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Analyzing Communication in Mother-Daughter Dyads Following the Mother's Cancer Diagnosis

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ANALYZING COMMUNICATION IN MOTHER-DAUGHTER DYADS
FOLLOWING THE MOTHER'S CANCER DIAGNOSIS

A Thesis
presented to
the faculty of the Department of Communication
Western Kentucky University
Bowling Green, Kentucky

In partial fulfillment
of the requirements for the degree
Master of Arts

By
Rachel Adams Walston
August 2009

**ANALYZING COMMUNICATION IN MOTHER-DAUGHTER DYADS
FOLLOWING THE MOTHER'S CANCER DIAGNOSIS**

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Sheldon Blair is dedicated to my mother, Helen, who lost her battle with cancer in 2002. We loved each other in the emotional, hectic, often hard to recognize way that only mothers and daughters can, and I miss her more than I can say.

*Your absence has gone through me
Like thread through a needle.
Everything I do is stitched with its color. – W.S. Merwin*

TABLE OF CONTENTS

I. Introduction

1. Rationale for Study

2. Literature Review

II. Methodology

III. Findings

IV. Discussion

1. Limitations and Directions for Future Research

2. Conclusion

ANALYZING COMMUNICATION IN MOTHER/DAUGHTER DYADS FOLLOWING THE MOTHER'S CANCER DIAGNOSIS

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August 2009

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The American Cancer Society estimates nearly 1.5 million Americans will be diagnosed with cancer this year. Existing on cancer and its effects on family communication indicate there are few things that have the potential to shake a family to its core like a serious illness (Anderson & Geist Martin, 2003; Gotcher, 1993; Northouse, 2005; Sherman & Simonton, 2001). Communication is one of the most important elements in determining and influencing families' emotions, patients' quality of life, patient care, family relationships and caregiver stress (Beach, 2001).

The mother-daughter dyad represents one of the most significant relationships to analyze with respect to the impact cancer has within the family since mothers are typically the primary role models for their daughters (Miller, 1995). Using interviews with mother/daughter dyads, this study seeks to examine changes in communication between mothers and daughters following the mother's cancer diagnosis. The mother-daughter dyad is of most interest in this study for several reasons, most notably that this relationship is the "first dyadic relationship a female child has" (Bishop, 1992, p. 58); additionally, mothers are typically the primary role models for their daughters (Miller,

1995). This study aims to shed light on the relational changes that occur following a cancer diagnosis.

CHAPTER ONE: INTRODUCTION

In its 2009 Cancer Facts and Figures document, the American Cancer Society estimates nearly 1.5 million Americans will be diagnosed with cancer this year. They predict more than 562,300 Americans will die of the disease before the year is through. The estimated number of children who will receive a cancer diagnosis, as well as the estimated number of children's cancer-related deaths, accounts for less than one percent of those figures (American Cancer Society, 2009); therefore, it is likely that many of the people who die this year from various forms of cancer will leave behind spouses, children and extended families.

Existing research on cancer and its effects on family communication indicates there are few things that have the potential to shake a family to its core like a serious illness (Anderson & Martin, 2003; Gotcher, 1993; Northouse, 2005; Sherman & Simonton, 2001). Due to this form of illness, children are suddenly faced with the possibility of losing a parent, while spouses who dreamed of growing old together must reconcile with the idea that their "golden years" may involve chemotherapy and radiation – or, worse yet, that their golden years together may never come.

RATIONALE FOR STUDY

As cancer becomes more prevalent across the nation and touches an increasing number of families each day, its impact on those families bears scholarly study. Communication patterns among family members tend to change dramatically when a

parent suffers a serious illness (Zhang & Siminoff, 2003); therefore, communication in cancer patients' families merits analysis from communication researchers.

Communication among families is "the single most important factor" (Beach, 2001, p. 242) in determining and influencing families' emotions, patients' quality of life, patient care, family relationships and caregiver stress. In a study of adult children's conversations with their parents following the parent's cancer diagnosis, Harzold and Sparks (2006) found that satisfying parent-child communication included "the initial disclosure of the cancer diagnosis ... and discussion of the treatment plan and procedures" (p. 73), while topic avoidance and withholding of feelings were rated as dissatisfying. Failure to communicate leads to anxiety and uncertainty (Gotcher, 1993); however, "patients who maintained honest interpersonal relations with their families coped with the disease more effectively than patients who were unable to maintain such relations" (p. 179).

Existing research points to many reasons for communication changes within families affected by cancer, but even as some articles strive to explain those changes, researchers mention the lack of research on the topic (Arrington, 2005; Sherman & Simonton, 2001). Some note especially the paucity of information regarding late-stage cancer patients and their families (Zhang & Siminoff, 2003). A cancer diagnosis has the potential to shake the foundations of a family and change its communication structure for better or for worse. A critical topic to examine remains how families cope when faced with the facts that their spouse, parent or child is going to die.

Of particular interest to this study are the changes in relationships between parents and children. Previous studies mainly concentrate on spousal communication (e.g. Arrington, 2005; Glasdam, Jensen, Madsen & Rose, 1996; Gustavsson-Lilius, Julkunen & Hietanen, 2007); however, the parent-child dyad has received less attention. Particularly among adolescents, a parent's cancer diagnosis results in a slightly higher risk of internalization of problems (Vannatta, Grollman, Noll & Gerhardt, 2008), with adolescent daughters seemingly more negatively affected than sons (Osborn, 2007; Visser, et al., 2005). Even if a child does not openly verbalize his or her concerns about a parent's cancer, the stress of the situation still affects them greatly (Northouse, 2005). Children begin to see their parents as vulnerable, a fundamental change that may result in difficulty accepting the diagnosis (Raveis & Pretter, 2005). If other family members are preoccupied with caring for the patient, children are often neglected, especially if their parent, the patient, does not know what to tell them about the disease (Sherman & Simonton, 2001).

Among families, caregivers for the ill are most often female (Northouse, 2005), and, among siblings, daughters most often assume the caregiving role for their mothers (Pecchioni & Nussbaum, 2001). In a study of adult daughters' thoughts and emotions following a mother's breast cancer diagnosis, Raveis and Pretter (2005) found that daughters simultaneously struggled with an influx of new emotions, perceived several changes in the mother/daughter relationship, and came to terms with their own mortality and chances of contracting the same illness. Pecchioni and Nussbaum's (2001) research

focused on the wishes of mothers and daughters regarding caregiving when the mother became too elderly to care for herself. However, many of the concerns voiced by mothers in their study echoed those given by cancer patients: the patient may be concerned about imposing or may resent no longer being able to care for herself (Zhang & Siminoff, 2003).

The mother-daughter dyad is of prime interest in this study for several reasons, most notably that this relationship is the “first dyadic relationship a female child has” (Bishop, 1992, p. 58). Mothers are typically the primary role models for their daughters (Miller, 1995). The mother-daughter relationship is often more complex than that between a mother and son because the mother is a daughter herself, and the relationship is constantly re-forming as the daughter struggles to find her own identity (Hershberg, 2006; Pecchioni & Nussbaum, 2001). Additionally, mothers are typically more supportive than fathers even during family crises (Gardner & Cutrona, 2004), and daughters are often thrust into the role of primary caregiver when the family matriarch can no longer care for herself (Pecchioni & Nussbaum, 2001). Through narratives given by mothers with cancer and their daughters, the results of this study shed light on the relational changes that occur following a cancer diagnosis.

In the following chapters, I give an overview of existing literature, review my methodology, present and analyze findings, and discuss limitations and directions for future research.

LITERATURE REVIEW

Immediately following a cancer diagnosis, “attitudes change, questions are asked, and emotions heighten, not only for the patient but also for family and friends” (Anderson & Martin, 2003, p. 133-134). Cancer patients may feel out of control (Anderson & Martin), helpless, and depressed (Arrington, 2005), while family members come to terms with becoming caregivers (Hinds, 1992; Mellon, Kershaw, Northouse & Freeman-Gibb, 2007; Northouse, 2005). At this time in a family's life, communication is paramount, yet family members hold back from communicating with the patient for a variety of reasons, including mutual protection, psychological distress, and positive thinking (Zhang & Siminoff, 2003). In their study on coping with cancer, Sherman and Simonton (2001) identified primary reasons communication is difficult among families affected by cancer: overpowering shock and confusion, cultural or religious mores that may block access to care, anxiety about treatments and their effectiveness, resentment or anger toward the patient for disrupting family life and coming to terms with death. This leads to what researchers call “a phenomenon of silence” (Zhang & Siminoff, p. 420) that is born of fears of treatment futility, thoughts of death and other difficult subjects raised by a cancer diagnosis.

Existing communication research regarding families coping with cancer focuses primarily on the family as a whole (e.g., Anderson & Martin, 2003; Beach, 2001; Gardner & Cutrona, 2004; Hinds, 1992; Mellon et al., 2007; Northouse, 2005; Sherman & Simonton, 2001; Zhang & Siminoff, 2003) or on the husband-wife dyad (e.g., Arrington,

2005; Glasdam, Jensen, Masden, & Rose, 1996). This ignores an important relationship within families; specifically, that of mothers and daughters.

Mothers and daughters

A healthy mother/daughter dyadic relationship fluctuates between progressive and regressive communication spirals and will undergo several changes as the daughter matures (Bishop, 1992; Hershberg, 2006). It is a relationship fraught with contradictions (Miller, 1995) as both mother and daughter struggle with the dual demands of autonomy and dependence. While mothers see themselves in their daughters (Hershberg, 2006), daughters, especially during adolescence, strive to differentiate themselves from their mothers to search for independence while at the same time being pulled back to the family relationship because she is still dependent on her mother (Miller, 1995).

Even after the daughter becomes an adult, this delicate communication balance can be changed again with an event that disturbs routine, such as the daughter's pregnancy or the mother's illness or old age (Hershberg, 2006). An unexpected and serious diagnosis may spur the daughter to re-think her role in the relationship (Raveis & Pretter, 2005) or withdraw due to fear, increased responsibilities, or negative self-image (Stiffler, Haase, Hosei, & Barada, 2008). The daughter may also act out as a result of stress brought on by a change in routine (Visser et al., 2005). Particularly in cases of breast cancer, which is sometimes hereditary, a daughter's sense of personal risk may increase along with concerns about the disease (Raveis & Pretter, 2005).

