INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each original is also photographed in one exposure and is included in reduced form at the back of the book.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

UMI

A Bell & Howell Information Company
300 North Zeeb Road, Ann Arbor MI 48106-1346 USA
313/761-4700 800/521-0600

Couple Processes as a Context for Breast Cancer Recovery:
Doing Everything We Can

by

Gretchen M. Zunkel

A dissertation submitted in partial fulfillment
of the requirements for the degree of

Doctor of Philosophy

University of Washington

1996

Approved by Frances Marcus Lewis
Chairperson of Supervisory Committee

Patricia Brandt
Monica E. Jarrett
S. Wayne Duncan

Program Authorized
to Offer Degree Nursing

Date December 17, 1996

UMI Number: 9716947

UMI
300 North Zeeb Road
Ann Arbor, MI 48103

Signature Gretchen M. Zunkel

Date December 17, 1996

University of Washington

Abstract

Couple Processes as a Context for Breast Cancer Recovery: Doing Everything We Can

by Gretchen M. Zunkel

Chairperson of the Supervisory Committee: Professor Frances Marcus Lewis
Department of Family and Child Nursing

This research study was an exploratory effort designed to explicate the relational processes that developed between women and their male partners as they negotiated the early breast cancer recovery. Case-intensive interview data obtained from individual interviews with women and men as well as couples together were analyzed using an interpretive approach. Within a family qualitative methodology, data analytic strategies were developed that allowed for analyses across individual and dyadic interview data.

Processes, as active strategies, characterized both the individual's as well as the couple's response to the illness. Relational or dyadic processes are the strategies that the couple developed together in response to the breast cancer diagnosis, the demands of the illness, and their interactions as a couple about the breast cancer. As well, the couple responded to the medical context inherent in the recovery.

The explanatory construct "Doing Everything We Can" organized the individual's and couple's overall response to the intrusion of breast cancer and exemplified their fight against the cancer. The processes that characterized the breast cancer recovery for these individuals and dyads demonstrated the enormity of the situation for each couple.

Individuals responded to the breast cancer by: Taking Charge of My Life, Seeking Support, and Protecting Self or Other. The dyadic processes included: Sharing in the Recovery, Helping Her, Moderating the Intrusion of the Cancer, and Normalizing the Household.

The individual and dyadic processes reflected attempts to both actively deal with the cancer as well as to moderate its intrusiveness into the family's previous day-to-day living. Families who placed a high value on getting their households back to the pre-diagnosis state may be ignoring the woman's individual needs for recovery. Nursing intervention for families must reflect the tension between the individual woman's needs during the recovery and the family's needs.

TABLE OF CONTENTS

Page

List of Tables iv

Chapter I: Introduction 1

- Background 1
  - Breast Cancer as an Illness 3
  - Overview of Relational Aspects of a Cancer Diagnosis 4
  - Individual Research and the Concept of Adjustment 5
  - Family Research Studies 7
  - Dyadic Processes Research 9
  - Summary 10
- Statement of the Problem 11
- Specific Aims 13

Chapter II: Conceptual Framework 14

- Coping as a Process 15
  - Individual Coping 16
  - Dyadic Coping 17
  - Family Coping and Family Functioning 19
- Context for Coping 21
- Primary Appraisal: Nature of the Breast Cancer Diagnosis as a Stressor 21
- Person Factors: Agency and Communion 22
- Women's Self-in-Relation 23
- Situation Factors and Secondary Appraisal 24
- Social Support and Relational Competence 25

Psychophysiology of Marital Interaction....................26

Summary....................27

Chapter III: Methodology....................29

Qualitative Family Research....................29

Dyad as Unit of Analysis....................30

Study Design....................31

Target Sample....................31

Context for Data Collection....................32

Data Analytic Strategies....................33

Data Coding and Analysis....................34

Standards for Establishing Trustworthiness of Data Analysis....................37

Summary....................39

Chapter IV: Findings....................40

Demographic Data....................40

Overview of Processes....................40

Individual Processes....................43

Taking Charge of My Life....................43

Seeking Support....................47

Protecting Self or Other....................49

Dyadic Processes....................54

Sharing in the Recovery....................55

Helping Her....................59

Moderating the Intrusion of the Cancer....................62

Normalizing the Household....................66

Doing Everything We Can....................68

Chapter V: Discussion of the Findings 73
  Overview 73
  Individual Processes 74
  Dyadic Processes 76
    Dyadic Processes and Women's Response 81
  The Breast Cancer Context 82
  Clinical Implications 83
  Implications for Future Research Studies 84
  Limitations of the Study 85
  Summary 85
References 86
Appendix A: Design of Family Home Visitation Study 96
Appendix B: Interview Questions 97
Appendix C: Researcher Background 99
Appendix D: Demographic Data 100

LIST OF TABLES

Number *Page*

1. Summary of Methods........33
2. Doing Everything We Can: Processes Evolving During the Breast Cancer Recovery........41
3. Comparison of Dyadic Coping Processes........79

ACKNOWLEDGMENTS

Many have contributed to the working phases and completion of this dissertation. It seems that there are so many to thank and not enough space here to properly accomplish the task. I hope that I can include everyone, but I'm sure there are others who have provided encouragement or support who are not listed in these acknowledgments.

I would like to acknowledge and thank my dissertation committee members: Dr. Frances Lewis, Dr. Patricia Brandt, Dr. Kathryn Barnard, Dr. Monica Jarrett, and Dr. Wayne Duncan. They have been extremely supportive and encouraged me along the way to make this work the best that it can be. I have benefited from the incredible wealth of knowledge and research expertise of each member of this committee.

My friends and colleagues both within the doctoral cadre and other work experiences have contributed both their knowledge and support at crucial times during this process. I would like to thank Drs. Carlene Boyd, Barbara Cochrane, Beverly Johnson, Andrea Kovalesky, JoAnn Perry, Roberta Rehm, and Lorie Wild for their sustained encouragement. Also, my friends Donna Linn and Bruce Brown have provided many creative ideas and extra support during this period of study. Drs. Kathy and John Dracup have been mentors for me over a period of many years and their quiet concern and wisdom at crucial times have lightened the load during the graduate school experience.

I'd also like to mention my children Erica and Mark. I am quite privileged to enjoy the company and perspectives of two such wonderful young adults. My brother Paul Staley, his wife Sandra, and my niece Amy have gone above and beyond a family's duty to provide a special kind of "being there when needed." My mother, Irma Staley, who recently celebrated the 50th anniversary of her nursing school graduation, has been a wonderful role model for me.

Finally, I would like to acknowledge the funding from the Psychophysiologic Interface Training Grant and Dr. Helen Kogan, the Family Home Visitation Study and Dr. Frances Lewis, and the Hester McLaws Nursing Scholarship Fund.

**Dedicated to my children: Erica and Mark,
a source of great joy and inspiration.**

CHAPTER I

Introduction

Background

A cancer diagnosis is something that causes fear and raises concern not only for the diagnosed woman but also for her family and friends (Lewis, 1983). The issues that must be dealt with after the breast cancer diagnosis are not faced in isolation. Women express concern about the effects of the illness on their male partners and children while these family members have their own set of responses and concerns regarding the diagnosis (Armsden & Lewis, 1994; Gotay, 1984; Kasper, 1989; Zahlis & Shands, 1991). Breast cancer is an illness that may create a crisis initially and then cause ongoing demands, for the family, having physiologic and psychosocial implications (Lewis, Ellison, & Woods, 1985; Lewis & Hammond, 1992).

The diagnosed woman and her family are faced with the illness and its treatment; the psychological domains of anxiety about the illness, self-esteem, and relationships; and the practical domain of work, finances, and family operations (Parle & Maquire, 1995; Spiegel, 1995). The aspects of cancer which increase the likelihood of psychological complications are: a silent onset, delayed diagnosis, its rank as a major cause of death, its potential to be treated over long periods of time, multiple losses which include body image changes, and the long periods of uncertainty within the recovery phase (Dunkel-Schetter & Wortman, 1982; Jevne, 1991).

Over time each individual as well as the couple and the family unit adapt to the illness using a variety of strategies and processes to manage the demands of the illness itself, the family operations, and other emotional aspects (Friedman, Nelson, Baer, Lane, & Smith, 1990; Hilton, 1996; Lewis & Hammond, 1996; Northouse, 1995, for a review of recent studies). The interaction of supportive relationships, the development of coping processes, and subsequent outcome or adaptation are intertwined in complex ways that need further examination. Individual response must be studied within its context. Spiegel (1995) noted the importance of looking further than adaptation or adjustment as an individual variable but "moving toward a recognition that the ecological validity of the phenomena we study is crucial" (p. 115).

Both the demands of day-to-day life and incorporation of the diagnosis must be processed interactively by the couple during the recovery process; they must manage the changes in family life as well as the emotional sequelae that follow a cancer diagnosis. Each partner must process his or her own problems and emotions as well as help to manage those of the other person. The level of complexity is greater when considering the impact of each partner's response on the other. Embracing these complexities may lead to a fuller understanding of affective and behavioral responses during the breast cancer recovery and eventually to an understanding of contextual influences on psychological and physical outcomes.

The couple, through the coping processes they develop, set the tone for the adaptation of the entire family including the children. The behavior that individuals and couples develop after the diagnosis reflects both their experiences with the breast cancer diagnosis; their previous ways of coping with problems; and the meanings of the cancer to the family (Germino, Fife, & Funk, 1995). "It is the meaning of cancer to the family that sets the context within which dynamic processes occur" (Lewis, 1993, p. 127). For younger women the stresses of the cancer diagnosis are superimposed on the activities of career and family responsibilities (Northouse, 1992). "Families may be particularly affected when the diagnosed woman is a mother with school-age or adolescent children" (Lewis & Hammond, 1992, p. 194). Noted frequently in the literature are the psychosocial consequences and the affect of cancer on interpersonal relationships (Dunkel-Schetter & Wortman, 1982; Jevne, 1991).

For women, the complexities of their lives within families can influence their response to the illness. In traditional nuclear families, the woman's response to breast cancer may reflect a tension between her perceived expectations as a wife and mother and her own interest in health and well-being:

> The women's accounts indicate that family ties may be so emotionally complex that the added burden of a cancer crisis makes it difficult for some family members to offer help . . . we see women with breast cancer turn to each other for the support they cannot find elsewhere, even though they are strangers. (Kasper, 1989, p. 529)

The caring nature of the woman's social self may cause worry for her because of her greater sensitivity to the worries of those around her (Hobfall, 1986). This type of worry may affect the appraisal process of the woman. Reiss, Gonzales, and Kramer (1986) reported that the ill person in a family valued family harmony and lack of conflict and constrained their own communication in order to maintain harmony for the rest of the family. The complexities of individual response were demonstrated in this study.

Breast Cancer as an Illness

Breast cancer is the second leading cause of cancer death in women and the leading cause of cancer death in young women in the 40-55 year age group (American Cancer Society, 1996). An estimated 84,300 new cases of breast cancer will be diagnosed in 1996, with an estimated death toll of 44,300 (American Cancer Society). The incidence of breast cancer rose between 1982 and 1987 by about 4%

per year and since then stabilized at about 109.6 cases per 100,000 women (American Cancer Society). Though the incidence of breast cancer has stabilized, recent media attention to factors including the breast cancer gene, lack of progress by researchers in determining the cause of breast cancer, and activism about research and treatment creates a climate of apprehension for women with regard to a breast cancer diagnosis.

Overview of Relational Aspects of a Cancer Diagnosis

Notable in the literature reviewing the impact of cancer are both emotional strain with interpersonal relationships and also communication problems (Bean, Cooper, Alpert, & Kipnis, 1980; Dunkel-Schetter & Wortman, 1982; Friedman et al. 1988; Krant & Johnston, 1978; Lewis, 1986; Vachon et al., 1977). Bean et al. reported explicit concerns about open communication and others acting differently toward the patient after the cancer diagnosis. Open communication about the cancer and its consequences may alleviate emotional distress between partners. Vachon et al. reported that the discussion of the implications of cancer and the possibility of death made bereavement more manageable for wives.

The behavior of others toward the person with cancer also plays a role in the relational and communication patterns that emerge after the cancer diagnosis. Many people assume that they must act cheerful and encouraging in their dealings with the cancer patient. This may result in behaviors that are unintentionally harmful, including physical avoidance as well as avoidance of open communication, especially about the disease and its effects (Dunkel-Schetter & Wortman, 1982). Peters-Golden (1982) reported that over one-third of the breast cancer patients in her study were avoided by family and friends, which resulted in feelings of isolation and loneliness. Thus, those who interact with the patient may at times attempt to keep the conversation superficial and therefore avoid the topics that are really on the patient's mind. While the person interacting with the cancer patient may think he or she is being protective, the patient may interpret this as a sign that others are not really interested in his or her feelings (Northouse & Peters-Golden, 1993).

From these studies it is known that interaction and behavior in response to the cancer can be influenced by responses and reactions from family and friends. Coping processes used by the couple may be in response to the others' rather than one's own reactions to the diagnosis. Examining the complexity of these interactive responses entails a basic understanding of individual and family level responses as well. The next sections will provide an overview of individual and family level studies.

Individual Research and the Concept of Adjustment

The purpose of this section is to review the key concepts that have been studied at the individual level of analysis but not to provide an exhaustive analysis of the research in this area. Current literature emphasizing individual coping strategies, emotional distress, and adjustment needs to be re-evaluated in terms of its ability to offer substantive areas for intervention. Under the rubric of psychological functioning, research on women's reactions to breast cancer have centered on two general variables: adjustment and emotional distress. Commonly used tools to measure these variables include: Psychosocial Adjustment to Illness Scale (PAIS) assesses general psychological adjustment to illness, Profile of Mood States (POMS) assesses mood, Beck Depression Inventory (BDI) and Center for Epidemiological Studies-Depression Scale (CES-D) assess depression, State-Trait Anxiety Inventory (STAI) assesses anxiety, Symptom Checklist 90-R (SCL-90) and the Brief Symptom Inventory (BSI) assess psychological symptoms (Gotay & Stern, 1995).

What is known from studies done at the individual level of analysis is that women do experience depression, body image disturbances, and increased emotional distress after a breast cancer diagnosis. Early research studies examined these psychosocial variables as important aspects of the woman's response to the diagnosis of breast cancer and its medical management (Bloom, 1982; Lewis, 1983; Lewis & Bloom, 1978; Morris, Greer & White, 1977; Quint, 1963).

Later, specific reactions noted in the diagnosed woman such as depression, anxiety, uncertainty, and also the nature of coping strategies were examined (Bloom, 1982; Taylor, Lichtman, & Wood, 1984). The next wave of individual research determined relationships among these psychosocial variables and coping strategies. Both cognitive and behavioral escape-avoidance coping strategies were linked with higher emotional distress and poorer adjustment while more active strategies such as seeking support, focusing on the positive, and distancing were associated with less emotional distress and better adjustment in cancer patients (Dunkel-Schetter, Feinstein, Taylor, & Falke, 1992; Friedman et al., 1990). Friedman et al. (1988) reported avoidant coping to be related to poorer psychosocial adjustment compared to active coping which was associated with better adjustment as measured by the Psychosocial Adjustment to Illness Scale (PAIS). In a related study, Friedman et al. (1990) found that a "fighting spirit" was related to better adjustment, whereas avoidant coping was related to poorer adjustment.

The findings of these studies indicate that active coping and a fighting spirit lead to more effective adjustment and less emotional distress. A simple relationship between these variables and factors such as type of cancer, time since diagnosis, and treatment regime has not been confirmed. In fact, several studies have reported that psychosocial variables are not related to these illness variables (Dunkel-Schetter et al., 1992; Hannum, Giese-Davis, Harding, & Hatfield, 1991; Pistrang & Barker, 1995).

Using terms such as active and avoidant coping, adjustment and emotional distress may be more reflective of the instruments that are used for measurement rather than the actual processes occurring for the individual. This terminology is included here because of its prevalence in the literature.

Family Research Studies

Wellisch (1981) and Lewis (1983) described the impact of the breast cancer diagnosis for the family as a whole and the importance of studying the entire family. The illness demands that accompany a cancer diagnosis can be overwhelming to both patient and family (Lewis, 1993; Lewis et al., 1985; Lewis, Hammond, & Woods, 1993). Studies have examined the partner's, children's, and family's functioning in a family living with a breast cancer diagnosis in the mother (Armsden & Lewis, 1994; Lewis, 1986; Lewis et al., 1993; Lewis, Woods, Hough, & Bensley, 1989; Loveys & Klaich, 1991; Northouse, 1992; Stetz, Lewis, & Primomo, 1986; Wellisch; Zahlis & Shands, 1991), and also spouse and marital adjustment as variables that impact an individual's coping and adaptation (Lewis et al., 1989; Northouse, 1990; also see Northouse, 1995 for a review; Wellisch, Jamison, & Pasnau, 1978; Zahlis & Shands).

