagnosed as well
as your experiences since that time. There are absolutely no right or wrong answers to any of my
questions. We can stop at any time, and you do not have to answer anything you do not feel
comfortable with. Do you have any questions or concerns?

PROBES
EXPLAIN – (re: perceived meaning)
EXAMPLE – (specific experience)
ELABORATE – (more detail)
EXTEND – (timeline—what happened before)

RELATIONAL CHANGES
I’d like to start off by talking to you about your relationship with your daughter/mother before
you were diagnosed before we move into that nature of your relationship today.

• Please describe your relationship BEFORE diagnosis.
  o Closeness—Emotional connectedness
  o Topics of talk
  o Frequency of talk
  o Time spent together
  o Open communication

• Supportive roles
  o You for her
  o Her for you

• Relationship CHANGE post-diagnosis.
  o Communication
    ▪ Topics of talk
    ▪ Frequency of talk
    ▪ Time spent together
    ▪ Open communication
  o Does she support you in any way in terms of dealing with BC?
    ▪ How so?
  o Are you a source of support for her?
    ▪ How so? (BC and life in general)
M/D’s SUPPORTIVE BEHAVIOR TO YOU
You noted before that your D/M was a source of support for you, I’d like to learn a little more about those experiences. OR You noted that you don’t go to your D/M for support—are there instances where she has attempted to give you support in any way

- Overall, how does your M/D **verbally** support you with cancer-specific concerns/feelings you have?
  - Example
  - Emotional support

- Overall, how does your M/D **nonverbally** support you with cancer-specific concerns/feelings you have?
  - Example
  - Emotional support

- What behavior from her has been **MOST** helpful to you?
  - Why?
  - Example
  - Emotional support

- What behavior from her has been **LEAST** helpful to you?
  - Why?
  - Example
  - Emotional support

OPENNESS
- How open have you been with your mother/daughter about your own experiences?
  - Why/why not?
  - Has this worked well?

- What topics are you open about?
  - Feelings; fears, treatment/side effects (factual or emotional); bodily changes/sex; death/future plans; daily life; communication practices.
  - Why/Why not?

- What topics are you **NOT** open about?
  - Why/Why not?

- Do you avoid any topics?
  - Why/Why not?

- How open has your daughter/mother been with you about her experiences with cancer?
IF APPROPRIATE… YOUR OWN SUPPORTIVE BEHAVIOR
You noted before that you often support your D/M, I’d like to learn a little more about those experiences.

• Overall, how do you **verbally** support your D/M?
  ▪ Example

• Overall, how do you **nonverbally** support your D/M?
  ▪ Example

• Type of supportive behavior from you, you think have been **MOST** helpful?
  o Why?
  o Example

• Type of supportive behavior (or lack thereof) from you, you think have been **LEAST** helpful?
  o Why?
  o Example

GRAPH GUIDE
Now I’d like to talk with you about the experiences you plotted on your graph from the point in time in which you were diagnosed and up until the present day. I’m interested in hearing why you thought these experiences affected you in positive or negative ways and how you adjusted to these experiences.

• **Life before the diagnosis** – MOOD ISSUES?

• **DIAGNOSIS**
  o When did you find out? How did your D/M **find out**?
  o How were you **initially feeling**?

• **How did you COPE?**
  o **Helpful?** How do you know? (change in feelings, behavior?)
  o **Seek support** from D/M?
    ▪ How
    ▪ Why
    ▪ **Helpful?** (change in feelings, behavior?)

• **How did your mother/daughter COPE?**
  o **Helpful?** How do you know? (change in feelings, behavior?)
  o Did she go to you for support?
    ▪ How
    ▪ Why
    ▪ **Helpful?** (change in feelings, behavior?)

Anything Else?
Next Point… Go through all points in same manner

I always end by giving you a chance to discuss anything in your experience as M/D with breast cancer—how breast cancer has affected you, your D/M, and your bond that you think are important to recognize or consider.
Mother/Daughter Version

INTRODUCTION
I’m interested in learning about how mothers and daughters experience breast cancer. I’d like to learn more about your relationship with your mother/daughter before she was diagnosed as well as your experiences since that time. There are absolutely no right or wrong answers to any of my questions. We can stop at any time, and you do not have to answer anything you do not feel comfortable with. Do you have any questions or concerns?

PROBES
EXPLAIN – (re: perceived meaning)
EXAMPLE – (specific experience)
ELABORATE – (more detail)
EXTEND – (timeline—what happened before)

RELATIONAL CHANGES
I’d like to start off by talking to you about your relationship with your daughter/mother before she was diagnosed before we move into that nature of your relationship today.