Although some research exists on relationships between mothers and daughters, it

either centers on mothers and daughters without cancer (e.g., Bishop, 1992; Hershberg, 2006; Miller, 1995) or analyzes the psychological rather than communicative effects of the illness (e.g., Osborn, 2007; Stiffler et al., 2008; Visser et al., 2005). Further, the studies cited that focus on cancer and the mother-daughter dyad concentrate specifically on breast cancer (e.g., Raveis & Pretter, 2005; Stiffler et al., 2008), which due to its hereditary nature may bring about a different set of emotional concerns (Raveis & Pretter, 2005). However, it is clear from other studies that any type of cancer has the potential to greatly affect the family structure (Anderson & Martin, 2003; Arrington, 2005; Beach, 2001; Northouse, 2005).

Support

Social support is an important part of family life (Gardner & Cutrona, 2004) and is defined as "verbal communication or behavior that is responsive to another's needs and serves the functions of comfort, encouragement, reassurance of caring and/or the promotion of effective problem solving through information or tangible assistance" (p. 495). As applied to cancer, emotional support refers to "a shoulder to lean on" or a sounding board during rough patches; informational support applies to those who assist the patient in gathering facts about the disease; and tangible support includes "concrete instrumental assistance" (Robinson & Turner, 2003, p. 229) such as financial donations or rides to doctors' appointments. Daughters who typically rely on their mothers for support may suddenly find themselves providing financial, emotional, or other support as their mother copes with her disease.

Although many variables may be present on the journey from diagnosis to remission or death, one thing is certain: patients need family support more than ever following a cancer diagnosis, and they reap physical and psychological benefits from it (Arora, Rutten, Gustafson, Moser & Hawkins, 2007; Glasdam et al., 1996; Gotcher, 1993; Gustavsson-Lilius, Julkunen & Hietanen, 2007; Nausheen & Kamal, 2007; Robinson & Turner, 2003). In a study assessing patient-family communication, Gotcher (1993) identified four aspects of family communication: frequency, honesty, emotional support and communication satisfaction (p. 182), and ultimately found that emotional support has the greatest effect on cancer patients' adjustment to the disease. Social support reduces psychological distress, a common problem among cancer patients, and fulfills a need for validation: "(Patients) expressed a strong need to be told that they were still important members of the family unit" (Gotcher, 1993, p. 186). It is during this time that daughters, now somewhat recovered from the initial shock and panic of their mother's diagnosis, may seek to intensify their bond with their mother and increasingly try to protect and support her (Raveis & Pretter, 2005).

Family members' attitudes tend to influence and affect one another (Osborn, 2007). In a study of Pakistani breast cancer patients, Nausheen and Kamal (2007) found that familial social support protects against patient depression; similarly, a study of cancer patients in Finland found that "partner support correlated substantially with patient optimism and hopelessness" (Gustavsson-Lilius, Julkunen & Hietanen, 2007, p. 83). Patients surrounded by supportive friends and family tend to fare better than those

surrounded by hopelessness (Miczo, 2004). As mothers are typically the most supportive parent in the family (Gardner & Cutrona, 2004), daughters whose mothers fall ill may find themselves without the emotional support they have come to expect.

Changes in communication

In the initial cancer diagnosis stage, families and patients are reeling (Sherman & Simonton, 2001). Patients struggle with the decision of how much to tell their children – or whether to inform the children at all. If the patient decides to inform the entire family, children of any age may react insensitively or callously to the news (Stiffler et al., 2008). A daughter who must now take on her mother's share of chores and responsibility may feel torn between sadness and irritation. Patients may feel like a victim, a warrior or a survivor – sometimes all in the same day (Anderson & Martin, 2003). In a study of Stage III and Stage IV lung cancer patients – those whose disease is terminal – Zhang and Siminoff (2003) found that patients deliberately avoided talking about the disease, either because they did not want to feed their own fear and anxiety or because they were angry at themselves, at the doctor, at cancer itself, for the diagnosis. Many patients did not want to cry in front of their children, while still others felt a deep sense of guilt because their long-term smoking led to their cancer diagnosis.

In a mother/daughter relationship, self-disclosure is key, yet the most important variable that impedes this self-disclosure is “the fear of being real” (Bishop, 1992, p. 68). Mothers worry that their diagnosis and subsequent treatment – which often leaves them ill, tired, or irritable – affects their home life and the way they interact with their

daughters, especially if the mother believes her illness will put additional responsibilities on her daughter or otherwise disrupt her life (Stiffler et al., 2008). Additionally, depression often sets in as fear subsides in the patient (Arrington, 2005; Zhang & Siminoff, 2003), which makes communication even more difficult. Some, particularly elderly patients, find themselves unable to reap support from friends and family (Robinson & Turner, 2003), especially if the family members in question are ill or elderly themselves.

As treatments get underway, some families are relieved that something is being done to combat the disease (Sherman & Simonton, 2001), while some patients discovered themselves feeling left out, feeling that their families did not want to hear about an illness they considered under control (Zhang & Siminoff, 2003). In fact, a study of breast cancer patients found that perceived familial emotional support, as well as the support of friends, drops significantly in the months following a diagnosis (Arora et al., 2007), even though a majority of women surveyed listed family and friends as their largest bases of support. For daughters of cancer patients, perhaps this drop in emotional support comes as the realities of living with an ill mother set in. Arora et al. (2007), advanced two theories for this possibility: access to support decreased as time wore on as family members bore the full brunt of caregiving responsibilities, or perceived quality of support declined because the patient learned to take care of herself after living several months with the disease.

Caregiving and role shifts

It is in the treatment and recovery stages that families deal with role shifts

regarding patient care (Northouse, 2005; Sherman & Simonton, 2001). It is here that families "tread the fine line between facing reality and giving up hope" (Hinds, 1992, p. 919) as they grapple with myriad feelings and try to balance their own lives with their new responsibilities. Northouse (2005) estimated that 59% of caregivers of seriously ill patients in America have full- or part-time jobs in addition to their caregiving duties, and that 39% of caregivers feel as though they had no choice in the matter. Additionally, cancer caregivers have a higher level of burden, averaging between 33 and 82 hours of caregiving per week (Northouse). Arrington (2005) noted in his study of prostate cancer patients that the patients' caregivers, their wives, took on the responsibilities of dispensing medications, looking up information about the disease, remembering appointments and caring for their husbands both emotionally and physically. Daughters who become caregivers for their mothers experience a role reversal that represents "a marked and unprecedented behavioral shift in their relationship with their mother" (Raveis & Pretter, 2005, p. 56). However, none of these studies analyze the caregiving responsibilities placed upon children, who may be prematurely thrust into an adult role.

Families, especially spouses who become the primary caregivers, may also be more apt to feel depressed or anxious than patients, feelings that tend to linger long after the patient is released from the hospital or ends treatment (Glasdam et al., 1996). Indeed, Northouse (2005) found the emotional effects of cancer may still be apparent 12 to 24 months following diagnosis. In addition to mental strain, caregivers may also suffer physical setbacks like stomachache, headache or illnesses like influenza (Glasdam et al.,

1996). However, none of these studies mentioned the physical effects that a daughter may feel while caring for her mother.

Caregivers are often overshadowed, the unsung heroes of the cancer experience (Arrington, 2005; Hinds, 1992). While patients are grateful for their help, little focus is given to the caregivers' needs during this tumultuous time. Hinds (1992) found that caregivers commonly experience uncertainty, helplessness, and abandonment by other family members or by an increasingly infirm patient; however, caregivers tended not to see themselves as suffering. Northouse (2005) wrote that, even though many gave up social activities and had to take time off from work to fulfill their new responsibilities, caregivers said the hardest thing about their role was watching a loved one die and being unable to stop it. Caregivers often feel as though they must conceal their emotions (Zhang & Siminoff, 2003), both from the patient and from other family members who may not be mentally equipped or prepared to hear details of treatment and care. A daughter used to confiding in her mother may not be prepared for a role reversal in which the mother shares her feelings about her illness.

Emotions and cancer

During the recovery and survival processes, some patients focus on positive thinking, which Zhang and Siminoff (2003) say can include faith in God or a higher power, being optimistic, and looking at death as a natural, transitive part of life. These beliefs made it difficult to talk about cancer, because cancer is a negative force that has no place in an optimistic household. Those who hold onto faith likely believe their deity

will guide the disease as is fit; therefore, there is no use in worrying or dwelling on the illness. Some families may find themselves paralyzed by fear of recurrence, sometimes more so than the patients themselves (Mellon et al., 2007). If the patient suffers additional health problems as a result of cancer, these fears are likely to rise; however, families with a high level of social support and positive thinking did not experience strong fears of recurrence. Given the fact that daughters run a higher risk of emotional internalization than sons (Osborn, 2007; Vannatta, Grollman, Noll & Gerhardt, 2008; Visser et al., 2005), new fears brought on by the mother's recovery may add another layer of stress.

Should the disease recur, families revert to initial feelings of shock and grief (Sherman & Simonton, 2001), while patients struggle anew with identity issues and the decision of whom to tell. Patients may also keep quiet about new pains to avoid upsetting their families (Zhang & Siminoff, 2003), which can result in life-threatening situations. It is in this stage that death and dying become inevitable; however, some families still do not discuss the possibility. Some are afraid of depressing the patient, while others are simply too scared to talk about death and mortality (Arrington, 2005). For daughters, the thought of losing someone so important to them (Bishop, 1992; Miller, 1995) may further complicate the matter.

Despite the many fears faced by families struggling with cancer, it is important to overcome the guilt, emotional pain or uncertainty and openly speak about the disease. A complex relationship such as that between mothers and daughters (Hershberg, 2006;

Pecchioni & Nussbaum, 2001) certainly requires open communication when complicated by cancer. In their study of a family whose matriarch was diagnosed with thyroid cancer, Anderson and Martin (2003) write, "learning how to openly communicate information with one another was central to being able to heal as a cohesive unit" (p. 140).

Additionally, "communication satisfaction could be critical to the development of effective adjustment mechanisms for cancer patients" (Gotcher, 1993, p. 178), an idea that previously discussed studies clearly illustrate.

Researchers make it clear both that the mother-daughter relationship is important in a family (Bishop, 1992; Gardner & Cutrona, 2004; Miller, 1995), and that effective communication is the key for families struggling with a serious illness (Anderson & Martin, 2003; Arrington, 2005; Zhang & Siminoff, 2003). Given that information, the lack of cancer-related research specifically targeting communication in the mother-daughter dyad is troubling. To that end, I propose the following research questions:

RQ1: How does communication change in the mother/daughter dyad following the mother's cancer diagnosis?

RQ2: How do mothers and daughters combat the "phenomenon of silence" through social support?