Variables that have been measured in relation to family functioning are the perception of illness demands, marital adjustment, depressed mood, and the family's introspective coping behavior (Lewis et al., 1989). The coping behavior of family members can have a documented effect on the level of functioning of the household including the dyadic relationship between the woman and her partner (Lewis et al., 1993). The more frequently the family coped with their problems, the higher the level at which the family functioned (Lewis et al., 1989). Lewis et al. (1993) reported that marital quality as measured by the Dyadic Adjustment Scale was significantly associated with family members' coping behavior: "When the marriage was less well adjusted, it negatively affected the family's coping behavior. Household functioning was positively affected by heightened coping activity and by higher levels of marital adjustment" (p. 1). The Familial Introspection subscale of the Family Coping Inventory (F-COPES) scale significantly predicted higher quality in the parent-child relationship as well as higher levels of family functioning as measured by Family Adaptation and Cohesion Evaluation Scale (FACES) (Lewis et al., 1989). In addition, "introspective coping behaviors were used more frequently by families in which the woman experienced high marital adjustment but depressed mood than by families in which the woman was not depressed but experienced marital difficulties" (Lewis & Woods, 1995, p. 135). It can be concluded that family coping and the ability to use introspective coping may be valuable to family functioning and the overall adjustment of the dyad. The woman's depressed mood may signify appropriate response to the breast cancer in light of supportive relationships. The family's coping strategies can be a predictor of relationship quality and overall family functioning in families struggling with the impact of breast cancer.

Stetz et al. (1986) described ten coping strategies that families develop for dealing with either non-metastatic breast cancer, fibrocystic disease, or diabetes. The three most frequently reported coping strategies are "alterations in household management," "seek assistance from outside of household family," and "mobilize household family to take action"; these strategies accounted for 70% of strategies reported by families for coping with their specific problem (p. 518).

Northouse (1995) reported that women were more depressed than their husbands and that the woman's and man's depression scores were significantly correlated. Also, husbands who reported more illness-related demands had higher levels of depression; husbands who reported more uncertainty, more hopelessness, and greater symptom distress in their wives had higher levels of emotional distress.

From these research studies we know that both individual and family coping behaviors are related to adjustment and adaptation. What is not known are the factors or elements that contribute to these coping behaviors or whether the coping behaviors have an important impact on physical health outcomes of the diagnosed woman or her partner.

Dyadic Processes Research

Researchers are beginning to examine the partner relationship for specific processes with which the couple as a unit negotiate the breast cancer diagnosis (Germino et al., 1995; Hannum et al., 1991; Hilton, 1996; Hoskins, 1995; Lewis & Deal, 1995; Northouse, 1995; Pistrang & Barker, 1995). A beginning set of studies focused on the meaning of the cancer to the relationship and the processes which couples use to manage daily life. Germino et al. observed that the specific process of defining the meaning of the illness to each person, not necessarily a convergence of meaning but an openness to sharing, may be an important aspect of the recovery process. Lewis and Deal analyzed interviews from couples with recurrent breast cancer and determined the processes used to manage daily life. They reported that one or both members in 60% of couples scored outside the normative range on either depressed mood or marital adjustment. In addition, the couple's management of the recurrence through "avoidant strategies" and "illusions" may facilitate their behavioral functioning but not necessarily enhance their mood or marital quality

(Lewis & Deal, p. 952). Hilton reported extensively on the family process of "normalizing" as a strategy to manage everyday life in response to early stage breast cancer.

Hannum et al. (1991) noted that "interpersonal variables are equal to, or more important than, individual variables in the effectiveness of coping" (p. 1). They determined that the husband's coping behaviors and ratings of the relationship were the best predictors of the wife's psychological distress. Pistrang and Barker (1995) determined that satisfaction with the partner's ability to provide support was associated with higher psychological well-being. They also noted that women with male partners appeared more distressed than women without male partners on five of the six variables that measured distress. Northouse (1992, 1995) examined the impact of cancer on the family and compared the distress levels of women and male partners. In the most recent study this research team found a significant relationship between the level of distress reported by women and that of her partner. Hoskins (1995) reported the husband's level of emotional distress as one of the strongest predictors of his wife's.

Summary

Response to breast cancer was initially studied from the perspective of the woman and her partner, individually. Subsequently, a group of studies incorporated family functioning as measured by the FACES, family coping as measured by the F-COPES and the Familial Introspection subscale of F-COPES, and marital adjustment as measured by the Spanier Dyadic Adjustment Scale, as important factors to the research in households experiencing a breast cancer diagnosis. A recent group of studies examines factors within the dyadic relationship and relational coping processes in response to illness.

The couple coping processes set the tone for the adaptation of the entire family. Both person and situation factors contribute to the development of these coping processes. Studies examining these factors have been primarily quantitative using researcher generated hypotheses driven by tools that may lack the level of abstraction necessary to determine the development of dyadic processes.

Statement of the Problem

Breast cancer as a stressor is considered a major life event which requires physical as well as psychological response. The initial diagnosis is thought to produce a crisis response to a potentially life-threatening situation. After that, the course of recovery poses more complex and long-term challenges such as the incorporation of an altered self-image and the derivation of personal meaning from the experience.

The stress of decision making, together with the inevitable uncertainty regarding the outcome of the decisions, can precipitate behavioral and emotional responses that reflect the feelings of fear, sadness, and anger in the individual (Jevne, 1991; Lewis & Bloom, 1978; Northouse, 1995).

Research examining the adjustment of the individual uses measurement tools that regard a person's response to a stressor or illness without regard for the context in which the response occurs. A common expression is that it is unfair to quote a passage "out of context" (Webster's New World Dictionary, 1968, p.319). Yet, this is precisely what is done in research studies that measure depression, anxiety, emotional distress, or adjustment to the diagnosis of breast cancer without consideration for the context in which the response occurs.

Adjustment and emotional distress as end points need to be reconsidered. Research, at the individual level of analysis, defines and labels women's response based on an arbitrary standard whereby women are classified and labeled according to their psychosocial adjustment. There is usually "an assumed, unclarified standard of 'normality' of reaction" (Rosser, 1981). The various models used in the recovery literature act to generate data that will confirm or reject the specified model so that the researcher is generating data that is useful to verify the specified model. The model for recovery becomes a hypothetical standard to be emulated rather than an individualized plan that would be appropriate for each woman within the context of past and current development.

Central to women's development is women's relational sense of self, the relational path of women's development, and the importance of empathy or responsiveness in relationships. "Women's sense of self becomes very much organized around being able to make and then to maintain affiliation and relationships" (Miller, 1976, p.83). For women, the self is organized and developed in the context of important relationships. Women's self-esteem develops on the basis of feeling part of and taking care of relationships (Surrey, 1991). Understanding women within family relationships is a crucial aspect of women's recovery. Isolating women's responses will lead to an inadequate picture of their adaptation.

Family functioning and coping are global variables which may obscure the processes of individuals and couples as defined by measurement tools currently in use. The balance and tension between the woman's, dyad's, and family's needs during the breast cancer recovery needs further examination.

Coyne, Ellard, and Smith (1990) suggested that examination of coping and support processes would have proceeded in a much different direction had it not been for the easy accessibility of tools designed to measure these processes:

> The necessity of theorists and researchers having some understanding of the experience of people grappling with stress in their close relationships may seem to be diminished by the availability of measures as substitutes. Yet, if

> we temporarily suspend our confidence that our measures and theoretical concepts are mirror images of the most crucial features of their daily lives, and if we allow our respondents to talk about themselves without being constrained by our theoretical frameworks or categories, we may begin to learn about how much we have been missing. (Coyne et al., p. 132)

Interpersonal relationships are an important context for recovery and negotiation of the illness experience. The interpersonal relationships that most impact the recovery of the diagnosed woman are those with her family and close friends.

What is needed now is a better understanding of the individual and dyadic processes that occur within the partner relationship, a long-range goal being correlation of these with physical and psychosocial health outcomes. The purpose of the present study is to extend the line of research focusing on the partner relationship by examining the development of couple processes that may impact the affective and behavioral responses of a woman to the diagnosis of breast cancer. A qualitative research study is indicated to examine the nature of the processes that develop between the woman and her partner.

Specific Aims

The specific aims of this research study are to:

1. Identify the interactive processes that develop within the couple relationship in response to the diagnosis of breast cancer.

2. Develop an initial theoretical explanation of how these processes may affect a woman's emotional and behavioral response during her recovery from breast cancer.

CHAPTER II

Conceptual Framework

Literature based concepts or themes are frequently included in the interpretive research study in order to explicate the perspective of the researcher. A guiding conceptual framework, explicit or implicit, influences the research project from the methodological approach to the report and discussion of the findings. The framework basic to this study concerns individual, dyadic, and family response to a non-normative transition, the diagnosis of breast cancer. I examined symbolic interactionism, a sociological theory, and dyadic coping, a psychological construct, to determine the most appropriate conceptual frame for this study.

Initially, I examined symbolic interaction, a sociological theory, as a frame for the research study. A basic tenet of symbolic interaction theory, that the actor "constructs his actions" based on inner deliberation, in order to cope with or otherwise confront a given situation, is useful to this study (Blumer, 1969). Another attractive feature of symbolic interaction theory is its implicit incorporation of context as a frame for meaning making. Other assumptions inherent in symbolic interaction theory--joint action, agreed upon realities, and equal contributions by each person to the construction of meaning--did not contribute to the frame for the research. Most importantly, symbolic interaction theory regards human beings as purposive agents. Cooley "noted that it is chameleonlike for a person to be interested only in the response of others and that a 'healthy' person is confident enough to pursue self-initiated and identity-confirming lines of action, as well as to resist behavior that violates personal principles or values" (as cited in LaRossa & Reitzes, 1993, p. 147). Prematurely assuming that agency, as active form of self, is an inherent individual characteristic may lead to faulty conclusions in empirical findings.

I began to examine stress and coping models because of the frequency of their use in the psychosocial oncology literature. Individual, dyadic, and family coping models were examined. An integrative approach emphasizing interactive coping as the context for the individual's response best captured the bi-directional yet separate response to the breast cancer diagnosis. A set of concepts as identified from the stress and coping literature are described in the next section.

Coping as a Process

Coping is one variable that is thought to influence recovery or adaptation to stressful events. Coping is defined as "constantly changing cognitive efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus & Folkman, 1984). Using this definition much of the literature emphasizes the individual and his or her cognitive and emotional processes. However, as Spiegel (1995) notes, "Coping has been studied in individual isolation. The interaction between social support and coping has received far less attention" (p. 116).

Interest has centered around the concept of coping as a mediator between stressful events and outcomes (Folkman, 1992; Somerfield & Curbow., 1992). Lazarus and Folkman (1984) proposed a transactional approach to coping which is defined as "the person and the environment in a dynamic, mutually reciprocal, bi-directional relationship" (p. 293). Furthermore, they theorized that a distinguishing feature of the transactional model that makes it different from the concept of interaction is: "Transaction implies a newly created level of abstraction in which the separate person and environment elements are joined together to form a new relational meaning" (p. 294). It is the new level of abstraction created by the transactional approach which accounts for the joint effects of the person and the environment.

Lazarus and Folkman's (1984) classic work is the basis for other models of coping which include factors that expand the original individualistic focus. Dyadic coping includes variables that develop interactively or within a relational context (also referred to by various authors as interactive coping [Barbee, 1990], interpersonal coping [Carpenter & Scott, 1992], or relationship-focused coping [Coyne & Smith, 1991]). Family coping is a concept aimed at the description of the entire family's coping behavior (Block, Brandt, & Magyary, 1994; McCubbin & Patterson, 1982; Stetz et al., 1986). Despite the interest and steady increase in coping research, little is known about "the mechanisms through which coping mitigates the harmful physical and psychological effects of stress" (Folkman, 1992, p. 32).

Individual Coping

Central to the transactional model of coping are the cognitive appraisals that are made when a person is faced with a stressful event. Coping at the individual level concerns the stressor which signals primary appraisal, a process by which the person determines the threat or loss that the event poses. Secondary appraisal involves the evaluation of resources for dealing with the event. Subsequently, the person engages in problem- and emotion-focused coping, and optimally develops a positive adaptational outcome: "The prime importance of appraisal and coping processes is that they affect adaptational outcomes. The three basic kinds of outcome are: functioning in work and social living, morale or life satisfaction, and somatic health" (Lazarus & Folkman, 1984, p.181).

Dyadic Coping

Coyne and Smith (1991) concluded that "coping is best conceptualized as a thoroughly dyadic affair" (p. 405). "So much of what people do involves interaction with others; hence, interpersonal functioning has the potential to be of great importance in the stress-coping response" (Carpenter & Scott, 1992, p. 93). The tasks or issues that coping entails are shaped by the partner relationship and by what each partner does as well as how the other responds. Furthermore, the process of interpersonal or relational coping significantly impacts how the illness event unfolds and what reverberations take place within the family's life (Coyne et al., 1990).

Theoretical models of dyadic coping have been proposed. Carpenter and Scott (1992) proposed the "**interpersonal model of coping**" (p. 104). "Given identical situations, people will respond differently depending upon the social context in which the stressor occurs" (Carpenter & Scott, p. 97). Their model focuses on the appraisal process in dyadic coping. Important are personal and environmental resources that lead to beliefs about oneself and about others. "These beliefs provide the context in which cognitive evaluation of potential stressors occurs" (Carpenter & Scott, p. 105). In their model, how a couple copes with a stressor will be determined by **relational competence** (the interpersonal skills of the individual) and **perceived support** (what others do for us). These lead to **beliefs about the self and others**, cognitive appraisal, and individual coping strategies activated by the appraisal process. The coping strategies of each individual reflect the beliefs and attitudes about the self as well as about the cancer and its treatment. Coping, then, involves taking an inventory of personal and interpersonal resources and best using them to manage the stress response.

Barbee (1990) identified the "**interactive-coping circumplex**" which focuses on dyadic coping behaviors. She integrated the problem- and emotion-focused personal coping identified by Lazarus and Folkman (1984) with the concepts of approach and avoidance coping identified by Roth and Cohen (as cited in Barbee, 1990). Problem-focused coping consists of direct action to the circumstances which have been appraised as threatening; emotion-focused coping consists of cognitive or affective strategies to manage the emotional response to the threatening circumstances. Approach and avoidance involve the ways that individuals address a stressful situation for the purposes of self-protection. Problem- or emotion-focused coping is crossed with approach or avoidance coping. The resulting two-dimensional interactive-coping typology includes: **solve** (problem-focused/approach dimension), **support** (emotion-focused/approach dimension), **dismiss** (problem-focused/avoidance dimension), and **escape** (emotion-focused/avoidance dimension).

Barbee (1990) hypothesized that dyadic level coping involves protecting or managing one's own emotional experience while helping to manage the problems and emotions of the person in distress. When the helping partner aids the distressed partner in dealing with the problem through the use of "solve" behaviors or tries to help with negative feelings through the use of "support" behaviors, the distressed partner will feel better. On the other hand, if the helping partner avoids or minimizes the situation or encourages the distressed partner to avoid or minimize through the use of "escape" or "dismiss" strategies, the distressed partner may remain depressed or become worse: "Ways of coping with a threat to one's own well-being such as minimizing or escaping may not be helpful to the other person" (Barbee, p. 50). Although this typology was developed through observations in a healthy college student population, it may serve as a heuristic to guide the understanding of dyadic coping processes in response to a serious illness.

Coyne and Smith (1991) defined "**relationship-focused coping**" as "grappling with each other's presence and emotional needs" (p. 405). They identified two broad classes of relationship-focused coping behaviors: **active-engagement** and **protective buffering**. "Active engagement is a matter of involving the partner in discussion, inquiring how the partner feels, and other constructive problem solving" while "protective buffering is a matter of hiding concerns, denying worries, and yielding to the partner to avoid disagreements" (Coyne & Smith, p. 405). They noted that relational coping can be a source of potential conflict for the individual in that "what is efficacious in reducing one's own distress or dealing with an instrumental task may be counter to what is needed to deal with a relationship, and vice versa" (p. 405). Coyne and Smith identified the key question in dyadic coping: "How does one contribute to the partner's well-being, avoid unnecessary conflict, and yet look after oneself, balancing concern for the partner with one's own needs?" (p. 405). Investigating the nature of this process and the competencies involved is an important step to extend the knowledge base in this area.