• Please describe your relationship BEFORE diagnosis.
  o Closeness—Emotional connectedness
  o Topics of talk
  o Frequency of talk
  o Time spent together
  o Open communication

• Supportive roles
  o Her for you
  o You for her

• Relationship CHANGE post-diagnosis.
  o Communication
    ▪ Topics of talk
    ▪ Frequency of talk
    ▪ Time spent together
    ▪ Open communication

  o Are you a source of support for your D/M?
    ▪ How so?
YOUR SUPPORTIVE BEHAVIOR
Now I’d like to talk a little bit about how you and your daughter/mom have communicated throughout this experience. I’m interested in hearing how you have supported her or how she has supported you both in terms of cancer-specific stress as well as other aspects of your lives.

- Overall, how do you verbally support your D/M?
  - Example
  - Emotional support

- Overall, how do you nonverbally support your D/M?
  - Example
  - Emotional support

- Type of supportive behavior from you, you think have been MOST helpful?
  - Why?
  - Example
  - Emotional support

- Type of supportive behavior (or lack thereof) from you, you think have been LEAST helpful?
  - Why?
  - Example
  - Emotional support

OPENNESS
- How open has your daughter/mother been with you about her experiences with cancer?
  - Why/why not?
  - Has this worked well?

- What topics is she open about? What topics is she NOT open about?
  - Feelings; fears, treatment/side effects (factual or emotional); bodily changes/sex; death/future plans; daily life; communication practices.
  - Why/Why not?

- How open have you been with her about your feelings/experiences?
  - Why/Why not?

GRAPH GUIDE
Now I’d like to talk with you about your perception of your mother’s experiences from the point in time in which she was diagnosed and up until the present day. These are the experiences you plotted on your graph that were for Line #1—her experiences. I’m interested in hearing why you thought these experiences affected her in positive or negative ways and how she coped with those experiences.
• Life before the diagnosis – MOOD ISSUES?

• DIAGNOSIS
  o When did she find out? How did you find out?
    o Talk to her? Anyone else?
    o How were you initially feeling?

• How did you COPE?
  o Helpful? How do you know? (change in feelings, behavior?)
  o Seek support from D/M?
    ▪ How
    ▪ Why
    ▪ Helpful? (change in feelings, behavior?)

• How did your mother/daughter COPE?
  o Helpful? How do you know? (change in feelings, behavior?)
  o Did she go to you for support?
    ▪ How
    ▪ Why
    ▪ Helpful? (change in feelings, behavior?)

Anything Else?
Next Point…Go through all points in same manner

I always end by giving you a chance to discuss anything in your experience as M/D with breast cancer—how breast cancer has affected you, your D/M, and your bond that you think are important to recognize or consider.
Appendix G

Sample Diary

Thank you for agreeing to keep this chronological diary of your interactions with your mother/daughter. Your responses will be very beneficial to health professionals who are helping other women and their families cope with breast cancer. Please contact me (814-574-6434; clf196@psu.edu) if you need any additional forms or have questions/concerns at any time. I will contact you after your 2-week period to set up a time to pick up the diary or to remind you to mail it to me as soon as possible. Once I have had the opportunity to read your entries, I may request a brief phone interview with you to hear about your experiences in more detail.

Instructions:

I would like you to diary about your interactive experiences with your mother/daughter for 2 weeks. Please do not share your entries with your mother/daughter.

Every time you interact with your mother/daughter, please complete one of the “Diary Entry” forms. These can be found behind the 1st tab labeled “Diary Entry Forms.” Please complete this form as soon after you have an interaction with your mother/daughter as possible. Be sure to answer all questions that are on this form.

Please start a new “Diary Entry” form for each interaction you have with your mother/daughter, even if the interaction is on the same day as other interactions. There may be days when you fill out multiple Diary Entry forms and other days when you have not completed any because you didn’t interact with your mother/daughter on that day. This varies for everyone.

Once you have completed the “Diary Entry” form, place it behind the tab labeled for that week. For instance, if it’s on the third day of your first week keeping the diary, it should be placed behind the tab “Week 1 Diary.” Behind each week’s tab, you will also find 7 “End-of-the-Day Survey” forms. Please put your “Diary Entry” forms in front of the “End-of-the-Day Survey” form for that particular day. For instance, if the “Diary Entry” form was filled out on the 3rd day of Week 1, place it in front of the “End-of-the-Day Survey” that you will fill out for 3rd day of Week 1.