CHAPTER TWO: METHODOLOGY

When attempting to understand the experiences of people in complex situations such as serious illness, researchers must "(get) out into the field and (find) out what people are doing and thinking" (Strauss & Corbin, 1998, p. 11). Thus, qualitative research is more suited to this study to show the intricacies of communication between mothers and daughters as they deal with cancer. Qualitative researchers aim to "capture the nuance and complexity of the social situation" (Janesick, 2000, p. 381) , and qualitative methods add a richness of data to research, as they focus on understanding and interpreting settings rather than making predictions about them. Research indicates that cancer is a complex family issue, one I felt could not be adequately explored without interviewing participants. Further, it would be difficult to predict the outcome of this study since the topic is not one previously studied.

In his case for a narrative paradigm, Fisher (1984) argued that human beings are natural storytellers, and states that "the ground for determining meaning, validity, reason, rationality and truth must be a narrative context: history, culture, biography and character" (p. 3). Further, Jorgenson and Bochner (2004) wrote that narratives lend "meaning and intelligibility" (p. 513) to families' experiences, and see family as an idea that grows from narratives and stories. Arrington (2005) used narratives in his study of prostate cancer patients, noting that "family communication scholars should ... recognize the importance of family stories during illness in shaping individual and family identities, enhancing esteem, and informing family members how to survive difficult illness

situations, whether literally or figuratively” (p. 142). Anderson and Martin (2003) wrote that “narratives serve as a method of working through the anguish and suffering brought on by life-threatening illness” (p. 135), noting especially the cathartic nature of shared stories. Although the researchers acknowledged that narratives may actually increase stress and anxiety by repeatedly requiring the patient or family to tell their story, “narratives may function as medicine for the ill person” (p. 135) by becoming a form of control with which they may learn more about themselves and their families.

Social construction of reality occurs “between human beings in their expressive and interpretive practices” (Lindlof & Taylor, 2002, p. 11). Since the mother-daughter dyad is the first dyadic experience a daughter has (Bishop, 1992) and mothers are typically role models for their daughters (Miller, 1995), a daughter's construction of reality must rely heavily on her mother's influences. Therefore, taking an interpretive approach to this study enables me to analyze the complex and dynamic details of day-to-day communication between ill mothers and their daughters.

Participants

I recruited five mother-daughter dyads via a convenience sample, using personal contacts (Lindlof & Taylor, 2002). Additionally, two professors in the Department of Communication at Western Kentucky University recruited a total of three dyads. I asked the local offices of the American Red Cross and the Barren River District Health Department, as well as the health issues reporter at the Park City Daily News, for potential participants. I identified and contacted a total of nine biologically related

mother/daughter dyads; however, several did not participate due to illness or unwillingness, or simply did not respond.

Three of the participating dyads are from the same biological family; the other two are not related. Mean age of mothers is 51; mean age of daughters is 19.8. All identified their ethnicity as Caucasian. Three of the mothers interviewed had breast cancer, one had ovarian cancer, and one had cervical cancer. Of the five daughter participants, all had mothers who were breast cancer patients. Mothers were at least three months post-diagnosis but no more than two years past completion of treatment at the time this project began in August 2008.

Procedures

Approval for the project was gained from the Human Subject Review Board at Western Kentucky University in December 2008. Potential participants were initially contacted via e-mail or telephone in December 2008 and January 2009. A summary of the research project was included with the initial e-mail or sent via e-mail as a follow-up to the initial phone conversation. Participants were contacted a maximum of two times; if they did not respond to either attempt they were eliminated from the pool of potential participants.

Data collection

I asked participants a series of open-ended interview questions probing the mother-daughter relationship both before and after the mother's cancer diagnosis. I conducted all interviews face-to-face except one, which was done via web-cam with the

approval of the Human Subject Review Board. Distance prevented me from interviewing the participant face-to-face; however, I found no difference between face-to-face and webcam interviewing. Interviews were conducted in January and February 2009 at participants' homes or offices, on campus at Western Kentucky University, or via webcam. All participants signed a consent form with the exception of one underage participant, who signed an assent form to accompany her mother's consent form. Biologically-related dyads were asked to come to the interview together but were interviewed separately; because the subject matter was potentially emotional, I felt it would be helpful for participants to know their mother or daughter was nearby in case they became upset. Two participants did become visibly upset during the course of the interview; however, both expressed a desire to continue. At the conclusion of each interview, participants were offered information on local support groups for cancer patients and their families.

During the interviews, I asked participants to describe their communication patterns before and after the mother's cancer diagnosis. I also asked participants to reflect upon the perceived depth of these communication changes and upon whether any cancer-related topics were considered "taboo" in the family, as well as how they talk about cancer and whether there was anything they wished they could talk about with their mother or daughter. Using a combination of the rigid interview schedule and more flexible interview guide (Lindlof & Taylor, 2002), I deviated at times from the protocol to clarify a response or to examine a topic further. Especially for those daughters whose

mothers were diagnosed with breast cancer, this tactic allowed me to spend some time asking about whether hereditary issues were a concern. Those questions were followed by basic demographic information such as age, name (not to be published), date of diagnosis and type of cancer. While participants' real names were used in the interviews, each participant was asked at the conclusion of their interview to provide a pseudonym. All did except one participant, whom I assigned a pseudonym.

Interviews lasted an average of 30 minutes and were recorded using a digital MP3 player. Written notes supplemented the recordings (Lindlof & Taylor, 2002) and allowed me to jot down future questions, as well as any information I felt was pertinent before the tape recorder was turned on or after it was shut off. With the exception of the web-cam interview, which had distorted and often hard-to-hear sound, recordings were clear and easy to understand. Each interview was transcribed by the researcher no more than one week after the interview occurred, resulting in 115 pages of transcripts and five pages of written notes. Transcriptions were verbatim; however, during the process of coding extraneous phrases such as "I mean" or "you know" were removed to clarify quotes. The Internet search engine Google was utilized several times during the transcribing process to identify or to find more information on unfamiliar health-related terms mentioned in the interview, such as "PICC line" and "BRCA gene."

Open and axial coding began after the conclusion of the final interview in February 2009. Using the constant-comparative method to identify common themes in the data (Lindlof & Taylor, 2002; Strauss & Corbin, 1998), I read through all transcripts

with an eye toward developing patterns. During open coding, I read through the transcripts and marked those sections of text that indicated a pattern (Lindlof & Taylor, 2002). Ultimately, I created a handwritten list of 33 codes. Following that, I began axial coding to “make connections between categories” (Lindlof & Taylor, 2002, p. 220), which also served to expand some categories while shrinking others. In the process of listing categories and sub-categories on index cards, I winnowed the list of sub-categories to 24 by discarding those that either did not seem to fit or were not supported by actual data (Strauss & Corbin, 1990). Finally, I collapsed those patterns into five categories: changes, information, emotions, coping strategies, and resolution.

At this point, I copied each category and sub-category into a word processing program, then read through the transcripts again to identify and highlight blocks of text that fit each category. Those chunks of text were then entered below the corresponding pattern on the word processing document. This *in vivo* coding – using phrases drawn directly from interviews and narratives (Anderson & Martin, 2003; Arrington, 2005; Beach, 2001) – lessens the risk of transformation as described by Jorgenson and Bochner (2004):

Sometimes we forget that our representations are transformations – images of the experiences we are trying to understand and/or predict. Then we need to be reminded ... that though we may speak as if we know what families are, the more we observe and study families the more unclear they may become to us (p. 514).

I repeated this process six times, each time moving a sub-category, removing a quote, or eliminating a sub-category altogether, and ended up with five categories and 17 sub-categories.

After I was satisfied with categories and sub-patterns, I returned to the transcripts to examine participants' words. I selected a variety of exemplar statements (Lindlof & Taylor, 2002) that described each sub-pattern, then reviewed the quotes and chose those I felt were "the best evidence" (Lindlof & Taylor, 2002, p. 234) I could present to structure my findings.

Use of these quotes also serves as a method of qualitative verification. This thick description, which adds richness to understanding and value to participant accounts (Lindlof & Taylor, 2002), provides a deeper look into participants' experiences by allowing them to speak for themselves and to "provide as much detail as possible" (Creswell & Miller, 2000, p. 129). Further, in the methodology chapter I went into great detail about my procedures in contacting participants, gathering data, and analyzing the transcripts (Creswell & Miller). Finally, I clarified my bias in the following section so the reader may fully understand previous experiences that shaped the way I viewed this study (Creswell, 1998).

Role of the researcher

It must be noted that mother-daughter communication following a mother's cancer diagnosis is a topic with which I am intimately familiar, having lost my own mother to cancer in 2002. Despite the passage of more than two years between her diagnosis and death, I never said goodbye to my mother because I was too frightened to address her mortality. Even as doctors conceded defeat in the face of aggressive brain tumors and sent her home to die, my family remained silent except to disseminate bulletins regarding

her health.

In preliminary planning of this study, I identified several pros and cons of being the sole researcher. As the daughter of a cancer patient, I have intimate knowledge of what these mothers and daughters are going through. While my experience with the topic could be seen as a positive asset through which I could develop rapport (Lindlof & Taylor, 2002) with participants, I felt knowledge of my mother's death could also be a hindrance if participants were told about it before their interviews. Therefore, I elected to reveal my story only after the interviews were finished. However, through mutual acquaintances, two participants already knew of my mother's death before their interviews. In those cases, I conducted the interview the same as the others to keep a sense of normalcy.

In qualitative research, "there is no value-free or bias-free design" (Janesick, 2000, p. 385), so key to this process was realizing that I have some very real biases and setting them aside (Lindlof & Taylor, 2002). I feared I would be jealous of daughters whose mothers were still alive; however, as the study progressed I was happy to find that I felt more kinship than ill will. When, about halfway through the transcribing process, I started feeling emotional, I vented those feelings by writing in a personal journal, talking with friends and mentors, and taking a weeklong break to step away from the material until I could continue with a clear mind.

As a former newspaper reporter I know the value of remaining objective and letting sources speak for themselves, and I was careful to avoid injecting my own opinion

into my findings. This was made easier by the fact that none of my participants had brain cancer, nor did any of their experiences mirror that of my family; therefore, I was not tempted to color their experiences with my own.