Family Coping and Family Functioning

Family coping is a global level concept based on family systems theory; as such it provides an overview of the importance of balancing the individual and the family but may not allow for identification of the discrete processes important to coping. Family coping refers to the efforts used by the family in response to a defined stressor. Family coping is a process that involves balancing the family system with individual growth and development (Stetz et al., 1986). Family homeostasis is maintained when the coping strategy of the family promotes overall adaptation permitting optimal family functioning (McCubbin, Caubie, & Patterson, 1982). Olson and McCubbin (1982) conceptualized family functioning as having the key dimensions of adaptability and cohesion. Cohesion is the family's ability to interact as a unit while adaptability refers to the family's ability to adopt new ways of operating (Olson & McCubbin).

These efforts to conceptualize family coping and adaptation have been useful in addressing the impact of illness on the family as a whole as well as beginning to identify family coping behaviors which impact family functioning and marital adjustment. Further refinement may be necessary to more fully understand the discrete coping behaviors that the couple use to improve their outcomes. For example, introspective coping behavior, in particular, significantly predicted better adjusted marriages in households with mothers diagnosed with early stage breast cancer (Lewis et al., 1993; Lewis & Hammond, 1996). Introspective coping behaviors are ones in which family members provide feedback to each other in managing their problems, review and adjust their goals, and alter how they work together: "These behaviors are introspective because they are self-reflexive and represent the family members' self-monitoring and review of their own behavior and future activities" (Lewis & Hammond, 1996, p. 458). Block et al. (1994) have identified "family organization" and "relationship building" as coping strategies used by families to respond to illness of a family member (p.10).

Stetz et al. (1986) claim that more research is needed "in order to understand the internal processes utilized by families to handle problems and challenges" (p. 521). This addresses the essence of the problem with family coping models. The global nature of identified factors such as adaptability and cohesion, for example, may obscure the nature and mechanisms of the internal coping processes that develop in the couple.

The remainder of this chapter will provide an overview of factors hypothesized to impact the development of the dyadic coping processes: nature of breast cancer as a stressor; person factors (agency and women's self-in-relation); situation factors (perceived support and relational competence); and psychophysiologic processes.

Context for Coping

Recently, coping has been conceptualized as occurring within a context or a frame that influences an individual's coping (Eckenrode, 1991). The context of coping is influenced by macro as well as micro influences. Coping with breast cancer can be influenced by decisions about medical treatment, provider relations, media attention, and lay publications among other things at the macro level.

At the level of the family context the nature of each individual family member's reactions and relationships contributes to the way all family members respond. Coping strategies are usually carried out within the context of interpersonal relationships. This family context creates and is created by the individual members of the family. The relational aspects of coping may impact women more than men. Therefore, it is important that breast cancer response be placed in a context.

Primary Appraisal: Nature of the Breast Cancer Diagnosis as a Stressor

The nature of a breast cancer diagnosis can be quite unsettling to a woman and her family, both because of the psychological impact of the diagnosis and also the resulting treatment decisions which must be made within a short period of time. The aspects of cancer which increase the likelihood of psychological complications are: a silent onset, delayed diagnosis perceived by many as a death sentence, treatment over long periods of time, multiple losses which include body image changes, and the uncertainty within the recovery phase (Dunkel-Schetter & Wortman, 1982; Jevne, 1991; Lewis, 1993). A notable feature of cancer is that it is not usually a single event but a series of transitions that may last over several years (Lewis, 1993).

Person Factors: Agency and Communion

Individuals first make a primary appraisal to determine the nature of what is at stake. Secondary appraisal follows in which the individual determines what can be done and whether the resources, skills, and support are available. "Secondary appraisal activity is a crucial feature of every stressful encounter because the outcome depends on what, if anything, can be done, as well as on what is at stake" (Lazarus & Folkman, 1984, p. 35). Secondary appraisal, so defined, is a crucial component in response to a diagnosis of breast cancer. The woman, in a family, with a breast cancer diagnosis may feel a need to consider her family before herself. As Kasper (1989) noted, women in families may feel a bifurcation between their families' needs and their own need to take charge of their health. Women reported difficulty in relying on their partners for support when they were "falling apart too" (Kasper, p. 529).

Person factors are thought to influence the coping process. At the level of secondary appraisal, person factors will help a person determine the course of action in response to a stressor. There are many person factors that may be regarded as important to the coping process. I have selected the concepts of agency and communion as a focus for the appraisal and coping behaviors. These are concepts that have been connected to physical and psychological well-being (Helgeson, 1994). Agency is the focus on self and forming separations. Bakan defined communion as the focus on others and forming connections (as cited in Helgeson, 1994), much like the women's self-in-relation, a concept that addresses women's unique development. Both agency and communion are required for optimal well-being. However, when one exists in the absence of the other, negative health outcomes may occur (Helgeson). Women and men can possess features of both agency and communion; however, in our society it is more likely that men are characterized by agency and women by communion (Helgeson). A balance needs to be achieved between concern with self (agency) and focus on others (communion). This balance may be difficult to achieve for women if they have been conditioned to focus on others. It may also be difficult for men if they are conditioned to focus on self. By definition, one extreme precludes the other.

Women's Self-in-Relation

The tendency to individualize women's reactions rather than looking to the context or environment in which they act results not only in victim blaming but also in undervaluing socio-cultural and historical aspects of women's experience. For many years research was genderless, that is, all concepts and theories that were tested were subsequently reported and generalized as if they pertained to both men and women. Later, it became obvious that research being done, in many fields, was being done by men with men as the primary participants, and then inaccurately generalized to women. Many aspects of the uniqueness and differences pertinent to women, their bodies and health, were overlooked. In addition, it is only recently that context--the social, political, and cultural environment in which women live--has been a consideration in discussions of women's health (Jack, 1991; Personal Narratives Group, 1989).

Women can become silenced in their interactions with family members depending on their own agency or sense of power (Jack, 1991; Personal Narratives Group, 1989) and on the need to maintain an important relationship. Jack describes women who adopt the culture's gender rules, those that prescribe "that a woman respond to a man's emotional and physical needs and that she hide her own strengths" (p. 59). "If a woman presents an inauthentic version of herself to the person with whom she lives most intimately, she may begin to feel a loss of her own self" (Jack, p. 60). Some women and their male partners may be creating this context inadvertently. Based on a need to preserve the relationship, normal for women's development, her behavior and inauthenticity may be confusing to her partner as well. The silencing of the self may be particularly detrimental to the woman but may be felt by both partners in a relationship.

The women's self-in-relation model is pertinent to breast cancer recovery in several ways. Women will be concerned about the impact of the breast cancer on their spouses and children. They may respond to the diagnosis on the basis of their family's needs rather than on the basis of their own needs for recovery. The number of stressors that need to be dealt with, including body image changes and self-esteem difficulties, may cause the woman additional worry about her relationship with her partner. These concerns will most likely impact the secondary appraisal process and the development of the woman's coping strategies and the couple processes. The coping strategies that are used by women contribute to the creation of the couple processes just as the couple processes that develop create a context for the woman's sense of the support from her partner. A woman considers her personal relationships, social support, and the reactions of other family members before making her own decision about the coping strategies she employs.

Situation Factors and Secondary Appraisal

A question posed by Butler (1995), "What are the concrete conditions under which agency becomes possible?" (p.11), is important when the stressor of an illness is introduced. Those women diagnosed with breast cancer who have not been conditioned to focus on self may have difficulty turning the focus to self for the first time. On the other hand, they may realize a need to do just that.

Situation factors include the context within which the appraisal takes place. The uncertainty and ambiguity of the nature of this type of stressor certainly influences the appraisal. As well, the appraisal of each spouse may be different with regard to their appraisal of the situation. Carpenter and Scott (1992) identified social support and relational competence as situation factors important to dyadic coping. The medical context also creates situation factors which can be additional stressors on top of the diagnosis.

Social Support and Relational Competence

Before individual coping strategies are employed, an appraisal is made of the situational or contextual factors. It is not the intent of this section to discuss the social support literature in detail. It is important to note that we know social support is important but the mechanisms by which it works have not been thoroughly understood. Perceived support is one factor thought to influence the coping process. Perceived support necessitates that the recipient of the support feels that support has been given. Barbee (1990) hypothesized that factors which help or hinder the helper in his or her attempt to deal with the recipient's problem are also important in the interactive coping process.

Relational competence is thought to be important to the stress and coping process because it emphasizes competencies needed during difficult times and contributes to the quality and effectiveness of relationships which are sources of support during the stress of illness (Carpenter & Scott, 1992). Relational competence is defined as those skills which contribute to the acquisition, development, and maintenance of a close relationship (Hansson & Carpenter, 1990).

As well, a large proportion of coping takes place within an interpersonal context; those most effective will have greater coping options (Hansson & Carpenter).

Psychophysiology of Marital Interaction

Research studies have documented a relationship between exposure to stressful life circumstances and immune system functioning. Major stressful life events such as bereavement and caregiving in Alzheimer's disease have been found to produce immune system changes (Fawzy et al., 1990). The quality and nature of the identified stressor is reported to influence immune system functioning. A recent meta-analysis by Herbert and Cohen (1993) evaluated both the nature and the duration of stress experiences and immune function. The results of the analyses show substantial evidence for a relation between stress and decreases in functional immune measures. Stressors were differentiated as objective vs. self-report and interpersonal vs. nonsocial. Both objective events and long-term interpersonal events resulted in substantial impact to immune system function. Greater immune alteration occurred with events defined as long-term objective and interpersonal stressors. The specific immune alterations that were sensitive to these stressor characteristics were NK cell activity, the helper: suppressor ratio, and the percentage of suppressor/cytotoxic T cells (Herbert & Cohen).

Marital interaction is an important context for physiologic reaction (Ewart, 1993; Kiecolt-Glaser, Malarkey, Chee, & Newton, 1993). Marital interaction involves interpersonal stimuli that are highly significant to each member of the couple and could be important to physiological processes (Notarius & Herrick, 1989). Self-disclosure is one variable associated with enhanced immune system functioning (Notarius & Herrick; Pennebaker, Kiecolt-Glaser, & Glaser, 1988). Other research has focused on examining negative behavior and hostility in the marital dyad and measuring the individual's cardiovascular and immune response. They concluded that "psychological distress and stressors (i.e. negative life events, both acute and chronic) are reliably associated with changes, that is, downregulation, in immunity" (Kiecolt-Glaser et al., p. 389).

Immune function, then, is influenced by the nature and quality of the stressor and also by marital interaction as a context for coping with the stressor. Self-disclosure as well as negative or conflictual behavior impacts the immune system. Fawzy et al. (1990) reported the effectiveness of an experimental psychosocial intervention which produced statistically significant immune system enhancement in the intervention group of melanoma patients.

Summary

A stress and coping framework was identified as an appropriate frame for the study. Coping, as a mediator between stressful events and outcomes, is one variable that has received a great deal of attention in the psychosocial oncology literature. Less attention has been paid to the social context in which coping takes place. Yet, coping and adaptation to stress often depend on the interpersonal component because coping responses are not carried out in isolation. Both person and situation factors influence response to stress and adaptational outcomes.

Person or individual factors interact with situation or contextual factors to influence the appraisal, coping, and adaptation process. The ability to balance agency and communion is important to each individual family member: "Families and individuals continually negotiate the twin demands of autonomy and connectedness across the stages of individual and family development" (Benson & Deal, 1995). Balancing individual and dyadic needs can be especially difficult during recovery from illness. Each partner will have the dual responsibilities of managing their own problems and distress while helping the other manage his or her problems and distress. Interpersonal coping processes will influence individual response.

Dyadic processes impact the recovery process in women and their male partners. The concepts identified here about the individual factors and the dyadic coping process will serve as sensitizing concepts that guide the interpretive data analysis.

CHAPTER III

Methodology

The study aims call for an inductive methodology within a family qualitative research paradigm. The development of the data analytic strategies were guided by the aims and framework of the study and orientation of the researcher. One of the aims of this study was to determine the couple processes that develop in response to a breast cancer diagnosis. A stress and coping framework is not normally associated with inductive methodologies but more commonly with tools deemed appropriate for measuring coping response. For the purpose of effectively bridging individual and dyadic coping, several methods were integrated in order to enhance the data analysis. Data analytic strategies from sociological and nursing research based on symbolic interactionism (Strauss, 1987; Strauss & Corbin, 1990), analysis of the everyday patterns and interactions of people from educational research methods (Bogdan & Biklen, 1992), and an interpretive approach for contextualizing the analysis (Denzin, 1989) were all employed to meet the aims of the study. Within this frame, a triadic analysis of the individual, the dyadic process, and contextual factors was undertaken with case intensive interview data obtained from 15 couples in a family study of reactions to breast cancer.

Qualitative Family Research

Broadly speaking, qualitative family research allows the researcher to pursue in-depth information about family interaction as well as perceptions, understandings, meanings, and experiences of family members; it may involve redirection of or modifications to existing research. No one approach to qualitative family research is universally recognized as correct (Gilgun, Daly, & Handel, 1992; Rosenblatt & Fischer, 1993). Similarities, though, include gathering data from two or more participants who speak through words or other symbols about family experiences and dynamics. In addition, it allows for an in-depth look at a smaller group of people. Benson and Deal (1995) note the value of the case-intensive examination of family data in order to discover the processes by which families respond to the normative or non-normative transitions of their lives.

Streubert and Carpenter (1995) outline six unique aspects of qualitative research. Each one represents a guiding principle in this study. The six principles are: a belief in the idea that multiple realities exist and create meaning; commitment to identifying an approach to understanding that will support the phenomenon studied; commitment to the participant's point of view; conduct of inquiry in a way that does not disturb the natural context of the phenomena of interest; acknowledged participation of the researcher in the research; conveyance of the understanding of phenomena by reporting in a literary style rich with participant's commentary.

Dyad as Unit of Analysis

Thompson and Walker (1982) suggest the following as essential characteristics of research when the dyad is the unit of analysis.

> 1) The problem is conceptualized at the level of the relationship--the pattern between two people. 2) The sample of participants is contingent upon involvement in representative relationships, although one or both members may be chosen as informants. 3) Regarding measurement, one or both members of a relationship may be assessed on self, other, and/or the relationship. 4) The analysis is interpersonal or interdyadic, providing information about the pattern between individuals or between relationships. 5) Interpretations of the data and implications refer to the relationship between two people. (p. 890)

Although these principles were constructed for the "quantitative" researcher, the authors acknowledge the importance of "qualitative endeavors to study the dyad" (Thompson & Walker, p. 889).

Study Design

The current study was part of a larger longitudinal study which included multiple occasions of data collection from women with early stage breast cancer, their male partners, and at least one dependent child (children's data were not used in this portion of the study). The design of the larger study, the Family Home Visitation Study (FHVS) (see Appendix A), was an experimental longitudinal intervention study. The FHVS included four intervention sessions during which time the session was tape-recorded. In addition, these same families completed sets of self-report questionnaires at entry into the study, immediately at exit, and at three and six month follow-up. The data for this study originated from couples in the intervention arm of the study during the initial relationship building visit. Case-intensive interview data were collected by either nurse clinician interviewers or by a certified mental health counselor.

Specific elements of the FHVS were: recruitment took place through nurse-intermediaries working in clinics and physicians' offices in a major northwestern city; women were invited by an intermediary to participate in a study about "families and breast cancer"; couples were approached over the phone by the project manager for potential participation and an at-home interview was scheduled.

Target Sample

From the FHVS sample of 87 couples, a purposive sample of 15 couples was selected for the current study using the Center for Epidemiologic Studies Depression Scale (CES-D) as a screening measure of the woman's and partner's mood and affect. The CES-D is a self-report measure of the frequency in which symptoms of depressed mood are experienced. The 20 items on the measure represent the major symptoms in the clinical syndrome of depression. It was thought that three ranges of scores on the CES-D would represent affective responses of women in three groups: non-depressed (scores below 10), mid-range (scores 10 to 15), and depressed (scores of 16 or higher). In all cases the partner's score was in the non-depressed range (lower than 16). Inclusion criteria for study participants were: diagnosis of breast cancer within 12 months; English speaking; in a partnered (heterosexual) relationship; and having at least one dependent child (see Appendix D for a summary of demographic data).