The “End-of-the-Day Survey” is a form you will need to complete every day but only once a day. Please try to complete this form as close to your bedtime as possible and answer each question. If you have “Diary Entry” forms to complete that day, please save the “End-of-the-Day Survey” for last. Since you will complete the “End-of-the-Day Survey” form each day, I have already inserted 7 of these forms behind the tab “Week 1 Diary,” as well as 7 forms behind the tab “Week 2 Diary.”
DIARY ENTRY

INSTRUCTIONS: Please write about each interaction as soon after its occurrence as possible. Also, please answer EACH question every time you complete one of these forms. Please keep your entries private. Do not share them with your daughter.

1. What time did this interaction occur?

<table>
<thead>
<tr>
<th>Estimated Time of Day</th>
<th>Day of the Week</th>
<th>Date</th>
</tr>
</thead>
</table>

**If you are not completing this form soon after the interaction first occurred, please indicate how much time has passed.**

| _______ hours | _______ minutes |

2. Where did this interaction take place?

- _____ My home
- _____ My daughter’s home
- _____ Face-to-face in another location. Please explain: __________________________________________
- _____ Over-the-phone. Please explain: __________________________________________________________
- _____ Via a letter
- _____ Via e-mail
- _____ Other. Please explain: ________________________________________________________________

3. How long did the interaction last? __________________________________________________________

4. Who initiated the interaction?

- _____ I did.
- _____ My daughter did.
- _____ Other. Please explain. _______________________________________________________________

5. Was anyone other than you and your daughter involved in the interaction? ________________

6. If you initiated the interaction, please explain why (what your motivation was) and how you approached your daughter. If your daughter initiated the interaction, please explain how she approached you and what you think motivated her to initiate this interaction.

   ____________________________________________
   ____________________________________________
   ____________________________________________

7. What did you talk about? (i.e., what topic was discussed)

   ____________________________________________
8. Sometimes during interactions we seek support from one another or we offer it. This support can be emotional (e.g., caring/concern, listening/being there, empathizing, reassuring, or comforting), informational (e.g., getting information to guide or advise you), or instrumental (e.g., assistance with household responsibilities, errands, money, transportation, etc.). Was this an interaction in which you or your daughter received or sought support from one another?

YES / NO

*If you answered “YES”, complete Question 9 and skip Question 10.
*If you answered “NO,” skip Question 9 and complete Question 10.
*Use the remaining lined pages to answer either Question 9 or 10.

9. If you were seeking support, please describe which kind (emotional, informational, or instrumental) and why you needed this support. Describe how you sought this support from your daughter, how she responded to you, and what the outcome was. Please indicate whether you received the support you needed and why you were satisfied or unsatisfied.

If your daughter was seeking support from you, please describe which kind, how she sought this support from you, how you responded to her, and what the outcome was. Please indicate whether you think she received the support she needed and why you think this (e.g., did she seem satisfied or not and describe her reaction).

This may have been an instance where support wasn’t really sought out but it was given or it was a supportive interaction. If you or your daughter gave one another support or received it, please describe this in the manner noted in the previous paragraphs.

Try to paint a picture of what happened as detailed as possible. Include details of what was said, how you reacted to each other, and the outcome or how it ended. Be sure to comment on your feelings and thoughts as well as your perception of your daughter’s feelings/thoughts. Include details of any verbal or nonverbal behavior you may have noticed (e.g., either you or your daughter made certain facial expressions, changed your tone of voice, offered affection, etc.).

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
END-OF-THE-DAY SURVEY

INSTRUCTIONS: At the end of the day, please complete this survey. Begin by noting the time of day, day of the week and date you are completing this survey.

_________ Estimated Time of Day ____________ Day of the Week ____________ Date

INSTRUCTIONS: Next, please circle the appropriate answer to question #1. If you answered “yes” to question #1, please circle all that apply for question #2:

1. I did interact with my daughter today in some manner.       YES / NO
2. We communicated in the following way(s):       Phone       Face-to-Face       Email
   Other ________________________________

If, at any time today, you had thoughts about your daughter’s health or anything related to dealing with cancer for her, you, or your family but you did not talk about it with your daughter, please describe your thoughts and feelings here. Please also indicate why you did not address them with your daughter as well as how you dealt with those thoughts (e.g., shared your feelings with someone else, prayed, pushed the thoughts away, listened to music, etc.).

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Vitae

Carla L. Fisher

Education
M.A.: Communication Studies, Arizona State University, 2004
B.S.: Communication, Florida Institute of Technology, 1999

Employment
Assistant Professor, Department of Communication Studies, Arizona State University

Publications


Grants
Joseph M. Juran Center for Leadership in Quality ($10,000, 2007-2008)
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