CHAPTER THREE: FINDINGS

The purpose of this study was to examine changes in mother/daughter relationships following the mother's cancer diagnosis (RQ1), and to learn how family members combat the “phenomenon of silence” using social support (RQ2). During data analysis, five themes emerged: changes, information, emotions, coping strategies, and resolution. The first category, changes, directly answered RQ1, while category four, coping strategies, addressed RQ2. Patterns and sub-patterns in the remaining categories offered further insight into how various other aspects of the mother/daughter relationship change immediately following a cancer diagnosis, during the mother's treatment, and after the threat of the disease lessened. This chapter provides a detailed portrait of the changes in mother/daughter relationships as well as how they support one another after the mother has been diagnosed with cancer, supplying ample quotations to support the emergent themes.

Changes

The literature suggests that changes in the family structure begin immediately following a cancer diagnosis as family members, including the patient, adjust to new possibilities and routines (Anderson & Martin, 2003). Some of the most commonly discussed changes in this study were role reversal, communication (both frequency and topics) and newfound advocacy.

Role reversal. One of the most marked changes in many participants' lives was the

reversal of roles between mother and daughter. Daughters found themselves taking on more of a motherly role, both in caregiving and in terms of worrying about their mother more than before. Belulah, a 24-year-old whose mother is battling breast cancer, summed up the changes in her relationship:

We've definitely had a role reversal in that I think I'm more concerned about her well-being like a mom would be than she is now. I mean, she's still the mom and she still wants to make sure if we have a problem we come to her, if we need something we'll go to her – “we” being me and my two sisters: I have a younger sister and an older sister – but now it's more so I'm making sure that she's eating, I'm making sure that she's sleeping, I'm making sure that she's taking her vitamins and she's getting to her oncologist appointments and her chemo treatments and making sure everything's covered. It really has been a role reversal, where you begin to take care of your parent.

Several daughters found themselves not only worrying about their mother, but physically caring for her as well. Eighteen-year-old Martie, the daughter of a breast cancer patient, recalled wiping her mother's mouth and brow as she battled nausea following chemotherapy, while 21-year-old Allyss, also the daughter of a breast cancer patient, cared for her mother's peripherally inserted central catheter (PICC) line, which is similar to an intravenous line and used for chemotherapy. Daughters who reported caring for or worrying about their mothers did not indicate they felt unhappy about doing so, although they did feel that it seemed overwhelming at times to be saddled with such responsibility.

Communication. Along with changes in the family structure come changes in communication, both in frequency and in the topics discussed. Interestingly, participants did not report difficulty in communication but rather indicated that communication

frequency increased along with the range of topics. Mama A., a 51-year-old cervical cancer survivor, said she felt the need to bring up “things that we had never really talked about before that I felt was necessary to talk about,” like the importance of regular Pap smears and the Gardasil vaccine against certain types of cervical cancer. Several participants also acknowledged that changes in communication following the cancer diagnosis enabled them to look past things that would normally trigger an argument. Natalie, 48, a breast cancer patient currently undergoing treatment, said it’s “easier to not see the negative now. It’s easier to say, ‘Yeah, yeah, yeah, that’s OK,’ about the bad things and move on.” Likewise, 15-year-old McKenzie said it was easier to argue with her mother before she was diagnosed with breast cancer.

Frequency of communication initiated by daughters was common among participants, a finding that goes hand-in-hand with the reversal of roles and increased worry about their mothers. Martie talked about leaving for college several months before her mother's cancer diagnosis:

End of August, beginning of September, we rarely talked. Rarely. ... And then when, now that she has been diagnosed, I talk to her every single day, probably more than once a day. I see her way more. I didn't see her from when I started school until the day I came home and she told me. I didn't see her at all. Talked to her maybe twice. And now I'm here once, twice every week, talk to her every single day. It's kind of weird to think that maybe because she was diagnosed I talk to her more now, and I am kind of ashamed of that in some way, but I mean, that's just how it was.

Like Martie, participants who did not live with their mothers during the period of time between diagnosis and treatment said they felt the need to see their mother face-to-face more often even though they still spoke on the phone or via e-mail every day.

Belulah, whose mother lives about two and a half hours away, said she would travel to see her mother every few months before the diagnosis, but now never lets more than a few weeks go by without seeing her mother face-to-face. Similarly, Allyss, who lives about a half-hour away from her mother, said she made an effort to visit more often while her mother was undergoing treatment. She would help her mother fix her wig or travel to a doctor's appointment with her, but "it's just mainly being here. ... I still try to come down and visit as much as I can." Beth, a 55-year-old breast cancer patient, said she called her daughter every day, just as she did before her diagnosis, but that her daughter "would answer the phone then."

Participants also reported changes in communication topics with their mother or daughter. Whereas communication before the mother's diagnosis largely centered around the daughter's life and problems, communication after the diagnosis shifted to focus on the mother, her health, and her treatment. McKenzie said conversations with her mother before the cancer diagnosis typically revolved around her life in high school, but shifted drastically after the diagnosis:

It does make it harder to have those conversations about things, but probably about 75 percent of the things we talk about now have to do with treatments or what's been going on when she's going to treatments. A lot of times it's how I'm doing with her being gone and she always makes sure to ask if I'm all right being here, what I want to do when she's leaving, she always gives me time in advance to make plans for what I want to while she's gone, and even though our subjects have changed quite a bit since this has happened, there's still definitely a good amount of communication there. It's just about different things.

McKenzie said she doesn't always like to talk about what she's feeling, so it's helpful that her mother is always asking if she's all right. In fact, she added, the

separation during her mother's weekly cancer treatments at a hospital several hours away has forced them to strengthen their communication skills. This includes text-messaging, which makes it easier to communicate while McKenzie is at school and her mother is away.

Most daughters indicated that communication with their mothers underwent a “flip-flop” in which the mother was now the main topic of conversation rather than the daughter. With a laugh, Natalie said, “I don't care for that, particularly.” Belulah talked about becoming the “afterthought” in conversations with her mother:

Originally, it was about other people and it was about me and that was how most of the conversation went and then it was a little bit about her, and since her diagnosis it's probably flip-flopped where it's more – my first questions are, “How are you feeling? How are you doing today? Are you lying?” ... I mean, we still talk about my problems and her problems and we still talk about (mom's boyfriend) and still talk about (my boyfriend), we still talk about work, but those are the afterthoughts now and not the topic of conversation.

Mama A. said she didn't notice a big change in communication among her three daughters following her diagnosis, but perhaps the little changes that happened were spurred by a need for action on her part: “Maybe inside of me I felt that there was more urgency to make sure that I had done everything I was supposed to do, or tell them everything I was supposed to tell them.”

Even in instances in which communication did not necessarily increase after the mother's cancer diagnosis, some daughters felt the desire to be more physically close to their mothers. Lafawnduh, 21, the daughter of a breast cancer patient, likened herself to the family's black Lab, who always wants to be nearby: “I really felt like I just always

wanted to be with her even though it was irrational, to just feel like I could help her more.” Mama A. said her youngest daughter experienced a similar need: “She was maybe more physically close to me at that time, but I’m not sure she really understood why she was doing it.”

Surgery, radiation and chemotherapy treatments, which are taxing on the patient as well on the family, presented a new challenge for some mothers, who said they experienced a breakdown in communication because they simply didn't feel well. Scarlett, a 60-year-old ovarian cancer patient who has undergone multiple surgeries and rounds of chemotherapy, said she didn't have much contact with her adult daughter following her chemotherapy because she felt so ill:

She and her dad would have talked, but I just didn't talk to her a whole bunch during that time because ... when I'm sick, everybody back off and leave me alone. I'll tell you when I want something, but other than that, let me alone.

It is clear that a mother's cancer diagnosis sparks changes in her communication with her daughter, both in frequency and topics of conversation. In this study, however, it seemed as though the biggest change mentioned by daughters were an increase in daughter-initiated conversations as a role reversal took place. Some participants experienced a change in communication due to a change in perspective brought about by the cancer diagnosis: a “wake-up call” that allowed them to let minor transgressions slide or made them think about things they still needed to say or do.

Advocacy. Another change following cancer diagnosis was a newfound sense of awareness and advocacy for cancer-related issues. Mothers and daughters alike said they

began participating in Relay for Life events, volunteering for cancer-related support groups or organizations, speaking out about cancer, or carrying physical proof of the family's battle with cancer. Four of the ten participants were wearing some sort of cancer awareness jewelry (pins, bracelets, and so on) and another appeared in a commercial for a local hospital advocating mammograms. Two mothers said they had lapses of several years between mammograms or Pap smears – tests that detect breast cancer and cervical cancer, respectively – and now make sure their daughters know how important annual tests are. Mama A. also reminds her female coworkers at a small northeastern college to get regular Pap smears:

This is one thing that I have talked to (my daughters) about, is I hadn't had a Pap test for about four years before I had the one that diagnosed the cancer, so I've probably become just a little more of an advocate, not just with them, but with anybody. I sent out a campus-wide e-mail last month telling all the women on campus to have one. Other than that, I don't think there's anything that I could have done differently to prevent it. It's just the crappy luck of the draw. Fortunately, I was lucky enough to catch it early enough, and because of that I think I have a strong ability to say to people, “This is what can happen if you do have the early detection – two years later you can sit here fine and healthy if you're lucky enough to catch it early.”

The first person in her family to have a form of cancer, Mama A. used her experience with cervical cancer to educate others about the disease and how it can be prevented or detected early. While her daughters were already educated about safe sex and how to keep themselves healthy, Mama A. took her story to the college level, sharing information about cervical cancer with young students and coworkers: “It was stupid not to have the regular Pap, and, since then, I have come in contact with many women my daughters' age ... that have similar cervical issues. There's a couple students on campus

here, too. It's become obvious and it's not even something that happens to older women, it's something that can strike someone young.” Martie made no effort to hide the fact that her mother has breast cancer; rather, she wears breast cancer awareness jewelry in the hope that her friends will ask her about it so she can share her mother's story.

Information

The time immediately following a cancer diagnosis is confusing and frightening for the patient and their family members. Questions arise about myriad topics as patients gather information in an effort to understand what is happening; however, information overload sometimes takes its toll as mothers and daughters alike find themselves confronted with information they would rather not have. Some participants took advantage of their daughters' prior experiences and knowledge, which proved useful to the mothers but was at times overwhelming for their daughters.

Daughter as information source. Several mothers in this study saw their daughters as sources of information following diagnosis and during treatment. One mother, Scarlett, was diagnosed with ovarian cancer after her daughter had battled breast cancer, and found that her daughter could fill informational gaps and answer questions: “If there was a question I had, she’d be one of the first ones I’d go to to ask because she’s more highly educated and she's studied on it after she had it, and so a lot of times she could explain things to me that maybe I didn't quite get from the doctor.”