Context for Data Collection

The context for data collection is described here because of the sensitive nature of breast cancer and disclosure of information about intimate relationships that took place in this study. Several factors contributed to create the context for data collection. Interviews were conducted in the family's home with skilled clinician interviewers (all female). A semi-structured interview format with open-ended questions was used to elicit information about the individual's and couple's reactions and responses to the diagnosis and treatment of breast cancer. Appendix B contains the structured interview questions for each of the four interviews that occurred during the visit to the family's home. To begin, an interview was conducted with the couple by paired interviewers (first couple interview, see Appendix B). This lasted approximately 20-30 minutes. The wife and partner were each interviewed separately by their own interviewer (woman's interview [2A] and man's interview [2B], see Appendix B) which lasted approximately 30 minutes. Subsequently the couple was interviewed again together by both interviewers (second couple interview, see Appendix B). There was quite a time range in the final interview lasting anywhere from 5 to 60 minutes. Four interviews were conducted with each of the 15 families selected for the current study (a total of 60 interviews).

Interviewing the couples in their homes created a naturalistic setting. The interviewers were skilled at following up with leads that were provided by the couple about their reactions to breast cancer. This enhanced the richness of the interview data.

Data Analytic Strategies

A three-phase process was used to analyze the transcribed interview data. Specific coding and analytic strategies were selected for each phase in order to better understand the interactions and patterns of the individual and the dyad. These are summarized in Table 1.

TABLE 1. Summary of Methods

INDIVIDUAL	DYADIC	CONTEXTUAL
Orienting to the phenomenon of the individual	Orienting to the phenomenon of the dyad (woman and partner)	Orienting to the phenomenon of the context
Open coding of individual interview data, identification of initial categories, using emic labels (Lewis, Haberman, & Wallhagen, 1986; Strauss, 1987; Strauss & Corbin, 1990)	Open coding of couple interviews, coding schema of patterns and everyday interactions, emic and etic labels to identify processes (Bogdan & Biklen, 1992)	Contextualizing the individual behaviors and the couple's processes (Denzin, 1989)
Axial coding and construction of processes occurring at the level of the individual	Construction of dyad processes, constant comparative analysis	

The following is a list of the steps in the data analysis:

Step 1: Transcription of interviews.

Step 2: Verification of transcribed data with audio-taped interviews by a trained professional transcriptionist.

Step 3: Overview and reading through of all interviews multiple times.

Step 4: Open coding and axial coding of each individual interview (data from interview 2A and 2B).

Step 5: Coding according to Bogdan and Biklen (1992) schema and analysis of couple interviews both within and between couples (data from interview 1 and 3).

Step 6: Identification of processes from open and axial coding of individual interviews and from the coding of couple interviews within and across couples.

Step 7: Identification of individual and dyadic processes.

Step 8: Contextualizing--placing the data analysis within the overall context.

Step 9: Determination of explanatory phenomenon from individual, dyadic, and contextual processes.

After the interviews were transcribed and verified by a trained professional transcriptionist, the first step in the data analysis was to read over the first couple interview focusing on the responses and interactions of the couple with the interviewer as well as to the breast cancer. It was important for me to have an overall sense of the interview data since I did not conduct the interviews. Similarly, the other interviews 2A, 2B, and 3 were read for the purpose of "orienting to the phenomenon" of individual and dyad, a technique recommended by Hartrick and Lindsey (1995).

Data Coding and Analysis

Individual methods, as outlined in Table 1, were used to code sequence 2A and 2B interview data. These strategies pertain to analysis of the individual's data; both open and axial coding were employed (Strauss, 1987; Strauss & Corbin, 1990).

A line by line analysis was conducted with a discrete data unit consisting of an interaction or strategy that the individual reported they used to respond to the breast cancer, the partner, or to the family. Open coding is the process of breaking down the data into small conceptual units and then examining, comparing, conceptualizing, and categorizing them (Strauss & Corbin). Whenever possible, units of analysis were the exact words of the participants (emics). The coding was limited to those specific instances in which the participant discussed their reactions to the cancer, the partner, or the family and did not include discussion of physical symptoms, fear of recurrence, provider relations, and questions about future risk, other areas mentioned by participants.

Axial coding was used to bring together the units of analysis identified in the open coding. The discrete happenings coded initially were put together in new ways by making connections between categories (Strauss & Corbin, 1990). The coded data units were also compared with each other within each category. By doing this it was possible to build up a dense texture of relationships by laying out properties of the category, that is, by explicitly or implicitly dimensionalizing it (Strauss, 1987). The categories were identified and compared to the discrete data units until they were all accounted for.

When the individual data analysis was completed, dyadic methods were used to code the data. This consisted of coding the couple data from interviews 1 and 3 and analyzing each couple's data within and between all couples using a modified version of the process coding schema suggested by Bogdan and Biklen (1992). Their schema, based on interactions between people (in education settings). serves as an heuristic for coding; it also points to general domains in which interactive processes take place. A two-level scheme such as theirs allows for a more general "etic" level, with a more specific "emic" level of participant identified codes nested in the etic level (Miles & Huberman, 1994). Components of the modified Bogdan and Biklen schema that were utilized are summarized below:

1. Setting/Context: general information on situations and surroundings that allows the study to be put in a larger context;
2. Definition of the situation: how people understand, define, or perceive the situation;
3. Perspectives: ways of thinking about the situation that are shared by informants;
4. Process: sequence of events, flow, transitions, turning points, changes over time;
5. Strategies: ways of accomplishing things; people's tactics, methods, techniques for meeting their needs;
6. Relationships and social structure: unofficially defined patterns that may or may not be acknowledged in relationships.

The within-case analysis for each couple was completed first. Comparative analysis between couple cases occurred second and allowed for differences and similarities to be understood. When data from the individuals and couples yielded categories at the level of the dyad, it was sometimes necessary to use researcher-generated labels for the processes. However, emic labels were used whenever possible. Some of the categories that were developed at the dyadic level were at a different level of abstraction because they were meant to be relational level categories. Dyadic level coding was the crucial process in this data analysis as it entailed looking at processes occurring between individuals but not at the individual level. This level of coding demands that the analyst conceptualize dyad rather than individual processes.

The final phase of the analysis was undertaken using the methods outlined in Table 1. Denzin's (1989) method to contextualize the meaning of the data analyses was employed after the individual and couple processes were determined and a better understanding of the context emerged. "Contextualizing locates the phenomenon in the personal biographies and social environments of the persons being studied" (Denzin, p. 60).

Standards for Establishing Trustworthiness of Data Analysis

Establishing trustworthiness in a naturalistic or qualitative paradigm involves addressing the practical standards that are adopted to judge the quality of the conclusions. While some researchers take the relativist's opinion that there is no way to specify criteria for good qualitative work, more commonly it is expected that a qualitative study will meet the criteria of credibility or internal validity, transferability or external validity, dependability or reliability, and confirmability or objectivity (Lincoln & Guba, 1985; Miles & Huberman, 1994). Each of these criteria along with methods used to meet the criteria are discussed in the next section.

Credibility or internal validity refers to the "truth value" of the data. Do the findings make sense? Are they credible to the people we study and to our readers? One way of making results credible is to become immersed in the data and secondly to carry out peer review of coding and data analysis (Lincoln & Guba, 1985). In this study the emergence of "thick description" as well as linkage of categories to the existing empirical studies enhances the credibility of the data analysis. Peer review was employed with two members of the dissertation committee and one clinical colleague. One set of debriefings was to extensively review the categories along with the participants' words. The other debriefing session was to evaluate the nature of the coding methods. Further debriefings were carried out with a clinical colleague to determine the nature of the couple processes from a clinical point of view.

One way to establish transferability or external validity is to provide the research audience with "thick description" of findings so that the reader can determine whether the findings are generalizable to other populations (Lincoln & Guba, 1985). As well, the characteristics of the sample population need to be adequately described so as to permit comparisons with other samples (Miles & Huberman, 1994). The qualitative researcher can only include descriptions of the sample, findings, and context in which the analyses occurred. The transferability judgments are then rendered by the consumers of the research.

In qualitative methodology dependability or reliability, which is often demonstrated by replication of study, can be difficult to achieve because of the context-specific nature of the data. Consultation or inter-rater reliability with clinical experts in the field is considered one method of establishing dependabililty. These experts may be called upon to "audit" both the process and the product of the analysis. The dependability of the data coding should be evaluated by comparing category definitions with sample transcripts. This process was carried out with two members of the dissertation committee on separate occasions (see description above).

Confirmability or objectivity concerns the basic issue of neutrality and freedom from unacknowledged researcher biases (Miles & Huberman, 1994). Is there a record of the study's methods and procedures detailed enough to be followed as an "audit trail"? An audit trail consists of records such as raw data, data reduction and analysis products, data reconstruction and synthesis products, and process notes, including methodological notes, trustworthiness notes, and audit trail notes (Lincoln & Guba, 1985). For this study, the raw data (participant transcripts) are contained in coding notebooks. Other methodological and trustworthiness notes are contained in a separate notebook. The data reduction and reconstruction products are stored on computer disks and hard copy. These items are available for inspection.

Summary

An inductive methodology was employed to determine the dyadic processes that developed during the breast cancer recovery. Interview data were analyzed across individuals and couples from all families. Methods were integrated to enhance the data analysis process. The findings of the data analysis are presented in the next chapter.

CHAPTER IV

Findings

This chapter will review the findings of the data analysis from the individual and couple interview data. Included are demographic data about the women, the male partners, and the children. Following this, the individual and dyadic processes are described.

Demographic Data

Fifteen couples comprised the sample. All were partnered men and women, and 93% (14) were married. One couple was not married but had been partnered four years. The age range for women was 29-51 with a mean age of 42.73 years (SD 5.06) and a median age of 42. The age range for men was 30-54 with a mean age of 43.87 years (SD 6.56) and a median age of 42. The couples had an average of two children ranging in age from 1 to 20 years old. Eight couples had been married for more than 20 years, and the mean length of the relationship for all couples was 17.6 years (SD 8.19); the median was 21 years. All women had early stage breast cancer Stage 0 (in situ), Stage 1, or Stage 2. The average time since diagnosis was 4.73 months (SD 2.65). Bi-modal annual income was $50,000 to $59,000 and $70,000 or more. All families were Caucasian. The sample was highly educated: 93% of the women and 100% of the partners had two or more years of college education. The specific demographic characteristics of the couples are listed in Appendix D.

Overview of Processes

The processes reported here were constructed using the procedures identified in the methodology chapter. Processes were the active strategies that individuals and couples developed in response to the breast cancer diagnosis, the demands of the illness, and their interactions as a couple about the breast cancer. They were aimed at managing or dealing with the cancer. Both individual and dyadic processes emerged during the data analysis. As well, a dyadic process that reflected the nature of the breast cancer context organized the individuals' and couples' responses. The core process Doing Everything We Can emerged during the process of contextualizing the data analysis. This is an overarching explanatory process relating both individual and dyadic processes to the context of the illness. The individual and dyadic processes are summarized in Table 2.

TABLE 2. Doing Everything We Can: Processes Evolving During the Breast Cancer Recovery

INDIVIDUAL PROCESSES	DYADIC PROCESSES
Taking Charge of My Life a. looking at things differently b. making changes c. taking care of myself	**Sharing in the Recovery** a. discussing concerns about the cancer b. disclosing feelings about the cancer c. appreciating my partner
Seeking Support a. seeking support from my partner b. seeking support from others c. seeking a support group	**Helping Her** a. helping her around the house b. encouraging her not to do too much c. little things making a difference
Protecting Self or Other a. protecting self or other from worry b. protecting the children c. having feelings but keeping them to myself	**Moderating the Intrusion of the Cancer** a. not letting this affect us b. not dwelling on the cancer c. asking her to forget it
	Normalizing the Household a. getting back to normal b. keeping up a schedule

Couples responded to the breast cancer diagnosis by developing strategies and behaviors that they believed were the right thing to do to manage the cancer. It became apparent in the final stages of the data analysis that individuals and couples wanted to believe that whatever they were doing was the right thing to do. The individual and couple behaviors and strategies reflected their desire to do everything possible to respond effectively to the cancer along with the desire to manage the uncertainty or lack of control over the cancer or their response to it. The processes the couple developed reflected this concern and the uncertainty of the proper course of action in response.

Disparate responses between individuals were based on a strong sense of having the right approach. Some couples negotiated about their disparate ways of responding. Other couples agreed explicitly or implicitly on the best course of action. Individuals went along with their partner or took their own stance which meant reaching beyond the partner relationship. Achieving an individual comfort level was paramount for some and others tried a variety of strategies to develop a comfort level as a dyad. Dyadic agreement did not always mean that both individuals were satisfied with their joint approach. Joint process consisted of an interaction between the individual's predominate strategy and that of his/her partner.

The processes are reported here by first discussing their definition and characteristics followed by "thick description" in order to support the categories using the participant's words. The interview excerpts are labeled with an M for data from mother or woman's data, a P for data for the partner or man's data, and an N-C for Nurse-Counselor. In parentheses the interview is labeled 1 or 3 for couple data, 2A for data from the woman's interview, 2B for data from the partner's interview, followed by the couple's study number.

Individual Processes

Three processes characterized the individual's way of dealing with the cancer diagnosis were: 1) Taking Charge of My Life, 2) Seeking Support, and 3) Protecting Self or Other. The individual processes represented active strategies and methods used by the individual woman or man in response to the cancer. The participant generally described doing something or taking action. These processes developed as a result of the individual becoming aware of changes in thinking or attitude and doing something active to affect changes in life or to manage the effects of the cancer.

Taking Charge of My Life

Taking Charge of My Life was a process that occurred primarily for the woman which she directly attributed to the breast cancer. She made a change in the way that she had been doing things in her life. Occasionally the partner took this opportunity to make changes as well. The cancer diagnosis jarred them out of a routine or pattern of doing things. For some, there was a realization that the way they were living life needed to be changed. The woman or her partner got a signal that changes needed to be made and the signal was an impetus to change. Subsequently, many couples constructed their relationship or their way of doing things in a different way.

Taking Charge of My Life is defined as a realization by the individual that a change in his or her routine way of functioning is needed and that they he or she takes an active part in making that change happen. Changes made allowed the individual to take time for themselves or their families in a new way. That is, changes were made as a result of the cancer in their lives; the individual focused on getting their own needs met or helping their partner get her needs met. The dimensions of this category include: Looking at Things Differently, Making Changes, and Taking Care of Myself.