Beth's daughter is a nursing student at a nearby university, something Beth found

invaluable in many ways. Her daughter used her contacts at the hospital where she works to identify the best surgeon and oncologist for Beth, and used her experience to help care for her mother in practical ways as well. Beth said:

Instead of inserting the IV, the chemo into my vein, we chose to have a pick line, and you've got it hanging out here (gestures to upper arm) and it's just little wires, and she was the one that showed us how to clean – 'cause you had to clean it every day with saline and something else – and she knew how to do it because she had done it at the hospital. My husband and I, we don't know this stuff.

Beth's daughter also accompanied her to doctor's appointments and chemotherapy treatments, learning each step of the way how to use a hypodermic needle or the best way to deal with hair loss. With a laugh, Beth recalled her biopsy, during which the doctor paid more attention to explaining procedures to her daughter than explaining them to Beth. Her daughter's support proved more than practical, however, when during chemotherapy her daughter kept encouraging Beth by letting her know her reactions to the treatment were normal.

Prior knowledge. Those who had prior knowledge of the medical or emotional aspects of cancer counted it as a mixed blessing. Allyss, a nursing student, said her education helped her to know how to handle her mother's pick line and medical treatment, but it also was “kind of scary because you learn about stuff and different scenarios and worst-case scenarios.” Similarly, Lafawnduh had experience dealing with cancer through prior volunteer work at a support group: “I've been exposed to ... a lot of people who have had cancer and have done well and haven't done well, and so I felt like I had a pretty realistic scared view of what was going on.” On the other hand, she said,

following her mother's diagnosis the club “was a really good place for me to find support.” Martie became familiar with cancer as a child because her sister's best friend had leukemia and considered herself somewhat knowledgeable about the disease and its side effects – chemotherapy, baldness, loss of appetite. However, she said, even that experience could not prepare her for the reality of her mother's cancer diagnosis: “It's just completely different than I would have ever thought.”

Too much information. As mothers and daughters sought out information about cancer, treatment options, and what the future may hold, some daughters found themselves buried under an avalanche of too much information. Many realized their mothers were trying to make sure they prepared for the reality of cancer, but said it was still overwhelming. Martie recalled talking with her mother shortly after her diagnosis: “She basically flat-out told me every single thing that was going on ... even if I didn't want to know it.” Belulah recalled sitting down with her mother to discuss what would happen if something went wrong during her surgery:

We actually have to sit and have this serious conversation about what she's going to do and, I mean, it's very life-changing to have to sit and talk to your mom about becoming her ... power of attorney. Me and my older sister were the powers of attorney. If anything had happened to her during surgery, the two of us were supposed to make the decision on what to happen, and talking about surgery in general, talking about chemo and radiation and names that I can't even pronounce and don't even try to understand, and learning way too much about what my chances of getting breast cancer are now, 'cause it's not just a fluke like it is for some people who just randomly get it. My family has a history of it. My great-grandmother had breast cancer and inevitably died because of it, but she also lived to be in her nineties, so it's not like she died while battling it. So, it's very hard to deal with sometimes.

Coupled with Belulah's worry about her mother was worry for her younger sister,

of whom she was admittedly very protective. Belulah's mother would like all three of her daughters to be tested for the breast cancer gene, but Belulah wasn't sure, not only for herself but for her little sister as well: "The idea of finding out whether or not (my younger sister) was going to get breast cancer or not was too great for me."

Emotions

Negotiating the new emotions that arise after a cancer diagnosis proved to be difficult for the daughters in this study as they grappled with their new circumstances. None of them expressed negative emotions toward their mother, but nearly all counted anger and fear among the new emotions in their relationship with their mother. It is interesting to note that none of the five mothers interviewed expressed any of these emotions, only concern that their daughters' lives may be disrupted by their own illness.

Anger. For many daughters, feelings of helplessness and worry manifested themselves as anger toward a higher power or fate. Martie said she believed that God had a reason to give her mother cancer and that one day she would understand, but that she still wrestled with anger and a sense of unfairness:

Honestly, I'm pissed off because ... I go to the tanning bed and I don't have cancer. Her boyfriend dips and he doesn't have cancer. People smoke every single day and they don't have cancer. It doesn't run in our family. No one in our family has cancer. And then one day she's going to go and get a mammogram run and come back and say, "They might have found a tumor in me."

Others became angry or frustrated with people in the outside world who didn't understand what it was like to have a mother with cancer. The breast-cancer diagnosis of

Lafawnduh's mother came on the heels of a series of illnesses in the family that caused her mother to neglect her own health, and well-meaning friends only made the situation worse:

My dad had a pulmonary embolism probably nine months before my mom was diagnosed with cancer and so with that, and then I had illness before, so kind of just with the whole succession I just got angry at the world. People kept on telling us that, after each event, that things have to get better, and so I think I just really rebelled at this idea. I was like, "Well, I'm going to make things worse if they're going to get worse anyway," almost.

For about a year after her mother's diagnosis, Lafawnduh vacillated between emotions, primarily anger: "I'd just yell a lot." During that time, she said, communication with her mother experienced a near-complete breakdown.

Overlapping feelings of anger for many daughters in this study were thoughts of unfairness that their mother, who didn't do anything to cause herself illness, was diagnosed with cancer rather than someone else whose behavior typically does lead to cancer. Allyss said, "(My mother) had done everything her entire life to prevent it, and for her to be the person that got it, it was kind of ironic. My father had smoked and done all this other stuff and then Mom's the one that got it." Martie struggled with the thought of her "free-spirited, loving, caring" mother now having to put away her independence and learn to accept help from others.

Fear. Fear was another prominent emotion among daughters, although fear of the mother's death was strangely absent. Daughters whose mothers were undergoing treatment at the time of this study were confident of their mothers' chances of survival, even when the diagnosis was bleak. McKenzie described her emotional state as a

“freakin’ roller coaster,” while Belulah admitted to a range of emotions:

Fear, and not so much fear of dying, but fear of changing life and fear of whether or not Mom's going to be able to eat for a week or not and fear of getting sick on both aspects – Mom getting sick or one of us getting sick and not being able to see her. I guess a lot of the same feelings that anyone else would get that had to deal with someone having cancer in their family – pain and anger for it happening and hurt, you know, all the emotions of, “Why is this happening to her? She's a good person, she didn't deserve it.” But I think trumping any of those is love and knowing that the unconditional love we have for each other will get us through anything, and regardless of the outcome we're going to be constantly there for each other.

Martie said she isn't afraid that her mother is going to die, but wondered aloud whether her mother was scared of recurrence or death. “I assume that my mom is the best thing ever and no, she's not scared, because she's Warrior Mom ... or I just assumed that she was scared because wouldn't anybody be? Wouldn't you be scared?”

Coping strategies

The influx of new emotions in a mother/daughter relationship affected by cancer calls for strategies to manage them. Social support, humor, positive thinking, pragmatism, learning opportunities, and protectiveness were the common ways mothers and daughters in this study coped with cancer.

Social support. Going hand-in-hand with role reversals and an increase in communication is social support, which lets the patient know that she is still a valued part of a family unit. Belulah talked about middle-of-the-night phone calls with her mother when each realized the other was unable to sleep, while Martie said she crawls into bed with her mother to show her love and support. For Beth, an important form of support

was her daughter's assistance with her classroom full of inquisitive seven-year-olds. Several participants expressed social support by viewing the fight against cancer as a group effort rather than a battle the mother must face alone. Natalie, who worried that her young daughters' lives may be interrupted by her surgery and treatment, was amazed at how quickly her daughters “jumped right on board” and how many responsibilities they undertook:

I have felt nary a moment of disappointment, like, “Get a grip – your mother has breast cancer. Get over yourself.” None of that. Never. So, I don't even know if I can think of a negative (emotion) as far as how I feel about them or my relationship with them because I'm just so tickled that they turned out the way they have and they are who they are and they're responding the way they're responding.

Belulah and her two sisters have formed a similar bond with their mother: “It might be Mom who has breast cancer, but it's four people who are dealing with it in their everyday lives, 'cause there's not a moment that goes by that I'm not thinking about it.” In Belulah's case, as in others, the cancer made an already-strong relationship better. Natalie said she was delighted to find how strong her relationships with her daughters really were: “There's plenty of opportunity at this point for us to not be moving forward, beating this thing. We just wouldn't be as good a team, I don't think, if we hadn't established ourselves earlier.” The saying goes that “two heads are better than one” in dealing with problem-solving situations, so it stands to reason that three or four heads are better than one in coping with an emotionally-charged situation like cancer. This idea of teamwork lets the patient know she is not alone in her experience, and that even though her daughters are not physically going through the same illness, they are willing to offer

their emotional support.

Humor. Several participants pointed to use of humor to lessen the stress of the situation, like Martie, whose mother named her tumor after a Dixie Chicks song in which the protagonist, Earl, is killed after abusing his wife. Martie said, “Because she is the way that she is and has the personality that she has, it's never been a problem for anybody, including me, somebody that she doesn't know, to just talk about it and make jokes about it. She's named it even: Earl is the cancer and Pearl is her wig. We're not trying to make it a horrible situation because it already is.” Even though her mother's fight with cancer was over, Allyss said her family still jokes about it: “If somebody was mean to her or something, we'll be like, 'Well, they didn't know you had cancer.'”

Positive thinking. Connected to the use of humor, mothers and daughters also used positive thinking to cope with cancer. Belulah, who along with her sisters and mother jokes about her mother's cancer, spoke to the importance of keeping an optimistic mindset:

I know that this is a time when we have to rely on each other, and it's one of those things that only the people directly involved really understand the value and the importance. Is my support medically going to make her feel better? I don't know, but at the same time I'm a firm believer in a positive attitude and that the more support a person has, the more prayers, the more belief that they're going to get through it, the more likely they're going to be to get through it. There are scientific studies on that – people who keep a positive attitude are more likely to survive, and my mom has definitely been probably one of the most positive out of us all, but then again, I've also heard it's always easier for the person going through it than the people who have to watch them.

McKenzie said she learned the importance of optimism from her mother, who “is so positive all the time ... she's taught me to look on the good side of things.” Even in

the face of sadness at her mother's illness and stress at having to juggle household tasks alone, McKenzie said it's this relentless cheerfulness that keeps their relationship from focusing on the negative.