Looking at Things Differently

Looking at Things Differently is a category devoted to participant's descriptions of a previous way of life that was reconsidered after the cancer. Either the woman or the man realized that they were doing too much either on the job or in personal activities. The participant described a change in attitude or a new way of looking at their life; there was a focus on the thought processes that have changed for them since the cancer diagnosis. Examples of partner thoughts and changes:

> P: So, it caused us, I think . . . well, me personally, to look at my life and my job and my relationship with this family a whole lot differently. . . . I've always loved my work and worked a lot and enjoyed my time . . . spending it with the people I work with, and would work evenings and stuff. And I still have to do that, just by the nature of my job. But through this whole year, I mean, we were in the process of doing some major pieces at work, that all of a sudden it just didn't . . . didn't matter any more. I had to be here. I wanted to be here. And there were things that I had to do at home. And it gave me a whole new perspective on how important some of that stuff was. So it changed my attitude towards my work. It changed my attitude somewhat here. Not that this family's taken for granted, but how precious this time is that we have. So, work will always be there. And so I kind of readjusted, I think, some of my time then,
> as far as where I spend my time and what I try to do. True or false?
>
> M: Yeah. I think so. I think you have. I think, particularly, when I was sick. I mean, I think . . . P was there through everything. When I . . . and he was there, really, in the times when he wouldn't think I would really necessarily need somebody. (1-159)

A woman looked at things differently than before:

> M: But because of that feeling, of being a mom of young children, I really, it's really important to me to be able to focus and define in my own mind, where before I had the time and energy to do everything or it didn't seem to bother me if I did burn the candle at both ends and get myself a little bit too stretched. Now I don't want to see that happen. Because if I have extra time, I'd rather just have it as down time and just spend it with my kids or something like that. (2A-007)

One woman realized changes that needed to be made for her after the cancer diagnosis:

> M: And so, P's been good. You know, I told him, right at the beginning when the doctor told him, and I said, "I mean it. I mean, you have to make the decision, now, today, whether you can handle this or you can't handle this."
> I said, "Because I'm telling you, I have two children, I can't handle a third baby on my hands." I said, "I have to think about myself right now. And I have to think about [daughter] and [son], and you're definitely going to have to take the back seat on this. I can't help it." I said, "Right now, I have to think about when I'm scheduling my mastectomy, who's going to help me take care of the kids for a couple weeks, and what I'm going to do after that, you know." And so that was a major decision. (1-147)

Another woman offered:

> M: So, I think that I want to take this time to really sit back in my life and re-evaluate things and try to make some real positive changes. You know, I'm 42 and it has made me aware of where I am at in my life. (1-023)

Another woman had this to say:

> M: It's almost like a wake-up call in a way. I think . . . if you can get through it and survive it and be better for it, it's kind of like a second chance, I guess, to say, "Hey, you are human and you will die. And it might just be a little closer than you thought. So just be aware. Be aware of things." (2A-133)

Making Changes

Making Changes occurred when an individual made changes in the way that he or she was doing things. The changes were behavioral. Some women developed new ways of acting:

> M: And I'm not good at confronting people. It's not a role I usually take on. But in that sense, I'm taking charge of my life more. And things that I can control and change, I'm doing so. Being more physically active, watching more what I eat, going to a breast cancer support group where we all get together and special speakers come in and we share how we're feeling. It's all been very helpful. (1-035)

Male partners realized other aspects of what needed changing:

> P: It has been much more apparent how much I was not involved, and trying to get involved more with them [the children]. (2B-035)

Women made changes in their thinking:

> M: I'm just aware now that . . . I've always been rather a passive person. And now I just . . . don't have time. And this is the way it needs to be done. And we need to do it that way. And if we can't do it that way, then you'll need to go somewhere else. (2A-133)

Taking Care of Myself

Women described the process of learning to get their own needs met. They were cognizant of getting their own needs met in a new way after the cancer diagnosis. Several women had not done this prior to receiving the cancer diagnosis:

> M: I spend a lot more time deciding what's important to me and trying to focus on those things that are important and weed out all the rest of the stuff and not clutter up my activities or my mind with um, other things, as much as possible. I pay more attention to how I feel and what my needs are. And I'm not sure that I meet my needs any better than I did before, but I'm much more aware of when I'm not getting my needs met. And I feel like I'm much more conscientious and more aware of taking care of my body. (2A-007)

She went on to describe how she didn't stuff her needs in the background:

> M: To take care of mom's needs or time when mom needed time by herself to take care of mom's needs . . . I am more aware of when I need to have my needs met, and I don't try to stuff them in the back, any more, quite as quickly anyway. . . . I feel a little more comfortable saying to my kids, "I need time to do this." (2A-007)

Women looked at themselves in new ways:

> M: And you know, be more patient with myself, and I'm also trying to take more time for myself. And I think that it's really easy as a mom, I just feel like I give and give and I . . . and there's never any time left for me . . . so I've decided that, you know, mom needs certain things . . . and I have some real needs that need to be met. And one is going to my support group. You know, it's just really important to me. (1-023)

Other women realized the importance of concentrating on self:

> M: But you just have to concentrate on yourself, which you're not used to doing. You're concentrating on focusing more on family and other things, other aspects. Um, so it's right now, it's been pretty well now that on my non-chemo weeks, that I can take some time. Cause we have a sitter coming in, five days a week, on chemo weeks. Now that I'm on my non-chemo weeks, I can have maybe a couple of days for myself with the kids and be able to play with them and kind of enjoy them more. And not have anything crammed in the day, but just the kids. And not to do too much. I have to

> learn how to step back a little bit. . . . But I know that every day I have to do something for myself, but I'm finding it really hard. (1-120)

She also talked about prioritizing:

> M: But I think, if nothing else, this experience has done for me, is that now I prioritize my days. . . . I have gone back to work, now, on a part-time basis. And it has been really good because I can spend time with the children. . . . I had to re-prioritize a lot of things and make sure that there is no stress in my life. I think stress needs to be kept to a minimum in my life and . . . I think, in a lot of people's lives. But, I just think I'm focusing now on me. . . . I've done that prioritizing, I think. I mean, God is number one, my husband's number two, my children are number three. Career . . . if it's number four, it's fine. It could be even farther down cause career is not . . . is not the most important thing. (2A-120)

Seeking Support

Seeking Support was something that women did to obtain emotional support, connect with someone about the cancer, and generally just talk to someone who understood what they were going through. Women spoke of seeking out a support group as a safe place for disclosure. The women were interested in giving support as well as receiving support. Behaviors enacted by the individual occurred in three areas: Seeking Support from My Partner, Seeking Support from Others, and Seeking a Support Group.

Seeking Support from My Partner

Several women asked for support from their male partners. One woman said:

> M: Well, I think maybe I've become more expressive with regard to my needs. I mean, I just have to say, "I can't do this. I've got to go lie down." And I've been seeking more emotional support from P when I'm down and he's just been right there. I've probably given him less emotional support than I used to. I don't have enough left to give. (1-019)

This woman felt that her partner could not give her the support that she desired:

> M: If it's bothering me, I want to talk about it. And I don't do that, no more. And if I'm crying . . . I feel like crying. You know, I don't discuss that with him. Cause, for one thing, he doesn't know what to say. And that would be okay if he just put his arm around me and would say, "That's okay, honey. I'm sorry you feel that way." That's really all I want to hear. .

> . . I felt like sometimes I wished P would have just cried with me. But that wasn't his comfort zone. I think he was worried about letting his guard down, around me. (1-049)

Seeking Support from Others

Many women mentioned that it was easier to talk to other women about their thoughts and feelings with regard to the breast cancer. A woman whose husband did not want to be a "sounding post" had this to say:

> M: I think most of the times when I do reach out to somebody else, I feel more comfortable talking to a woman. I think men wouldn't be interested, just kind of girl talk. Cause I think my feelings are a lot of what other women's feelings would be. So it really helps sounding off to a woman. (2A-010)

One woman spoke of her need to talk to other women:

> M: But I feel that, that I really need the support of other women right now. I have some really close friends, but I don't . . . like right now I'm not working, so I don't have like women colleagues at work for a support group. I mean, for days on end, it's just, you know, the work I do at home and the children, maybe P. I don't see anyone else. So I need that interaction and I need, I guess, to talk to other women about the things I'm feeling. (3-023)

Seeking a Support Group

Many women found that a support group provided for the kind of disclosure that they were seeking. The connection of the women seemed to be an important aspect of disclosure in a support group. A few women said that giving was as important as receiving in the support group.

> M: If it's bothering me, I want to talk about it. . . . And that's why I like going to the support group. And I never thought that I would like it. My one girl friend, you know, drug me there. And I like it because you can go in there and if something's bothering you, you can say it. And there's nobody, you know, they don't have to say anything back. You just got to say it. And there's nobody there saying, you know, "That's dumb. You shouldn't do that." So that's been kind of different for me. (1-049)

Another woman talked about support groups:

> M: And I think that the support groups, initially, were really important . . . advantages of the support group have been . . . most of the women in the group have breast cancer, types of breast cancer or stages of breast cancer, that are more advanced than mine was when it was determined. And so that

> most of them are undergoing other treatments. And some of the them have gone through treatments as radical as bone marrow transplants. And so, in view of that, when I know that statistically I'm technically cured from the surgery, by the surgery, I still have to spend some time wondering. Because I don't ever hope to be in like that situation where I would need to have that radical kind of treatment. (2A-007)

Another woman discussed her need to be in touch with her feelings:

> M: But I need, well, I guess I focused on really needing to be more in touch with my feelings. Every time I get more in touch with my feelings, I start crying. I mean, yesterday, after my support group, I cried for about 45 minutes. I couldn't stop crying. And, you know, it's just a real problem for me. I'm not being very articulate. I mean, I don't like crying so much, but I think I have so much sadness right now. (2A-023)

One man talked about the support he felt from a support group:

> P: Um, one of the things was, it was very hard to talk about it. I mean, even with M. Timing was real unique for us. I got into a kind of men's support group through our church. They started this, not because of M, but because enough had been going on. The plans to actually start and put this group together were starting before M even found the lump. And just things worked through. I had that feeling where I needed to put and show strength all the time, when she was really down, to help keep her up. And there were times that I didn't feel like that, but . . . and I couldn't say anything. I just felt like I couldn't say or have any avenues to go through to release that. We had friends, but it was real tough to call on a man too. To go out, even though a lot of the guys had said, if I needed to go out and talk or anything, to do it. But it's real tough to do. Where, with the support group, it's easier to do. Because that's what . . . I mean, we do that every week. Somebody's talking about a tough time or some struggles they're going through. And I didn't really realize how important that was, until
> I got into it. (2B-035)

Protecting Self or Other

Protecting Self or Other was a process that happened when an individual was trying to protect self, partner, or children from worry or discomfort about the cancer. Dealing with the cancer and the reactions of self and others seemed to trigger protectiveness. In the face of uncertainty and ambiguity which accompanied a cancer diagnosis, men, particularly, seemed to want to protect their families from experiencing the effects of the cancer. For some men there was the poignant realization that they could do this. Sometimes there was worry about the reactions of others to the cancer. The dimensions of this category are: Protecting Self or Other from Worry, Protecting the Children, and Having Feelings but Keeping Them to Myself.

Protecting Self or Other from Worry

Individuals talked about the ways they protected themselves either from their own experienced emotion or that of others. They spoke of having to deal with others' reactions and changing their reactions or hiding their concerns in order to protect from the other's reaction or to protect the other person from their own worries and concerns:

> M: Cause I know I don't tell my husband much about what I worry about. Cause I figure, why both of us worry, you know? There's a lot of feelings I keep inside. (2A-010)
>
> M: Well, I know I have a lot of worries about the breast cancer. And I'd like to know if P has the same worries, or worries like I do about recurring and, you know, common . . . our daughter maybe getting it? Cause these are worries that I have that I don't, I try not to talk about. Mainly, cause I don't think about it when I'm around him.
>
> P: I don't give you the opportunity.
>
> M: That's true. You keep me busy all the time.
>
> P: I don't even allow myself to think about it, because no amount of thought or no amount of worry is going to change what may happen. (3-010)

Several women commented on the reactions of others and their own worry about those reactions. Here is what one woman had to say:

> M: Don't talk to me. I don't want to talk about it. I don't have anything to say about it. You know, how to prepare yourself for the reactions. That was the hard part. All of that to me is the hard part.
>
> N-C: That's the hard part for you, preparing yourself for other people's emotional response to what's happening with you.
>
> M: Yeah, right. I think that was a major concern as . . . how other people were going to react to it. Because we can deal with what's happening, probably a lot easier than we can deal with somebody else's reaction to it. . .

> . And we're okay with it, as long as nobody around us breaks down. We can stay strong enough to keep going. But when you have to try to deal with trying to deal with making somebody else, help somebody else deal with it, it's too much. It's all you can do, to do it yourself. . . . That's why I always, "Just let me do this." (2A-055)

Protecting the Children

Women worried about their children. The age of the child did not seem to influence the level of worry, although women with younger children were very concerned about having their children see them sick; the thought of dying from the cancer was unbearable. Some women talked about how difficult it was for parent and child to openly discuss the cancer. Here is one woman's story:

> M: What happened was, I had the conversation, I talked with [one twin] because we happened to have time alone. And I told him that I had to have an operation because I had a disease and he says, "Well, what kind of disease?" And immediately my mind goes into overload trying to think of some way to say it, besides saying cancer. I couldn't think of any other way to say it, so I said cancer. And that threw up all kinds of horrible images on his mind. I mean, even at the age of six, they know that cancer is bad. They know that their grandmother died of cancer. So I reassured him, of course, that mine was very early and that I wasn't going to die from it. But that I was going to have an operation. Then when I had planned to sit down and speak with my other son about it, [the first twin] had already talked to [the second twin] and told him. So the next opportunity that [the second twin] had, he came up to me and says, "Mommy," in this really kind of shaky voice, "[first twin] says you have cancer." And I just, I just fell apart. I mean, I thought, "Jeez." That was really hard. So I ended up going through the whole thing with him and trying to reassure him, but I felt just horrible. And I think in retrospect I would have done them both a better service if I'd sat them both down instead of trying to do it individually. Because that, I just wasn't happy with the way that happened. (2A-007)

Another woman shared her story:

> M: Yeah, fear. And I guess the other real emotion I have, it was also a fear, was of having a bad prognosis and dying in front of my children. I thought, you know, that would just be the worst thing in my life. That, you know, it's hard to lose anyone or to confront death. But, you know, with a young child, two young children, I think it would just be devastating to me. And I just prayed that that wouldn't happen. Because I always thought that it was like the saddest thing to have real young children lose their mother, or to like have me sick for a long . . . you know, for like a couple of years dying in front of them. I think it would just be awful. (3-023)

This woman talked about telling her children about the cancer:

> N-C: How did it go when you did tell the children?
>
> M: I thought it went okay. At that point, we didn't really know all the options, yet. All we knew was that we had cancer and was going to be looking at, at least two more surgeries. But felt that they needed to know before they heard it from our church friends and people at school. Um, we just sat down one evening and my son got really quiet and just went and sat across the room and didn't say anything. And my daughter just says, "Are you going to die?" And I said, "No, I'm not going to die. But I might not be feeling very well for a while and very tired. And mom just needs lots of hugs." And she came over and sat and cried and hugged me. Sort of expressed what she was feeling. We sat and talked for a while that evening, and then, you know, as news went on, then would . . . was pretty open about how I was feeling about radiation, when it was making me tired and . . . but on the other hand, they can hear it, but it doesn't get put into action. (1-035)

The couples struggled to maintain a sense of calm around their children:

> P: The main thing with the kids was to try to keep a straight face. I mean, we were so emotional about it that every time I turned around, you know, I would want to cry. And shoot, I'd cry in the car and I'd cry in bed. I'd cry in the living room. And, you know, with [son], I mean, he was . . . four and a half, I guess. So, he knew that something was wrong. But he didn't know, you know, what. To this day, he knows that mommy has to go in and get medicine. And when she gets the medicine she doesn't feel good for a week, and then she starts feeling good. And then she can't rough house and do things like that. He understands that. I don't think he has any understanding as far as, you know,
> the type of sickness or anything like that is concerned. But the hardest thing there was just to hold the emotion back so that you just didn't break down in front of the kids. (2B-120)

Another couple felt that keeping on "an even keel" was important for the kids:

> P: No, basically, the daily routine hasn't changed that much. The kids are, you know, taking all our free time. And that had to go on. You know, we tried our best to keep the situation on an even keel because . . . the kids are still small and they . . . had enough scare. They went . . . with us to the hospital, you know, and then we were waiting for M's surgery and everything. You know, we just didn't want to blow it out of proportion. We wanted them to have a normal house and, you know, they are aware. They know; we keep them posted about the situation. But, on the other hand, we try to keep it on an even keel. And I think it's been working pretty well. (1-066)

Another woman talked about her children's anxiety:

> M: But we really do feel that this is probably one of the most difficult things that we've been through in our lives. I think the children feel some anxiety. They don't always let us know about it, but you know, I'm very close with them and they're still pretty dependent and I think they feel frightened of it.
>
> N-C: What do you see in them that makes you think that?
>
> M: Well, obviously when my daughter was first told, and my husband told her, she acted very emotionally. She seems to be concerned. When she sees me she shows a lot of affection . . . and I'm not sure it's all her giving to me. It's her taking too. Her needing some mommy-ing, at 21. And my son, too, has been more physically affectionate. I think he just needs some reassurances, those kinds of little connections that mom's still here. They don't talk about it a lot, other than asking me how I feel. And if I'm not feeling well, expressing, you know, regret that I'm not feeling well and offering whatever help they can give. (2A-133)

There was also the worry of genetic risk for daughters:

> M: So then I worry about my daughter, cause now it is family history. So then, I'm thinking about her.
>
> N-C: Has she brought it up to you?
>
> M: No. No. She doesn't talk about it hardly at all. I know she's worried about . . . thinks about it. But she doesn't communicate that much about it. [She's 14.]
>
> M: Yeah. So it's kind of that age where you know everything. I know she thinks about it, but she'd rather not talk about it, especially with mom. I mean, if it's
> a girl, it's something different. Cause I don't think she knows that, you know, she's susceptible to it or anything. . . . I don't have the nerve to ask her, though. It means pushing it, you know. When she wants to talk about it, she will. (2A-010)

Having Feelings but Keeping Them to Myself

Some male partners talked about having feelings but not wanting to let on or show their feelings. In some cases they described the feelings as being deeper than they were able to show. Staying strong was important for some men, and for others expressing feelings was difficult.