Pragmatism. Conversely, some participants viewed cancer pragmatically, as an interruption to their daily routine. Said Scarlett, “It's just pretty cut-and-dried. It's a way of life.” Beth, who remained at her job as an elementary school teacher throughout her treatment, viewed her journey from diagnosis to cancer eradication as something to be tolerated until it passed:

One of my friends at school said, “Beth, this is just a little interruption in your life,” and that's truly – it interrupted my life. I didn't get to go to ball games and I didn't get to do things, but then I had the wig and I had to wear the wig and didn't want to go as much, but now that I've got hair I can. But that's just the way I got through. It was just an interruption and I'm doing what I've got to do.

For Beth, surgery and radiation were “nothing” – it was chemotherapy that took its toll. Still, “you just do it,” she said.

Learning opportunities. Coping strategies also took the form of learning opportunities for both mother and daughter. Trixie, a 56-year-old breast cancer survivor, said the focus in her life was always her adult daughter until her cancer diagnosis refocused the attention on herself. She realized she needed to stop “babysitting” her child and learned to “say, ‘I'm going to do what I want to do, more of what I need to do’” in respect to her life. A bad experience with a plastic surgeon inspired Trixie to switch doctors, an experience she used to teach her daughter about taking charge of your own life and health. Further, the breast MRI that caught her tumor when a regular

mammogram did not spark another health-related conversation with her daughter, a topic that would not have surfaced had Trixie not had breast cancer.

Fifteen-year-old McKenzie, a high school student involved in two sports, often found herself stressed out by having to coordinate her own schedule while her mother was out of town receiving chemotherapy, but acknowledged that she is growing as a person because of it:

I can't say that I always do an amazing job, but yes, I've had not just responsibilities, but being more independent, just learning to take care of myself. She's still here to take care of me and do what I need to do, but those days when she's not here I've had to learn to figure out how to get from here to here and to practice, make sure that I've got everything done for school tomorrow and I've got rides and food and stuff like that, and then taking care of the house and making sure she's OK while she's in Lexington. Sometimes it's a lot, but I'd rather do that than just let it all flop and none of it works out.

Natalie, who said she has always tried to be honest with her daughters even during life's unpleasant moments, considers herself and her family lucky to be able to learn from a situation that will eventually be over:

It's been great for my girls to witness people loving on each other and what they can do for somebody else maybe some other time. I have said that this is a weird little blessing wrapped up in a big, ugly package and that they are learning life's lessons at an expense that we can afford. You know, yeah, it's an inconvenience for a couple of years and yeah, financially it's going to do this, and medically, whatever, and socially – blah, blah, blah, blah, blah. But we're learning about loving on people and being supportive and having faith and meeting things head-on and not denying and whatever – we're learning about all that kind of stuff and after we learn all these lessons then we're all going to be back at health. There are some people who learn these lessons because they've been in a car wreck, either they lose somebody tragically, I don't know, you end up paralyzed for the rest of your life. That doesn't go away. Our teacher is going away and, to me, that's an invaluable opportunity for us to take advantage of.

The experience also taught Natalie and her daughters about people, including

those who Natalie was sure would be there for her but haven't come through. Still, she takes it in stride and counts her blessings that others she never thought would support the family have come out of the woodwork.

For Mama A., who has three daughters, her experience with cervical cancer was akin to a wake-up call, both for her girls and herself. Her daughters learned not to take her for granted, and she was spurred to take a closer look at her role as mother:

I still think about it in relation to them, so I still have that underlying goal of making sure that I'm doing my best to prepare them for the future because that experience made me realize that there is no guarantee and I have to do everything they can to make sure that they are going to be OK. I'm not going to be here forever regardless of whether it's cancer or whatever, so ... I'm more focused on making sure that I prepare them for the future. I always did that, I used to tell people that my most important job was to prepare them to leave me and I used to think I did pretty good with that but I've now taken a closer look at, "Have I really done that? Are they really independent people?"

A common thread through most mothers' interviews was the desire for their daughters to emerge from the experience either unscathed or as better people. Even as mothers faced surgery, chemotherapy, radiation, and other treatments, they still focused on their daughters and how their own fight with cancer could impact their children's lives.

Part of the learning curve for some daughters was finding out that their mothers were not super-human; that they are vulnerable just like everyone else. Allyss had the scary experience of finding that her mother was not as invincible as she originally thought: "You learn that they're not, that bad stuff just happens." Likewise, Martie was jolted by seeing her normally happy-go-lucky mother lethargic and in pain:

It just really upsets me that she's having to go through this, because it has – she has done a 180-degree turn with – all I ever do is see her sleep, lay in her bed, cry,

get sick, you know, and I'm not used to that at all. And even though I'm kind of grown into an adult, I still want my mommy there and that's not my mommy. Seeing her laying in the bed like that crying because she's sad that she has cancer, and that she can't help me and my sister because she doesn't have enough energy to do it.

As difficult as the adjustment was for daughters, mothers had trouble slowing down as well. Martie said her mother struggled with having to allow others to do things for her like cooking meals, cleaning the house, or setting up an e-mail list to update friends and family on her condition. At times, Martie said, she has to force her mother to sit down and let someone else take care of a problem rather than feeling like she has to fix it herself.

Protectiveness. Although most mothers and daughters indicated there were no taboo topics when it comes to discussing cancer, several said they try to hide their feelings from each other to spare pain or worry. Scarlett didn't want her young grandchildren to worry about their grandmother, so she made sure not to talk about cancer in front of them. Even though Belulah was sure her mother knew how scared she is and how much she worries about her, she never gave voice to those feelings to avoid hurting her mother:

Everyone around us is constantly telling us to keep a firm upper lip as the old saying goes, and to always be strong for our mom and we've all discussed how strength isn't always about keeping the firm upper lip or being the one to carry the other, sometimes strength is both realizing that you're knocked as low as you can go and crying about it. But I don't think it would be good for Mom to know how much I think about her and how much concern I have for her and how much it really has totally screwed up everything that I think about on a daily basis. ... I don't think she deserves to have to think about how she is messing with one of her children.

Likewise, Trixie said she keeps quiet about how she feels physically because she knows her daughter is prone to worry. If there were a serious change in her health, she said she would definitely tell her daughter, but “I wouldn't want to worry her about something.” McKenzie said her quiet personality and fear of hurting her mother's feelings make it difficult to talk about emotional topics, even though her mother encourages her to:

It's not really a touchy subject, but it's so emotional and can be so sensitive for people. You don't ever want to say the wrong thing and she always says, “No matter what you say ... it's not going to hurt my feelings,” but there's still the part of you that's like, “OK, don't want to say this 'cause that might hurt her feelings.”

Because of McKenzie's reluctance to talk, her mother asks her every week how she's feeling and whether she's handling the situation well, one of several examples of mothers still caring for their daughters despite their own illness. Natalie said she makes sure to always discuss everything with her daughters, even potentially uncomfortable topics, because “the feelings are in there whether they're communicated back and forth or not. I think it's not fair to expect people to understand how to manage those feelings all by themselves. I mean, what's a mommy for? To help them learn about that kind of stuff.” Beyond emotion, Martie's mother physically showed her where in her breast the tumor is located and allows her to feel it so she knows how to examine her own breasts for lumps: “She wants to make sure that I know, she wants to make sure that I'm OK with what's going on, if I have any questions.”

Resolution

Five of the 10 participants either were or had mothers who were past the initial diagnosis and treatment stage, so an important topic became how they managed life and relationships once cancer became a memory rather than reality. Those families saw a return to normalcy, which was marked both by a hesitance to talk about recurrence and the feeling that cancer should be talked about on an as-needed basis rather than being a constant topic of conversation.

Return to normalcy. Allyss said her family's life was “back to normal now. It's kind of like it never even happened, more or less. ... It's kind of just like a bad memory.” Mama A., who recently was told by her doctors she could go back to yearly Pap examinations rather than coming in every few months, said her clean bill of health perhaps means her daughters have put it out of their minds:

I think enough time has passed now and all of my subsequent check-ups have been good. I think the fear for them, even the fear for me – it's still there, it's something I'm never going to forget, but it's gone on long enough now we're fairly confident enough that it's not going to recur. ... So I think for them, they've managed to even put it farther behind them. I'm not sure that they even think about it, except maybe in passing.

Beth, who said her daughter would answer the phone more often immediately following her diagnosis and during her treatment, said with a laugh that her daughter has gone back to not answering every phone call right away. Now that she only visits the doctor twice a year, Beth said, her focus returned to getting her daughter through school.

Recurrence. No one mentioned outright a fear of recurrence; however, two daughters said they avoid talking about the possibility with their mothers. Allyss said she does so because her mother feels badly that her cancer was curable; however, doctors

warned her that if the cancer recurs it may not be. For Lafawnduh, avoidance of the topic of recurrence has more to do with living in the present rather than projecting what may happen:

I think that we don't want to jinx it. ... I don't know if this makes any sense, but worrying about something that you don't know if it's going to happen or not is kind of pointless and I'm kind of trying to stay away from that and so the cancer's going to do whatever it wants to do no matter what, so letting it be a part of our lives now seems a little stupid while it isn't a part of her body.

Lafawnduh admitted being nervous about a recent MRI her mother had, which indicated several small tumors in her brain, but said she avoids talking about it because she doesn't know whether they're malignant or benign, and because “talking about that would mean that she would have cancer again.”

No need to talk about it. Finally, after the initial cancer scare was resolved, some felt no need to bring up the topic again unless the conversation specifically warranted it. Trixie sends articles and news clippings about cancer to her daughter and makes sure she knows when to get mammograms, but cancer was never a regular topic of conversation in her family. Similarly, Mama A. asked her three daughters received the Gardasil vaccine against cervical cancer and made sure they know to get regular pelvic and breast exams, but says cancer is “not something that I would bring up to them specifically ... (unless) it's a current topic or something they want to know.” Scarlett, who is still undergoing surgeries and treatments for her ovarian cancer, said she will talk about cancer “if there's something to say about it, but there's no sense in dwelling on it. It's my life, so I can't just wear people out with it.”

Summary of findings

In reviewing the data, five patterns emerged: changes, information, emotions, coping strategies, and resolution. These patterns were arranged chronologically (Lindlof & Taylor, 2002), following the timeline of disease progression from the participants' narratives and the researcher's own recollection. Sub-patterns in the "changes" category, which focused on mother/daughter communication before and after the cancer diagnosis, included role reversal, communication frequency, topics, focus, and newfound advocacy. "Information," which referred to the family's and patient's need to understand what was happening, included relying on the daughter as a source of information, prior knowledge of cancer, and too much information. "Emotions," which are in a state of flux throughout the cancer journey, included anger and fear. With emotions come "coping strategies" such as humor, protectiveness, learning opportunities, and pragmatism. Social support also came into play here, as mothers and daughters lean on each other for emotional validation. Finally, the "resolution" category examines how mothers and daughters return to normalcy following the end of treatment.