> P: She'll say, "You don't know me, and you don't understand what I'm going through." I know I can't, and I know I don't. But I think she's wrong in saying that she knows that I don't. I might not let on, but I might know more than I show. And I might feel more than I show. And I guess . . . it

> irritates me sometimes, when she says, "You don't know what I'm going through." And I don't say anything back. And I want to say, "Honey, you don't know me either. So how do you know whether I know or not?" . . . I'm very much interested and very much concerned what happens to her. (3-049)

Another man had this to say:

> P: I don't want everybody in the world to think I'm, you know, a callused asshole. But most of the people that know me, know me the way I am. Um, I can care. You know, I can show emotions, too. That's just, more or less, to help out other people. You know, she knows I, you know, I love, I love her and I love my kids. And I may not say it everyday, but I do, you know. (2B-010)

Some individuals realized that keeping the emotions in check was their natural style and they seemed to prefer it that way, even if the partner wished for a different reaction. One partner said:

> P: In my family, you never did show a lot of emotion. Kept a lot of things in. I didn't find out until after my mom had died that there were talks of divorce and stuff like that . . . several years before she died. So, they hid it well, let's put it that way. So, maybe it's in the genes, I don't know. It's just the way I am. She knows I am. (2B-092)

Dyadic Processes

Four dyadic processes characterized the couple's strategies for dealing with the cancer: 1) Sharing in the Recovery, 2) Helping Her, 3) Moderating the Intrusion of the Cancer, and 4) Normalizing the Household. Dyadic processes were those processes in which both members of the dyad were involved in discussing, managing, or otherwise working on dealing with the illness. Attempts were made to actively deal with the cancer on the one hand, or the efforts of the couple were channeled into moderating the intrusiveness of the cancer. Whether the couple could effectively interact about the cancer and give each other feedback regarding difficulties and problems influenced how the couple chose to manage the cancer recovery. Some couples were better than others at finding a level of comfort with their partner about the strategies they chose. In this section, the dyadic processes are described.

Sharing in the Recovery

Sharing in the Recovery occurred when the dyad took part jointly or were both concerned with issues of their lives concerning the cancer or their relationship. This category involved behaviors aimed at actively processing such as discussing, disclosing, and appreciating aspects of the partner's response to the cancer or their relationship together. The sub-categories are: Discussing Concerns about the Cancer, Disclosing Feelings about the Cancer, and Appreciating My Partner.

Discussing Concerns about the Cancer

Couples talked, in the interviews, about the time they spent discussing the cancer and negotiating the joint responses to the cancer. Participants varied in their comfort level with communication about the cancer. Some participants shared openly their feelings about the cancer and worked together to deal with the cancer. Others reported their communication about the cancer was problematic; they talked about their different responses and the ways they negotiated talking about the cancer. Some partners wanted to help the woman discuss her concerns about the cancer but were not sure exactly how to go about doing it. There were partners who recognized their different perspectives on the cancer and the way that each thought about it. These couples attempted to discuss rather than dismiss their concerns. This partner expressed his perspective:

> P: We'd prop each other up. You know, we'd get M so that she was, you know, doing pretty good and feeling pretty good and she'd take the kids. And I'd come over here and work on the house and then just break down. I mean, you know, just totally break down. And then I could go home. And um, you know, I'd take over the kids and M would go in the back room and she could let it out . . . . But you just had to let the emotion out. (2B-120)

A couple of male partners articulated their understanding of the differing perspectives from their wives that they held about the cancer:

> P: We talked about it. She, you know, we, yes, she did look to me for how I felt, what my feelings were. At times, it was hard for me to explain where I was coming from, why I didn't see it as a big issue on some of this stuff. But, and it was hard for me to see why she couldn't, you know, why she was making such an emotional deal out of it. But it was because I didn't have to deal with it. I mean, it was something where my level of emotional involvement on it was, was totally different from M's. I didn't have to go through the physical discomfort and the pain and the lack of mobility and the tiredness. I didn't have to face that. M did, you know, and that's . . . I mean, I had to face what it would do to M and what I may have to do as a result of it. But I didn't have to go through it myself. (2B-035)

Another partner echoed these thoughts in a slightly different way:

> P: I try not to be insensitive to . . . this is something that is probably something that she thinks about more than me. Because it's . . . she had it, I didn't. And so I don't know everything that's going through her head. But it's . . . you know, trying to be sensitive to that. Understand. I mean, she could live to be a 120 and so could I, and it would be fine. But it's going to be different, these next however many years, just being cognizant there's something out there. . . .You know enough that it might come back, but you don't know that it really will. Just . . . just not being insensitive to it. To be aware that it might . . . enter her thoughts more than mine. (3-159)

One partner wanted to discuss concerns about the cancer:

> P: And I told her that I would rather, if I'm saying something at the time that is going across her grain, not just to clam up and never talk to me about it. But to tell me at the time, "Honey, that bothers me. I want to talk to you more about this. But your attitude bothers me. Could you just listen this time?" And I guess I would. (2B-049)

One partner summed it up by saying this when asked what the couple needed at this time:

> P: Communicating better. Trying to figure out whether we are communicating accurately, and managing stress, related to myself, more than us. (1-092)

They also wondered about whether the communication strategies that they were trying were effective for them:

> P: Just need to make sure that whenever she wants something, just to communicate it to me, directly. And not to beat around the bush. Because then we get it done. And I think that that's worked. Hasn't it? (1-092)

Other couples felt secure about their communication strategies:

> P: And you know, I think we're basically fairly open and although there are things that we don't talk a lot about, issues, it's not something . . . there aren't things we don't talk about. I mean, we talk to each other openly about everything, most everything. . . . I think that pretty much, you know, what we are feeling and the issues that we're addressing, individually and collectively, we've talked about. What do you think?
>
> M: Yeah. (1-019)

Disclosing Feelings about the Cancer

Disclosing Feelings about the Cancer included disclosures about the emotional experience of cancer. Disclosing is defined as talking about feelings associated with the cancer. The emotional experience of the cancer was overwhelming for some. Disclosures relied on a partnership, one person to disclose and the other to be the recipient of the disclosure.

> P: We were both basket cases at the beginning. We would sit, you know, sit in the middle of the living room floor and cry for an hour. . . .
>
> N-C: Together? . . .
>
> P: Yeah. Yeah. We did it apart; we did it together. And I think one thing that was, for M, because I mean, it was kind of like the "C" word. You just kind of equated it with . . . "Well I'm going to die." And it was a tremendous emotional thing for M, because all she could say is, "What about the kids? What about the kids?" (2B-120)

The emotional nature of the experience that was felt by both partners was something that they had not experienced before:

> P: But the hard part about the cancer was the emotional part, with part, with having to deal with--M is a very emotional person. And when the cancer struck, her emotions just flew. And no matter what I tried to do, I couldn't control . . . I can't say control her, but I couldn't help her control her emotions. All I could do was sit back and watch it happen and just try to be there for her. But that was the hardest part. (2B-147)

One man talked about his wife's anger:

> P: Well, I guess what I was saying, or getting back to what I was saying, is that I can handle the kids. I can handle cooking dinner. I can do everything. But the hardest part is when she gets angry because she's hurting. And she comes out . . . and actually, it sort of makes life miserable for the other three of us. . . . I guess it's when she's worn out. She says, "I want the kitchen clean. I want this clean. I want this done." And it's like, you know, we're trying to do everything, but we can't. Just wait a couple of days and be patient. But what she does . . . is she's hurting, so she wants other people to hurt too, not, she doesn't want us to hurt, but when she's angry, she takes it out on other people. (1-147)

Appreciating My Partner

Partners appreciated each other in ways they hadn't before. Some talked about becoming closer as a couple. Others talked about sharing the experience and dealing with it together:

> M: Well, I think in some ways, it's made us closer. We're sharing a real crisis here. I think we're both frightened, but we've been able to share that with each other and to support each other. I'm in the midst of chemotherapy. I'm half way through. And that's a real difficult thing for me, so I'm having to call on my family to give me a lot of help day to day, and they're certainly doing that, very willingly and happily. Plus the general overall emotional ups and downs of chemotherapy. I need a lot of, just kind of encouragement. You know, "You're going to get through this" kind of thing. And the family is giving that, mostly P. But the children too are very responsive and helpful. (1-019)

One woman said this about her relationship:

> M: I think we've pulled together more. Shared more feelings with each other. (1-035)

Another woman realized that she really appreciated her husband:

> M: I don't know, you've kind of gotten back to, you know, when you had time for yourselves and I guess maybe, I'm . . . instead of just focusing on me, I'm kind of thinking about, you know, I do have a husband. . . . He is a good person and, you know, he thinks about me and he cares about me. And maybe I'm just kind of re-learning and re-focusing on that. I don't know. Its just . . . it's been better. (2A-147)

Women, especially, appreciated their partners:

> M: No. I think P and I are really . . . there hasn't been anything we haven't talked about. Whether it be um . . . physical, mental, emotional. I mean, I

> just . . . I think the key to a relationship is trust. And therefore I trust him to know every part of me. So when I'm vulnerable and feel a certain way, I felt that I could tell him. And he would understand, and if he didn't understand, he at least would just hold me. And I think that has been his role probably more than anything . . . is just, when I wake up in the night, wracked with sobs, he just holds me. You couldn't ask for anything better than that. (3-133)

Helping Her

Helping Her was a process in which the partner and children helped the woman with her life in some way, either with chores around the house or with managing the demands of the illness. Helping is defined as: making it easier for a person to do something, giving something necessary, doing part of the work, or causing improvement in some way.

Some male partners recognized that their wives needed help and tried to change the things in their lives that could facilitate this help. Most often, this process involved tasks that they did to take over things that she did in the past and was unable to do in the present. The partner was more involved with the children or with the tasks around the house. Sometimes, this resulted in the recognition for him that hers was not an easy job. In some cases it also resulted in creating an environment in which he felt more involved with his family. Sometimes a woman described "little things" that made a big difference to her. The categories in this domain are: Helping Her Around the House, Encouraging Her Not to Do Too Much, and Little Things Making a Difference.

Helping Her Around the House

Male partners described the changes in their lives that prompted them to become involved with helping their wives around the house:

> P: Essentially my life, the family life has changed. We try to be, assist her and be more helpful to her. And give her more support. Um, emotional support . . . talking together about it or the difficulties she's having with the chemotherapy. (1-019)

Another partner was able to offer assistance to his wife because he was not working:

> P: Well, the majority of the changes would be in the relationship of what I do around the house and helping out. We said earlier that I'd taken more duties on. Part of that is because I don't have a steady job to go to work during the day. And so I have more time to do that. More involvement with the kids. (1-035)

A woman described the help her partner provided:

> M: He helps a lot. He helps a lot. I think what I said earlier was true, was we became more of a couple. Um, and I don't know that it was as a result of the diagnosis. I'm not really sure. Cause there were a lot of really, you know, things that were going on with me, before the diagnosis. And that diagnosis just motivated me into action. And I just started talking about it a lot more. And a lot of people weren't very supportive. And, at first, he wasn't real supportive.
> I mean, he wasn't negative or anything. But, we just never talked about them. My decisions were my decisions. And I would go off and do some things. (1-055)

Male partners realized the need for helping out with the family and helping the woman. One partner said this in his interview:

> P: But I'd say, for my part, I'd still probably still try to be more helpful than I was before any of this happened.
>
> N-C: More time with the family is the big . . . is the main change.
>
> P: More time helping, I guess. Trying to take things over for her that might help her. (2B-090)

One partner had this to say about his way of helping:

> P: And I told her that she needs to remind me that she isn't well. And that I can't lay here like a lump. I've got to get up and do something. And that's all she has to do. But, otherwise, I'll probably turn into a jerk again. And . . I don't want to do that. (2B-092)

A woman described how her partner became more involved with the family:

> M: And I think we changed some roles of what's done around the house. And I think that . . . when I was going through treatment and I couldn't do and he picked up. And now, even though I'm feeling better, he continues to do more of shared responsibility around the house. I think he's taken a little more active part in what the children's activities are, helping with school work. (2A-035)

Encouraging Her Not to Do Too Much

Male partners tried to recognize when the woman needed help and sometimes worried that she wasn't asking for enough help. A partner said this:

> P: Yeah. And trying to pick up more on nuances of her moods, if she's up or she's down. Helping her do things. Asking her probably more often if she needs help or she wishes help. Being conscious or more conscious that she needs rest during this thing. She's very tired. And seeing that she gets it. (2B-019)

Another partner wanted to help his wife but didn't want to take over for her:

> P: Sometimes, I feel that she doesn't ask for enough help, you know, kind of frustrated about that. Cause she has the things she wants to do and the way she wants to do them. And my attitude is, instead of busting in on her and just sort of taking over, she can tell me, "P, will you do this or do that?" Or set the table, or empty the dishwasher, or take out the trash or whatever. (2B-133)

Women also picked up on when they needed help:

> M: Well, you train yourself, though. For a long time I tried to do things that would hurt my hands and finally I just said, "I'm going to ask for help here. It's not worth it to do that." And so, there are just certain things that I'll always ask for help on. And the kids have gotten used to that, too. You know, there are some things that mom can't do and so we help her. So it's been maybe an easier transition for us because we've had a long time of dealing with this kind of thing. (1-019)

Little Things Making a Difference

Little Things Making a Difference are special times a woman described when either a male partner or a family member did something that really made a difference to her. These times did not involve the crisis times but were other times when little things that helped her in the recovery process were important.

> M: P was there through everything. . . and he was there, really, in the times when he wouldn't think I would really necessarily need somebody like . . . especially . . . I got really sick with my chemotherapy. And I'd be sick for a whole week. And even after like the fifth day, when you'd think you start recouping, that would be, for some reason, one of the hardest days for me. Cause I'd live through four days of like not eating and being so sick. . . . I had chemo on Monday and by Friday I was just so depressed. And P would stay home and rent a movie and make me go downstairs. Sometimes, I hadn't even been out of bed. He'd get me downstairs and turn on some wild

> movie, that at least it got my attention. He'd bring me food. And I mean, it just was really helpful. I mean, those kinds of things. And I knew that he had a million things going on at work. But I was so sick that I couldn't say, "Go to work." So I didn't say those things. And it was really nice that he was there through that. And that was . . . you know, it was those kinds of times, and of course, he was there through the major surgeries and all that. But, it was the little times . . . if you want to call those little times, but the times when I just felt kind of at my wits end and I'd just about had it. And um, he would be there. And that would be really nice. (3-159)

Another woman described the little things this way:

> M: I don't usually ever sit still. I'm always doing something. And so I would find myself just sitting. And so it would occur to me how unusual it was. And then after about five minutes, then P would come sit down, and then [one boy] would come and sit down, and then [the other boy] would come and sit down. And pretty soon, we were all, like sitting there, talking about something . . . or not talking about something very important, but maybe some goofy thing. But it still was time we rarely had, unless we were eating. . . . So this was a really nice thing. And I've tried to keep doing that as much as I can. So I think the changes in my daily life, a little bit, is saying, "Now, what will happen if I sit? What'll happen here?" And I'll find there's more time to talk. And I find also that I find times to be with the boys when . . . when they'll talk to me. (2A-007)

One woman talked about something her sister did:

> M: I guess the other thing is the vulnerability. How vulnerable I felt . . . after the mastectomy, too. . . . My sister came over for Labor Day and I hadn't been out of the house. I had the surgery, you know, the week before. And I really wasn't anxious to get out of the house. I didn't know how I was going to not have . . . be lopsided and so forth. And [sister] just said, "Okay, M, come on. We're going to Molbaks. I don't care what you do to yourself. I don't care if you wrap sweaters around you. I don't care what you do. Put a big heavy coat on. You can have my coat. But you're coming out." And so she drug me out of the house. And, which was wonderful, it was really good for me. (2A-133)

Moderating the Intrusion of the Cancer

Moderating means presiding over, keeping within bounds, restraining, avoiding excesses or extremes. Moderating the Intrusion of the Cancer was a process which occurred when one person dismissed or in other ways attempted to avoid the impact and effect of the cancer on the couple or on the household. The moderator took an active role in minimizing what the cancer means and how it is reacted to by other members of the family. The categories that are present in the domain of moderating the intrusion are: Not Letting This Affect Us, Not Dwelling on the Cancer, and Asking Her to Forget It.

Not Letting This Affect Us

This is an example of a man who did not want the cancer to affect his life. He was determined not to let it slow them down as a couple. He "moderated" or "presided over" the recovery in assuming that his wife felt the same as he did:

> P: Well, I was determined not to let this slow us down.
>
> M: Yeah, I know.
>
> P: We've been told about hormone problems and other things that, that might keep us tied down, more than we want to be tied down. We've made some plans, I mean some intermediate plans for the near future to do some traveling. This nice equipped motor power trailer out here, that we want to travel around in. And I would hate to see those plans dashed because of something like this. It may sound selfish, but I think she'd tell you the same thing. (3-010)

In the second couple interview the woman asked if he had any of her same worries.