CHAPTER FOUR: DISCUSSION

In this chapter, I discuss my findings and answer the two research questions posed at the beginning of this study. I discuss each theme as set forth in Chapter Three and how those themes address the research questions before focusing on limitations and directions for future research. Finally, I discuss the contributions of this research to the communication field as well as its implications for family communication research.

Changes

RQ1 asked how communication changes in the mother/daughter dyad following the mother's cancer diagnosis. Current literature indicates communication patterns change dramatically when a parent suffers an illness (Northouse, 2005; Zhang & Siminoff, 2003), and the findings of this study support that idea. Eight of 10 participants reported an increase in communication frequency, especially daughter-initiated communication, after the initial diagnosis and during the mother's surgery and treatment. This represents a shift in the mother/daughter role, wherein daughters take the focus off themselves and begin to worry more about their mothers. Daughters who do not live at home and typically communicated with their mothers by telephone reported feeling the need to come home more often, even at the expense of their work or school lives. In families in which the daughter lived at home, both mothers and daughters said they noticed an increase in the daughter's desire for physical closeness.

It seems this role reversal, as well as the increase in face-to-face communication, is a manifestation of the daughter's realization that the mother is not immortal, nor is she

immune to life's ups and downs. Raveis and Pretter (2005) found in their study of daughters of breast cancer patients that the mother's cancer diagnosis was a shock that motivated daughters to increase communication. Feelings of helplessness, uncertainty, and even abandonment are not unfamiliar to family members of cancer patients (Hinds, 1992), so perhaps the need for physical proximity is a natural response to the feeling that one must do *something* even if one doesn't know quite what to do.

Communication also underwent a topic and focus shift, as conversations revolved more around the mother, her treatment, and her health. It is interesting to note that even in the midst of treatment, both daughters and mothers reported the mother's desire to talk more about the daughter than herself. A mother is, at her core, a caregiver, and exhibits “empathetic attunement” (Hershberg, 2006, p. 37) to her children as babies and throughout their lives. Therefore, it follows that mothers would continue to be aware of and respond to their daughters' needs even in their own illness. Further, in a study of breast cancer patients with adolescent daughters, mothers reported feeling the need to minimize disruption as much as possible (Stiffler et al., 2008), so it is not surprising that mothers, even those whose daughters are now adults, would seek to “protect the rhythms of their lives” (p. 117) by maintaining “normal” conversation.

The “information” theme shed light on patients' and families' information gathering and disseminating following the diagnosis. Mothers who reported an exceptionally close relationship with their daughter or daughters seemed to have little trouble being upfront about cancer, treatment options, and what exactly was going to

happen, sometimes to the point that the daughter felt overwhelmed at the amount of information being given. Including family members in reports on a patient's treatment and progress results in “enhanced and shared knowledge” (Beach, 2001, p. 223), which in turn leads to a feeling of being in the battle together, a shared journey. Those who had a history of being upfront and honest with their daughters perhaps saw their cancer diagnosis as another stop in the journey they were already on, and saw no need to hide information from them.

Additionally, according to Anderson and Martin (2003), cancer patients are more likely to share information if they feel they are validated by the people around them. Further, in their study of one family matriarch's battle with thyroid cancer, Anderson and Martin noted that once people learn in whom they can confide, ties are formed that only grow stronger as the disease progresses. Perhaps mothers who gave their daughters too much information or relied on their daughters for information were simply doing so because their existing relationship was one of validation and positive reinforcement, and they felt comfortable tackling tough issues and asking for help.

It was not surprising that some participants experienced an influx of new emotions following the cancer diagnosis; however, what was surprising was that none of the mothers reported a change in emotions, while nearly all the daughters did. Daughters who noticed a change in emotions said those new feelings tended toward the negative: anger, fear, and a sense of unfairness. Anger and unfairness are understandable for families grappling with this new information and trying to find sense in the news. Some

daughters said they were angry with God or with fate because their mother didn't deserve what had happened, while others lashed out at other family members or friends because they didn't understand what she was going through. No daughter indicated that she was angry with her mother for requiring assistance or for inconveniencing the family during her illness as the literature suggested they might (Stiffler et al., 2008); in fact, some participants said it was easier to let transgressions slide rather than argue. Mothers didn't explain why their emotions remained steady, but it may be that mothers, no matter the circumstance, are still mothers and still desire what is best for their children (Anderson & Martin, 2003).

The sense of unfairness led some daughters to list aloud the people in their lives who “should” have cancer – those who engage in activities commonly associated with cancer like smoking or going to the tanning bed – yet do not. Perhaps because all the daughters involved in this story had mothers with breast cancer, which people cannot cause themselves to get, daughters saw their mothers as innocent victims of the disease. Fear was also counted among the emotions that sprang up after a cancer diagnosis, but again, only daughters spoke of fear, and none of them voiced a fear of the mother's death. This can be explained by families’ need for positive thinking and optimism, or perhaps patients’ or daughters’ reluctance to admit their fear. Zhang and Siminoff (2003) found that late-stage cancer patients and their families refused to discuss death “for fear that such talk would accelerate the patient's death” (p. 426). None of the participants interviewed were considered late-stage or terminal cancer patients; however, if families

avoid talking about death when it is imminent, it stands to reason they would avoid talking about it if the patient believes they will be fine after surgery and treatment.

Despite the lack of fear of death voiced by participants, at least two families made preparations just in case the mother's surgery didn't go well. While this doesn't necessarily show fear on the part of these families, it is a sign that optimism and positive thinking must also be balanced with pragmatism.

With those new emotions came the need for coping strategies. Social support was one of several, which answered RQ2: How do mothers and daughters combat the “phenomenon of silence” through social support? The “phenomenon of silence” is defined as “the absence of vocal concern about the existence of cancer” (Zhang & Siminoff, 2003, p. 420). This research question was only partially answered, as none of the participants in this study said they outright avoided talking about cancer; rather, that certain aspects like possibility of recurrence or blunt honesty about the emotional effects of cancer were less likely to be topics of conversation because of a sense of protectiveness. Again, it is important to note that none of the patients in this study were considered to be in the late stages of cancer; two mothers were diagnosed only several months before being interviewed, while the other three mothers were past their last treatment. Additionally, perhaps the fact that participants were willing to participate in this study – to discuss their experience with a complete stranger – meant they were more likely to communicate with each other about cancer.

Social support played an important role in coping with the disease. Four of the

five participants who were – or whose mothers were – actively going through treatment at the time of their interviews spoke in terms of “we” rather than “I” or “my mother” when describing the family's battle with cancer, indicating that they viewed the fight as a group effort rather than something the mother must negotiate alone. Cancer can be a lonely, debilitating experience that erodes a patient's autonomy and independence (Sherman & Simonton, 2001), so having a sense of cooperation and teamwork in the family is paramount. Social support took the form of shared pain when daughters cried with their mothers, assistance with chores and meal preparation so the mother could relax, and cheering the patient on as she underwent treatment. Emotional support lifts patients' spirits (Arrington, 2005), decreases “anxiety, guilt, hostility, and depression” (Gotcher, 1993, p. 185), and eases adjustment to the disease (Gustavsson-Lilius, Julkunen, & Hietanen, 2007).

It was gratifying to find that the phenomenon of silence did not exist within this participant sample, especially as communication between parents with cancer and their children is important for a variety of reasons. Harzold and Sparks (2006) found that children of parents who failed to disclose information felt their parents were not communicating competently, and noted that “the discussion of feelings with the child during the cancer experience appears to be an important topic element” (p. 74). Honesty is an integral part of successful family communication following a cancer diagnosis, as lack of honesty may lead to feelings of rejection at a time when support is most needed (Gotcher, 1993). Additionally, those who avoid talking about cancer with their children

also run the risk of creating more anxiety on the part of the child (Sherman & Simonton, 2001), who is left to their own devices to figure out what is going on.

Other coping strategies included pragmatism, reframing the situation as a learning opportunity, and use of humor as a way to lessen the seriousness of the situation. Half the participants in this study used humor as a coping strategy, keeping in line with their respective families' tendencies to joke and tease before the cancer diagnosis. Naming the tumor and referring to surgery as its “funeral date,” rubbing and kissing a mother's bald head, and telling jokes about cancer diagnosis were all ways participants eased stress while dealing with a mother's cancer. It seemed to work because families were continuing to be their goofy, silly selves, as if there was no need to be serious just because cancer had come along. As long as families are “laughing with,” not “laughing at” the patient, the use of humor can be an effective coping strategy and may trigger a relief effect for both the patient and their family (Harzold & Sparks, 2006). Remaining optimistic in the face of a serious illness, including “reframing negative events” (Northouse, 2005, p. 748) such as a mother losing her hair after chemotherapy, enables a family to better cope with the situation and its emotional and psychological demands. Laughter also helps decrease anxiety levels (Harzold & Sparks, 2006), increasing patient health and boosting morale. In a study of nine breast cancer patients, Johnson (2002) found that women saw humor as a helpful coping strategy to give themselves hope and to lessen the impact of the disease on their families. Participants in this study who reported the use of humor as a coping strategy seemed to share their feelings more openly among

family members, perhaps because laughing about a shared experience made them more comfortable with it.

Following the patient's last treatment, when the threat of the disease has passed, or after a doctor's assurance that they are fine, families return to “normal” and stop talking about cancer. Five of the 10 participants were in this stage, and all of them said they felt no need to discuss the disease unless it was relevant; for example, Trixie said she clipped news articles about breast cancer to give to her daughter, and Mama A. said she used her experience to periodically remind her coworkers and daughters to get Pap smears. While some participants admitted to intermittent worries about recurrence, they acknowledged that the days of cancer as a “white elephant” – something ever-present yet which is not discussed – were over. Fear of recurrence is another area in which families and patients affect each other (Mellon et al., 2007), so it makes sense that both mothers and daughters would be loath to talk about the possibility of the cancer coming back.