> M: Well, I know I have a lot of worries about the breast cancer, and I'd like to know if P has the same worries. . . .Cause these are worries that I have that I don't, I try not to talk about . . . when I'm around him.

Not Dwelling on the Cancer

The process of Not Dwelling on the Cancer or specifically asking that the woman not dwell on the cancer was common. This message frequently came from male partners. It seems that the thinking of the male partners was that if either one of them were to dwell on the breast cancer too much, there would be negative consequences.

> P: And I guess I was trying to act accordingly and not let all these aches and pains . . . not let her dwell on it. She had enough fight and enough problems, just with the breast cancer, to start worrying about this. And spend her whole time obsessed with this, that every ache and pain was cancer, and everything else. And I guess I wanted to help her channel her energy into fighting it. Not worrying about it, that it's in her feet, it's in her elbows, it's in her neck. And everything else. So I guess I came from that point of view. And at times, as only I can, I guess, I seemed kind of cold and callus. But

> then, after she and I would sit down and talk about it, I think she realized that I was as much concerned and maybe, by myself, sat down and cried about it. But no, I didn't do it in front of her. And I didn't do it with her. And if I had it to do over again, I still wouldn't. I didn't want to show my concern and my fear in front of her. That only would have compounded her fears. And I don't think it would have done either one of us any good. (1-049)

This couple agreed not to dwell on the cancer:

> P: Well, personally, by this time, I've put a lot of it behind me. I guess the only effect that I have is still the wondering whether it will come back again. But as far as this surgery has gone and this event, it's in the past.
>
> M: I don't dwell on it. I haven't thought about it. I mean, every once in a while, I'll think about it. But it was minor, as far as I was concerned. And it's a small step I had to take and it's over with and it doesn't really bother me too much. (1-003)

This man wanted to get on with his life:

> P: Okay, let's get it over with. And let's get on with your life, type attitude, I have. And I'm not trying to be rough or anything, but I know you got to deal with it and be delicate, but you also got to go on with your life. You can't dwell over a problem. I guess that's the way I handle it. You just . . . like I said, I just keep stressing. I'm not trying to be mean, I'm just trying to say that . . . I see too many people just sit there and feel sorry for themselves and it's not going to get them anywhere. (2B-147)

Another couple had a disagreement about the way they reacted:

> P: No. I guess, while I'm concerned about that, I'm not dwelling on that at all. Because we have influence over the way we react to situations. But we really don't have any influence over, once we've finished this round of chemotherapy and we go to the doctor and do the things that we're supposed to do, we . . . after that, it's out of our hands, really. You know, and if it recurs, then we deal with it.
>
> M: That's easier for him to say.
>
> P: Yeah, well, it is easier for me to say. But . . . .
>
> M: Maybe not. I don't know.
>
> P: I've had a chance to think about it a little longer, in some ways. Because both my parents have had cancers. (3-092)

Asking Her to Forget It

Male partners used different ways of asking the woman to forget about the cancer. Sometimes it was straight forward; other times they made it clear that discussing the cancer anymore was not an option. This may represent a reasonable request from the partner. At some point discussing it over and over again may have been more than he could tolerate. One partner said:

> P: Well, if you're going to forget about it, why even mention it? . . .
>
> M: Well, it's still there. There's still that little bit of fear there. . . . Yeah, I still kind of worry about that 2%. And he said, "Forget it," you know. And so I have to just try and forget about that 2%. (3-023)

At a different time he had this to say:

> P: Oh, but also I think, you know, more importantly is, I think if you're going to survive, especially cancer, but other . . . major illness, that you've got to have that will, that "Hey, yeah. I'm fine." You know, cause I think that really helps. You know, and I know I've read that . . . some people say they've overcome cancer, mentally. Uh, I'm not sure whether I buy into that, but I'm sure those good feelings, positive feelings, help. So I don't think it's just they . . . trying to make M feel better. It's . . . really, you know, more trying to make her feel, "Yes, I am cured." (2B-023)

Another partner got tired of hearing about all the possible consequences of the cancer. He asked her to limit her discussion of these:

> P: And it was . . . there were times when, in a period of two hours, when you would say about . . . I remember one evening, it was your sixth or seventh time that you brought up about it spreading to your spinal chord or spinal column. And you were talking to me about it. The book you were reading on it. And I guess I said something, somewhere along the lines, "Enough is enough." I mean, when it gets to your spinal column, we'll talk about it and we'll worry about it. (1-049)

Some men could not talk about this as long as the woman may need to:

> P: So . . . that's really about the only thing. And she has, she's read something in a book or something. She'll bring it up, you know, and we'll sit and talk about that for a little while. Sometimes I act like I'm not paying attention, but I really am, sort of, sort of, you know. We've gone over several things, several times before, and every once in a while I'll say, "We've been over this before." (2B-010)

Normalizing the Household

Normalizing the Household was a process that occurred when the family had a strong desire to return the household to the pre-cancer state. The normal functioning of the household was the primary goal for the woman and her partner. The children had an influence on this process. Many of the couples did not want their child/ren's life to be disrupted. The categories in this domain are: Getting Back to Normal and Keeping Up a Schedule.

Getting Back to Normal

Getting Back to Normal is defined as returning the household to the pre-cancer state. The process consisted of thoughts and activities that the individual and couple used to return their household to the way it was before the cancer. It was one way to exert some influence over the illness state and I believe a signal to the household that the woman would again function in the way she did before. One couple was very concerned with the length of time this process was taking:

> M: But I feel uncomfortable about, I guess the length of time, for one thing.
>
> P: But it looked ugly there, for about five weeks. But all of a sudden, you were just like . . . .
>
> M: You were getting pretty desperate by end of the time.
>
> P: It kind of like flipped. You know, the curve was real slow. And I like, "Is she going to get better, is she going to get better?" you know. And it was taking a long time. And I think both of us felt that. Then all of a sudden it just zoomed right up. And, like overnight, her energy started coming back and you started getting more involved and doing a lot more things. (1-007)

Some couples did not wish to make changes in their lives:

> P: Yeah, we were really happy with our life. And you know, satisfied with it. So we didn't want it to change, greatly. (1-090)
>
> M: But I was real perfectly happy with my life the way it was when I got the cancer. So I didn't want things to change. So we did work hard at getting everything, you know, as back to normal as it could be after, you know, the

> surgery and everything. I didn't have a lot of serious side effects, so probably, other than if I hadn't lost my hair, I don't know if the kids would have been even been aware of it, you know, anything was going on. Except that I had to go to the doctor a lot more. So I think that was our goal to get things back to the way they were. (1-090)

This male partner indirectly voiced his desire to normalize. In his opinion thinking about sickness would produce sickness and the opposite was also true (i.e. thinking about health would produce health). Here are his words:

> P: If you go around thinking that you're sick, then you will be sick. If you go around feeling that you're old, you will be old. So, um, just move towards the opposite, and there you go. (3-010)

In his own interview, the same man had this to say:

> P: We've come back to a lot of normalcy in our lives since we first . . . since we first found out about the breast cancer and stuff. So . . . um, we're, we're not allowing it to interfere with our normal life as a family or any other way. (2B-010)

Keeping Up a Schedule

Keeping Up a Schedule was one way that participants accommodated to all the activities and appointments that needed to be kept.

> P: There's more scheduling because of not feeling up to, M's not feeling up to doing everything or needs more rest. And so there's a certain amount of scheduling conflicts. And then there's additional doctors' visits, this type of visit, support group visits, those type of things that require a lot more scheduling. (2B-007)

Another man shared this:

> P: Anyway, I guess it's just a change in the way that . . . kind of scheduling change and then adding some more duties. . . . During the treatment time, was putting up with the some of the fluctuating schedules and changes that we would go through on a day to day basis. Had to be really be conscious of what time of day it was. Making sure that if M was tired, that she was able to get somebody to go if I couldn't take her to the hospital. So she didn't have to worry about that, you know, driving there and back when she was super tired. Making sure the kids were picked up, that type of a thing. (2B-035)

Another man talked about his schedule:

> P: We work into our schedule having to go to the doctor, mammograms, being at the hospital. So that part has changed, of the daily schedule. Just all the visits to the hospital and the doctor and everything else. (2B-049)

Doing Everything We Can

The explanatory process was identified from an analysis of the individual data across men, individual data across women, and couple data from both sequence 1 and sequence 3 interviews. Doing Everything We Can is defined as a process that involved taking all the steps necessary to "safeguard" the woman's health and enhancing her chances for recovery from the breast cancer. It was paradoxical because several couples appeared to be having a very difficult time negotiating the cancer recovery. Later in the analysis it became clear that the magnitude of cancer as a stressor in these child-rearing families was monumental. All of their defense mechanisms and other cognitive and behavioral responses were called into play as they tried to manage the cancer. They tried to manage it individually, with their providers, with each other, with friends, and with other family members. It was not hard to understand why some couples wanted to get everything back to normal and to moderate the intrusion of the cancer in their lives. The difficulty of managing a stressor such as cancer is the double-edged nature of it. It is a stressor which demands immediate attention to the treatment process as well as the emotional and behavioral adjustment that goes on in the family. Determining the best course of action was a high priority and at the same time caused tremendous anxiety about decision making. The individual and dyadic processes had as much to do with management of the fear and anxiety as they did with couple interaction.

The breast cancer context is very powerful in our society at this time in our history. The processes that characterized the breast cancer recovery for these individuals and dyads demonstrated the enormity of the situation for each couple. Every one of these couples took this recovery process as a life or death matter, which it is. The explanatory process Doing Everything We Can exemplified their fight against the cancer. They discussed the cancer, talked about their feelings, moderated its intrusion, and tried to put things back to normal; individually, they protected each other, made changes in their lives, and sought out support and opinions from providers of all kinds. Yet, no one was reassuring them that they were indeed doing everything possible.

Current research does not inform providers about the best course of action, emotionally, for these couples. No one really knows what the best course of action is. Is it better to cover over the feelings and move on or is it better to talk about the feelings and experience them? Based on current information we cannot answer these questions and therefore it is prudent to assume that the couples are doing their best considering their own circumstances. Here are some examples of what participants said about Doing Everything We Can. One woman had this to say:

> M: I hope that we haven't made any errors along the way. That something wasn't overlooked or inadvertently, you know, sampling errors or whatever, happened. And there's never any way to know that, for sure. And having been closely involved with the medical field and cancer detection programs, specifically, I know that it happens. And so I just don't want to be one of those. But there's no protection. There isn't. I mean, everybody tries to do the best that they can. . . . Medicine isn't a perfect science, it's more of an art form. (1-007)

Other male partners commented:

> P: So that we have the feeling that we're doing everything we can, within reason, in order to deal with the problem. (2B-019)

> P: I just want to be able to do something to make it so she doesn't have to be sick. (2B-092)

> P: You know, you just kind of have to do the things you have to do. (2B-023)

> P: I'm not happy about it. What do you do? I can't change that, so I have to work with it. I wish I could. (2B-159)

One woman had this to say:

> M: But, I don't know what else I could do. Except try to be constructive about the way I deal with it, and not get hysterical about it. Because I think you need to make good decisions on these things. And I just don't know what else to do. (2A-055)

One man summed up his wife's situation:

> P: I think weight control is do-able. And that is something that may help. The rest of it, I don't know really, what she could do and I don't know what I could do. . . . I guess the medical care that my wife has gotten probably contributed a great deal to our acceptance of what happened. I think we both really felt, especially in leaving both times, that everything that could be done, was done. And I think that would probably bother me more than anything else, if we left something unturned . . . or if I didn't do something to make sure that she had the best possible care. I feel very good about the care that she's gotten. (2B-003)

The hope was that everything was being done to keep the cancer under control. For people who experienced an intense need for control, this was a difficult situation. They spoke of ways to feel in control or at least to be comfortable with their lack of control. Here are some examples:

> P: But they [doctors] are not as communicative, I think. I feel, you're in a situation where you feel you have no control, whatsoever, you see. And that's very insecure, for me especially. I feel that I can abrogate some of that insecurity by becoming knowledgeable, you know, and it seems to me the doctor could assist.

> N-C: So, you feel like you could get some control if you had some more knowledge?

> P: No. I don't think I could get any more control. But I'd feel more comfortable with the lack of control.

> N-C: Ah. All right.

> P: See, it's sort of like being happy to go over the cliff. But, yeah. There's no way that I'm going to have any control over it. And I think that troubles

> me more than it troubles her. I think men have a need, sociological or whatever, to be in control of the situation. Say, "Ah ha. You know, see, I can be a shield for her." And you see, "Ah ha. I can't." In this situation.
>
> N-C: Yeah. Is that something that's really true for you, P?
>
> P: Yeah. I mean, you know, I'm not overly macho or anything, but I've always felt a responsibility to care both financially and emotionally for my family, yeah. And I am doubly concerned about my financial care of the family as well as the medical care. And the emotional care I can deal with. See, I'm dealing more successfully with supporting her. I'm in control of that, you know, I'm in control of supporting her. I'm in control of helping her. I see that those things happen. But I can't see that this thing will go away. And it's not comfortable feeling that way. (3-019)

Another partner had this to say:

> P: You know, it's not something we like to talk about, but cancer is serious stuff, don't take it lightly. And there's always hovering there, this gray cloud, you know, she may not survive it. We're optimistic and we're hopeful and what have you. And we're planning for the fact that she does, but we don't . . . that's why, I guess, I'd like the doctor to be more communicative. You know, what the hell's going on? What are you finding in all these blood tests? You know, educate us more. (2B-019)

Here is an example of a man and woman who talked about gaining knowledge about the cancer:

> P: We had literature searches done at the libraries on the various, well, things going back up to 10 years, I think it was, on ductal type tumors. Probably can tell most anybody most anything they ever wanted to know about tumor types and percentages . . . so I think we made a very logical and straight-forward decision from that. But, you know, it always comes back to the 2% factor and you wait. You just wait and you know, hopefully, nothing happens. And hopefully the surgeons did their job correctly and the pathologist did his job correctly in sampling the breast and looking at the tissue sections. I don't doubt that he read them correctly. If there's anything I doubt, it's making sure that he sampled.
>
> M: There's always that possibility of sampling error. . . . And there's never any way to know that, for sure. (1-007)

At a later time in the interview she said:

> M: It was too overwhelming to be deciding all the other issues and, I don't know, if there are very many medical situations where the physicians would give you as many choices as I was given. I mean, with the experience that I've had with doctors, I was really surprised. Basically, they said, "These are all the things that we can do. You tell us which ones you want us to do."

> And it's like, you feel like you needed to go to medical school to answer the questions, you know? (1-007)

Another partner expressed his desire that the doctors were doing everything for his wife that they could:

> P: So, when M goes to see the doctor, what's the first thing that crosses my mind? Do you have my wife's interest at heart? Are they number one, above money, above research, above their interest in cancer, above your home and job? And I don't know if they do. And that bothers me. I have my wife's interest at heart, number one, above anything else. And I guess I'm looking for the doctors to assure me, that's what they have too. And maybe they all do. Maybe there are some Marcus Wellbys out there. (2B-049)

A discussion of the data analysis with clinical and research implications will be presented in the next chapter.

CHAPTER V

Discussion of the Findings

This research study was an exploratory effort designed to explicate the dyadic processes that develop between a woman diagnosed with breast cancer and her male partner and to hypothesize about the effect of these processes on the woman's recovery. A long-range goal for this line of research is to better understand the contextual factors that enhance psychological and physical health outcomes in both the diagnosed woman and her male partner. Contextual influences are those which are present at the level of the dyad, the family, the participant's health care provider, and the larger macro context. The focus for the current study was the dyadic processes that were inductively identified from a study of 15 women with early stage breast cancer and their male partners. Because of the exploratory nature of the study, I concentrated on constructing the pivotal processes that developed across individual and couple data rather than undertaking an analysis of the discrete interactions or causative effects of the interactions. In this chapter I discuss the processes, their interactive nature, and implications of the results for nursing intervention and also for future research.

Overview

Individual and dyadic processes were identified during the inductive data analysis. Processes are the active strategies that individuals and couples developed that aimed at managing or doing something about the cancer. The processes were not self-contained or static; they were recursive and bi-directional. That is, individual processes influence and were influenced by dyadic processes.