Finally, although it is not discussed in Chapter Three, another interesting finding is that, despite research indicating that caregivers within the family are most often female (Northouse, 2005) and that daughters typically assume this role for their aging mothers (Pecchioni & Nussbaum, 2001), daughters in this study only shouldered the bulk of the caregiving if their mothers were divorced. Otherwise, caregiving duties fell primarily to the husband because the daughter was unwilling to help, the mother did not want to interrupt her daughter's life, or the daughter did not live close enough to take on such a role. Arrington (2005) found in his study of prostate cancer patients that the men's wives

took on the responsibility of making sure their partners were informed; since mothers whose daughters participated in caregiving no longer had partners living at home, it makes sense that their daughters would step up to the task.

Children of divorced parents often develop characteristics such as self-reliance, value of hard work, and independence by watching their mothers and fathers tackle life as a single parent (Lewis, Wallerstein, & Johnson-Reitz, 2004). Although this study did not dwell on whether mothers were divorced or married, the topic still arose in discussion of how families managed cancer. Despite literature that indicates parent-child communication in divorced families is poor (Lewis, Wallerstein, & Johnson-Reitz, 2004), daughters in this study indicated their relationships with their mothers grew closer as a result of living as “just the girls.” This mindset, coupled with the characteristics mentioned above, may be the reason daughters of divorced families are willing to shoulder the responsibility of caring for their ill mothers.

Limitations and Directions for Future Research

This study fills a void in communication research by addressing the mother/daughter dyad and examining the changes that occur following a cancer diagnosis. While it offers a unique look into this complex relationship at a difficult time, it is not without limitations. This study serves as a graduate thesis and is therefore restricted by both time and finances. Nine of 10 participants live in the southern United States, while one resides in the northeast. As well as a lack of regional diversity, there is

a lack of ethnic diversity in the participant group, as all participants identified themselves as Caucasian. Additionally, while the mothers in this study had varied cancer diagnoses, all the daughters interviewed had mothers facing breast cancer. I include this as a limitation because I believe different types of cancer bring with them different concerns and fears, and I would have liked to see how daughters dealt with ovarian cancer or cervical cancer.

Participants in this study represented a range of experiences; however, in their responses it seemed there was a marked difference between participants who are or whose mothers are currently going through treatment versus those whose treatments were completed some time ago. Even though a time limit of two years past the end of treatment was set, those participants who made it past the hurdles of diagnosis and treatment were recalling information from the past, which may be clouded by the passage of time. It also seems as if family communication undergoes yet another change as seen in the resolution category when the mother reaches the end of her treatment. A future study may restrict participants to those actively undergoing treatment.

Another area of interest may be examining why some women choose to become advocates after their cancer experience or their mother's cancer experience, yet others do not. One participant said she agreed to be interviewed for this study to feel as though she was doing something, as she felt unable and unwilling to get involved with cancer advocacy events like the American Cancer Society's Relay for Life because she was still overwhelmed by her mother's cancer. Celebrations like Relay for Life and Breast Cancer

Awareness Month effectively bring the disease to the forefront and offer many opportunities to share stories, so it is not for lack of opportunity that cancer survivors and their families do not participate. Probing the reasons behind a lack of advocacy or latent advocacy (e.g. wearing jewelry) as opposed to active advocacy (e.g. fundraising, speaking out) may offer further insights into how families deal with the emotional aspects of cancer.

Eight of 10 participants in this study were affected by breast cancer. A daughter who is party to her mother's experience with breast cancer may have a greater sense of personal risk and disease-related concern (Raveis & Pretter, 2005), as breast cancer is sometimes hereditary. Those participants were asked whether they discussed the possibility of the daughter also developing breast cancer, and all indicated they had; however, the interviewer did not discuss the matter beyond asking whether the topic had come up. A more probing look at mothers with hereditary cancers and their daughters may show a more complex change in communication.

While this study may be the first to examine cancer-related communication changes between mothers and daughters, it is certainly not an exhaustive look at the topic. Other researchers may expand upon the topic by examining relationships between adopted daughters and mothers with cancer; whether birth order or the presence or absence of siblings changes communication after a cancer diagnosis; or how communication changes following the diagnosis of other serious, but not terminal, illnesses. Still others could explore the relationships among siblings, fathers and sons, or

step-families in the face of a similar health crisis.

Conclusion

This study found that communication in the mother/daughter dyad changes in a variety of ways after the mother is diagnosed with cancer, and that communication undergoes yet another change when the threat of illness has passed. This study also found that families utilize many coping strategies to handle the influx of emotions, including social support. While no families in this study experienced the phenomenon of silence, they acknowledged that communication was nevertheless important in keeping the family and patient happy and optimistic.

Cancer is a prevalent disease in America and around the world, so it stands to reason that most families will have an experience with cancer sometime during the course of their lives, either in the immediate or extended family unit. The results of this study underscore the importance of communication, especially in the face of a serious or terminal disease, evident in the existing literature.

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INFORMED CONSENT DOCUMENT

Project Title: Analyzing changes in mother/daughter communication following the mother's cancer diagnosis

Investigator: Rachel L. Walston, Department of Communication, (270) 799-8522

You are being asked to participate in a project conducted through Western Kentucky University. The University requires that you give your signed agreement to participate in this project.

The investigator will explain to you in detail the purpose of the project, the procedures to be used, and the potential benefits and possible risks of participation. You may ask her any questions you have to help you understand the project. A basic explanation of the project is written below. Please read this explanation and discuss with the researcher any questions you may have.

If you then decide to participate in the project, please sign on the last page of this form in the presence of the person who explained the project to you. You should be given a copy of this form to keep.

1. Nature and Purpose of the Project:

Existing research indicates that communication changes greatly after a family member's cancer diagnosis, but no study has yet examined mother/daughter communication in the face of cancer. This study seeks to fill that void by analyzing changes in communication between mothers and daughters following the mother's cancer diagnosis. It serves as a graduate thesis for the interviewer.

2. Explanation of Procedures:

Mothers and daughters will be asked to report to the interview together, but will be interviewed separately. Interviews will be recorded on a digital MP3 player. The interviewer will also take written notes. Interviews may also be done via web-cam, in which case both the audio and video will be recorded. You may answer each question with as much or as little information as you wish.

3. Discomfort and Risks:

Interviews will ask probing questions about the mother/daughter relationship, so emotional discomfort may occur. If at any time you wish to take a break or stop the interview, you will be permitted to do so with no consequence. Interviews may be resumed at a later time or stopped altogether, in which case your information will be removed from the study. At the conclusion of the interview, you will be provided with information about local support groups.

4. Benefits:

The interview may raise topics mothers and daughters wish to discuss further, which may lead to a deeper understanding of the mother/daughter relationship and the

**INFORMED CONSENT DOCUMENT
FOR RESEARCH INVOLVING MINORS**

ASSENT FORM

I, _____, understand that my parents have given permission for me to participate in a study concerning communication between mothers with cancer and their daughters, under the direction of Rachel L. Walston, Department of Communication, Western Kentucky University.

My participation in this project is voluntary, and I have been told that I may stop my participation in this study at any time. If I choose not to participate, it will not affect me in any way.

Signature _____ Date _____

Interview questions

Questions for mothers:

1. Describe your relationship with your daughter prior to your cancer diagnosis.
2. How, if at all, did your relationship change when you were diagnosed with cancer?
3. How, if at all, does your daughter offer support to you (financial, emotional)?
How important is that support to you?
4. Describe the communication between you and your daughter prior to your cancer diagnosis. How frequently did you communicate? What channels did you use to communicate (face-to-face, phone, e-mail)? What did you talk about?
5. Describe the communication between you and your daughter following your cancer diagnosis. How frequently do you communicate? What channels do you use to communicate (face-to-face, phone, e-mail, etc.)? What do you talk about?
6. How, if at all, do you and your daughter talk about cancer? What, if any, cancer-related topics are considered “taboo” between you and your daughter?
7. Why do you discuss (or avoid) topics dealing with cancer?
8. What are the primary emotions present in your relationship with your daughter since the cancer diagnosis? How does this differ or compare to your relationship before your diagnosis?
9. What, if anything, do you wish you could talk about with your daughter that you feel unable to? What prevents or deters you from talking about these topics?

Questions for daughters:

1. Describe your relationship with your mother prior to her cancer diagnosis.
2. How, if at all, did your relationship change when she was diagnosed with cancer?
3. How, if at all, do you support your mother (financial, emotional)? How important do you think that support is to her?
4. Describe the communication between you and your mother prior to her cancer diagnosis. How frequently did you communicate? What channels did you use to communicate (face-to-face, phone, e-mail)? What did you talk about?
5. Describe the communication between you and your mother following her cancer diagnosis. How frequently do you communicate? What channels do you use to communicate? What do you talk about?
6. How, if at all, do you and your mother talk about cancer? What, if any, cancer-related topics are considered “taboo” between you and your mother?
7. Why do you discuss (or avoid) topics dealing with cancer?
8. What are the primary emotions present in your relationship with your mother since the cancer diagnosis? How does this differ or compare to your relationship before your diagnosis?
9. What, if anything, do you wish you could talk about with your mother that you feel unable to? What prevents or deters you from talking about these topics?

Demographic information for mothers and daughters:

What is your name?

Are you the mother or daughter?

How old are you?

What race/ethnicity are you?

What is your profession?

When were you/was your mother diagnosed?

What type of cancer do you/does your mother have?

Information distributed to potential participants

My name is Rachel Adams Walston, and I am a graduate student in the Department of Communication at Western Kentucky University. My graduate thesis study is entitled “Analyzing communication in mother-daughter dyads following the mother's cancer diagnosis,” and aims to learn more about the communication between mothers with cancer and their daughters by doing interviews with both the mother and daughter. Existing research indicates that communication does change among family members after a diagnosis, but no one has examined the mother/daughter relationship specifically. This is a topic with which I am very familiar, so it holds a special interest for me.

To participate in this study, daughters must be at least 15 years of age. Mothers must be more than three months past diagnosis and no more than two years past end of treatment. Both mother and daughter will need to sign a consent form before participating; additionally, mothers of minor participants will need to sign a release form granting permission.

The interviews, which are about ten questions long, will begin in January and can be done either at your home or at Western Kentucky University. Mothers and daughters will be interviewed separately. Interviews should take no more than an hour, although time may vary depending upon how detailed your answers are. Interviews will be tape recorded. Each participant will be assigned a pseudonym (which you may choose), and participants' real names will not be used anywhere in the written study. There is no monetary compensation available to participants in this study.

Upon its completion, final copies of the study may be e-mailed or mailed to participants who wish to see it. While this study serves as my graduate thesis, it may also be submitted for publication following graduation.

If you have any questions or would like more information, please feel free to contact me at rachel.adams590@wku.edu or (270) 799-8522. Thank you!