This study only begins to further the understanding of recovery from breast cancer as a relational process. It is clear that the dyadic processes influenced the way each partner framed the recovery. Both members of each dyad struggled to deal with their own and their partner's recovery and well-being. The dyadic processes were the foundation for the family's emotional climate as well as the individual processes.

Individual Processes

Individual level processes were generally active. The individual engaged in behavior to take charge of his/her life, to protect him/herself or others from the vulnerability inherent in the cancer diagnosis, or to obtain support in response to the diagnosis. Primarily women and some men said after the cancer diagnosis that they re-evaluated their current way of life, made changes in ways they were living life, and insured that they found ways to meet their needs. The cancer diagnosis acted like a signal for some people. They made a decision about how to travel through the journey of cancer with all its twists and turns. Some took an active role, making changes in their life because of the cancer. Others took a different stance, focusing primarily on limiting the impact of cancer in their lives. Still others acknowledged the cancer but focused most of their energy on getting their life back to its pre-diagnosis state.

Agency may be an individual characteristic which influenced the development of **taking charge of my life**; this process most likely influenced other processes both at the dyadic and at the contextual level. Agency, as active form of self, is the focus on self and forming separations. A person "taking charge" dealt differently with others and this influenced the way other processes developed. It can be argued that agency has some characteristics that overlap with self-efficacy, perceived control, sense of coherence, and perhaps even the "fighting spirit" discussed by Freidman et al. (1988). A similar response was described in other literature (Dowling, 1994; Kasper, 1989; Predeger, 1996). For example, Dowling quoted a woman who said, "I no longer think of myself as a person with cancer. I've discovered something else growing in me. I call it my voice, a voice that now tells me who I am and what I want to do. I first started hearing it after my breast cancer in 1986" (p.81). It is not clear why some women developed a new outlook or ways of getting their needs met. However, it is clear that this phenomenon has been reported as a common response to breast cancer across types of literature and experience. That is, this concept of "taking charge," "expressing needs," or "discovering a voice" was reported in prior research literature (Kasper; Predeger), lay literature (Dowling; Lorde, 1980), and in seminars and conferences in which breast cancer survivors described their experiences.

Seeking support was an active process primarily used by the woman to help her meet her needs for emotional expression. Women frequently talked about seeking out sisters, friends, or other women in order to help them process or talk about the emotions associated with the cancer. Women talked about going to a support group whether or not they felt supported in the relationship with their male partner. However, women who were frustrated with the level of emotional support in their relationship and who needed more intense emotional support seemed to reach out to others and especially to support groups more frequently than did women who wanted their lives back to normal or who were satisfied with the partner's emotional support.

Men rarely talked about seeking support. One man reported that he attended a support group which had been in place before the cancer diagnosis. Another man wondered if he would have benefited from counseling but made a decision not to pursue it. Men were more comfortable with "helping her" and talking about helping and doing things rather than about using or seeking support.

Support is an important aspect of the cancer recovery. Within the illness experience, the characteristics and aspects of social support which provide a beneficial or buffering effect are unknown. What is known is that seeking or using social support results in lower emotional distress (as measured by the Profile of Mood States) (Dunkel-Schetter et al., 1992). Furthermore, "seeking or using social support" was related to greater perceived stress from the cancer, more functional limitations, more frequent worry about cancer, and higher levels of education (Dunkel-Schetter et al.). Also reported were consistent effects for support group attenders, who were more likely to be female. Those having attended a support group "applied more coping efforts of all types, except distancing, to manage their cancers compared to those who had never met with a group" (Dunkel-Schetter et al.).

Protecting self or other reflected the overall vulnerability and uncertainty created by the illness. Partners protected each other, their children, and themselves. Protecting was a behavior which shielded emotions and concerns from another's view. Protecting behaviors involved insulating family members from exposure to distress about the cancer diagnosis. Protecting children from distress was especially important to these couples. They desired to protect their children and in many cases this influenced their expressed desire to return the household to its pre-cancer state.

Some women used coping behaviors approved of by others rather than what was best for their own recovery. They revealed concerns in the individual interviews that were not talked about in the couple interviews. They expressed concern about dealing with others' reactions to the cancer.

Dyadic Processes

Dyadic processes were those processes in which both members of the dyad were involved as compared to the individual processes accomplished by one person. The dyadic processes reflected patterns inherent in the couple's relationship before the breast cancer diagnosis, one's own response to the cancer, concern about the partner's response, and the desire to explicitly or implicitly deal with their partner's distress or style of coping.

Dyadic processes involved the couple's adaptations to each other as well as to the cancer. Partners influenced each other in direct or indirect ways to stay within their own emotional comfort level. Participants varied in their comfort level with communication about the cancer and its affect on the couple relationship and their personal lives. Couples generally supported treatment decisions but did not always agree on the proper course of action to take about the emotional aspects of the illness. Some couples talked and disagreed in the interview about their ideas for how much to discuss the cancer. Others implicitly agreed to normalize the household as if there were no other options. Getting the family back to normal was important for them. A few couples shared in the recovery process at an emotional level that seemed to satisfy both partners.

Sharing in the recovery and **helping her** were processes the couples developed which included actively engaging in the cancer recovery. Sharing in the recovery involved discussion of thoughts and emotions about the cancer and being able to appreciate the other's role in the cancer recovery. Couples using this process did not have a need to place limits on the other's response to the cancer. Helping her was an active problem solving approach and seemed to fit well with a male partner's need to be doing something to help out. In some cases male partners took on new tasks and behaviors that were not part of their previous repertoire.

Moderating the intrusion and **normalizing the household** were processes that couples used to limit the impact of the cancer on themselves or to return the household to the pre-cancer state. The process of moderating the intrusion of the cancer may have represented a way that male partners felt they could shield their wives from worries and concerns. Normalizing the household was different from moderating the intrusion in that it was more common that both partners actively participated in this process.

Dyadic processes in the current study fit a pattern of strategies identified in other research studies. Approach and avoidance coping, terms commonly used in the coping literature, represent the way that individuals address stressful situations for the purpose of self-protection. Barbee (1990) hypothesized that when the helping partner aids the distressed partner in dealing with the problem through the use of approach behaviors, "solve" or "support" strategies, the distressed partner will feel better. On the other hand, if the helping partner avoids or minimizes the situation or encourages the distressed partner to avoid or minimize through the use of "escape" or "dismiss" strategies, the distressed partner may remain depressed or become worse: "Ways of coping with a threat to one's own well-being such as minimizing or escaping may not be helpful to the other person" (Barbee, p. 50). Avoidant coping, also identified in studies by Dunkel-Schetter et al. (1992) and Friedman et al. (1990), has been associated with a higher level of emotional distress.

Labeling these processes as approach or avoidant does not seem useful to this study. Therefore, I have simply called them Type I and Type II. Type I processes were those in which the couple engaged in the cancer recovery by talking about the cancer, negotiating ways of doing things differently, and generally thinking about and processing the cancer experience. Type II processes were those in which the couple engaged in moderating the intrusiveness of the cancer recovery by talking about its disruptiveness and thinking about ways to moderate the cancer or return the household to the pre-cancer state. A comparison of dyadic processes identified in the current study along with those identified by Coyne et al. (1990) and Barbee (1990) can be found in Table 3.

TABLE 3. Comparison of dyadic coping processes

	Coyne et al.(1990)	**Barbee (1990)**	**Current Study**
Type I Process: Engaging in problem solving or emotional aspects of the recovery	**Active Engagement** a. involving partner in discussions b. asking how the partner feels c. other problem-solving methods	**Solve: Problem-focused/approach dimension** a. asking partner what's on their mind b. asking questions about the event	**Helping Her** a. helping her with household tasks b. encouraging her not to do too much c. little things making a difference
		Support: Emotion-focused/approach dimension a. affirming their ability b. doing something funny c. giving them affection	**Sharing the Recovery** a. discussing concerns about the cancer b. appreciating my partner c. disclosing feelings about emotions
Type II Process: Engaging in moderating the intrusiveness of the illness or returning the household to the pre-cancer state	**Protective Buffering** a. hiding concerns b. denying worries c. yielding to the partner	**Dismiss: Problem-focused/avoidance dimension** a. telling them their problem is not serious b. talking about own problems	**Moderating the Intrusion of the Cancer** a. not letting this affect us b. not dwelling on the cancer c. asking her to forget it
		Escape: Emotion-focused/avoidance dimension a. talking about the tasks b. talking about something the helper wants to talk about	**Normalizing the Household** a. getting back to normal b. keeping up a schedule

Coyne et al. (1990) developed the relational coping model in a study of myocardial infarction patients and their wives, a population more closely matched to the one in the current study than Barbee's (1990) sample. The overall categories of relational coping fit well with two of the dyadic processes that emerged in this study. Active engagement was comparable to **sharing the recovery** and protective buffering was comparable to **moderating the intrusion of the cancer**. The sub-categories for Coyne et al. were also similar to ones in the current study.

Barbee (1990) developed the interactive coping model by examining the behaviors of college students involved in helping or romantic relationships where no particular stressor was involved. The overall categories were: solve, support, dismiss, and escape. These categories were generally comparable to the ones that were identified in the current study. However, discrete sub-categories were moderately different between the two studies. This reflects the differences in study population, I believe.

Northouse and Peters-Golden (1993) noted that the spouse's protective buffering or moderating the intrusiveness of the illness was not effective: "It is precisely this response that is overwhelmingly cited as unhelpful by breast cancer patients" (p. 79). In her study of the family's experience with early stage breast cancer, Hilton (1996) noted that "getting back to normal" was the central family experience. The family may feel more secure when women are functioning as they were before the cancer. However, the question remains: Is this the best process for the woman as well? As a family coping process, normalizing the household best served the purposes of the entire family but may have put pressure on the woman.

As Gottlieb and Wagner (1992) suggested in their study of couples coping with a child's illness, it is possible that these dyadic processes were not entirely about the issues of dealing with the illness itself but may have more to do with conflict over amplification and modulation of emotionality. Discrepancies in responses and coping strategies may concern being emotionally over involved or under involved, as perceived by the partner, than with adaptation to the cancer. Partners may become occupied with reinforcing responses they approve of or that they think will fight the cancer, for example, positive thinking rather than feeling sad.

Lewis and Deal (1995) noted the use of avoidant strategies in couples coping with recurrent breast cancer. Couples used the strategy of "balancing their lives" but possibly at a high cost to their marital satisfaction and mood: "Although avoidant strategies may be helping some to manage what they are experiencing, these strategies may not necessarily be helping all of the couples to regulate their mood or marital tension" (p. 951).

Dyadic Processes and Women's Response

One aim of the current study was to hypothesize about the effects of the dyadic processes on the woman's response. This aim reflected the question posed by Butler (1995): "What are the concrete conditions under which agency becomes possible?" (p. 11). The Type II strategies, **normalizing the household** and **moderating the intrusion of the cancer**, most likely interfered with the development of agency, although it is difficult to conclude that agency could not develop in the presence of those processes. In some cases the woman actively described taking charge of her life despite the partner's response.

Taking charge of my life may be a pivotal process in the overall schema. Women who were able to enact this process were more likely to negotiate to get what they wanted from providers and partners, to gain compensatory emotional support from support groups in the absence of support from their partner, and to take care of themselves in ways they did not before the cancer diagnosis.

In the absence of **taking charge of my life**, women were more likely to go along with a partner who was intent on **moderating the intrusion of the cancer** or striving to "normalize the household" for the sake of the family. Hilton (1996) observed this as well when she described a normalizing response as "We're back to typical mother. She's functioning on all 27 of her 14 cylinders" (p. 608). **Normalizing the household** may not be an optimal process for the woman's recovery even though partners and other family members desired this outcome. Unknown are the consequences to the woman when normalizing the household is the basis of dyadic process.

The Type I processes, **sharing in the recovery** and **helping her,** may facilitate the woman's recovery although that is not something I can conclude from this type of data analysis. The couples who were able to share and discuss issues about the breast cancer recovery may have had this type of relationship prior to the diagnosis.

The Breast Cancer Context

The overall breast cancer context is one that engenders fear. The context within which coping occurs may influence the development of the coping strategies used in response to a breast cancer diagnosis. The dyadic process of **doing everything we can** developed during contextualizing the data analysis. Placing the data analysis in a larger context resulted in a broader perspective or understanding that the couples, regardless of strategies, were doing their best. As one man said, "We are doing everything we can to safeguard my wife's health."

In previous research studies, there is evidence that the use of avoidant strategies or the type of strategies that focus the family's energy away from the issues of the cancer are associated with increased emotional distress at the individual level (Dunkel-Schetter et al., 1992; Friedman et al., 1988). Whether this is true at the dyadic level is unclear. No one really knows what the best course of action is. Is it better to cover

over the feelings and move on or is it better to discuss the feelings and experience them? Studies examining self-disclosure revealed that disclosing feelings about traumatic situations can result in improved immune functioning (Pennebaker et al., 1988). In addition, articles appearing in the popular press attract attention in their appeal to public interest regarding the influence of psychological variables and positive thinking on the development and prognosis of cancer. Our societal view regarding positive thinking may be misleading but nevertheless some couples have embraced that concept. It will be an important future step to determine which processes promote effective health outcomes.

Clinical Implications

The nursing care of families at the system level may obscure the needs and concerns of each individual for the sake of the greater good. Nursing intervention for families will be enhanced by the recognition of the tension between the individual and the family. Women may be particularly susceptible to putting their own needs aside for the good of their families. It is imperative that women's needs during the breast cancer recovery are placed at the forefront. Women may need specific instruction to help them take charge of their cancer experience and explicitly learn communication skills that will assist them in their interactions with both providers and partners. Carpenter and Scott (1992) suggested that relational competence will lead to the use of more effective coping strategies.

Women felt that their needs for self-disclosure were not always met within the partner relationship. Several women discussed their need to seek helping relationships outside of the partner relationship in order to meet their own needs for support. Pistrang and Barker (1995) found that satisfaction with the partner helping relationship was associated with psychological well-being but that a good helping relationship with another person did not compensate for a problematic helping relationship with the partner.

The current study suggested that both men and women are doing everything they can to manage the cancer recovery. One way to assist couples is to help them understand the range of coping strategies that are common after the breast cancer diagnosis. Couples may need instruction that addresses the different types of processes, those aimed at facing the issues of the breast cancer and those aimed at moderating the cancer or returning to the pre-cancer state. Both may be important to the recovery process. As well, learning about the preferred strategies of the partner may facilitate couple coping. Men and women who were more comfortable with embracing the cancer issues or those more comfortable with hiding or denying worries may need to learn to understand and better fit with their partner's pattern. For example, active discussions about the cancer may lead to emotional flooding and excessive worry. However, a letting go may occur with these discussions while protective buffering may provide a rest from some of these discussions.

Implications for Future Research Studies

The current study is a foundation for future research aimed at linking the couple processes with health outcomes. The most needed research study concerns the health outcomes associated with each type of dyadic process. It will be important to include aspects of the medical context to determine the best communication strategies for health care providers when discussing the couple's response to the diagnosis and emotional demands. Future studies might focus on the couple's awareness of the differences in coping between the woman and man.

Limitations of the Study

Limitations of the present study included single occasion data analysis and homogeneity of the sample population (the couples were primarily middle-aged, middle-class, educated Caucasian couples, all with children). Audiotaped interviews did not allow the researcher to observe discrete intricacies in interaction such as body language, eye contact, and voice qualities of the participants, which may or may not have influenced the data analysis.

Summary

This study was an initial attempt to inductively describe the individual and dyadic processes of couples during early stage breast cancer recovery. Couples responding to early stage breast cancer are doing everything they can to deal with the cancer diagnosis and to secure their own comfort level in doing that. Their engagement in the different types of individual and dyadic processes may be reflective of the openness of their marriage, their comfort level with different coping strategies and their abilities to communicate about the cancer recovery. Nursing intervention addressing these issues can enhance the cancer recovery process. Couples may need specific interventions that help them to better understand their own and their partner's responses and coping strategies.

REFERENCES

American Cancer Society. (1996). Breast cancer facts and figures. Atlanta: Author.

Armsden, G. C., & Lewis, F. M. (1994). Behavioral adjustment and self-esteem among school-age children of mothers with breast cancer. Oncology Nursing Forum, 21, 39-45.

Barbee, A. P. (1990). Interactive coping: The cheering-up process in close relationships. In S. Duck (Ed.), Personal relationships and social support (pp. 46-65). Newbury Park, CA: Sage.

Bean, G., Cooper, S., Alpert, R., & Kipnis, D. (1980). Coping mechanisms of cancer patients: A study of 33 patients receiving chemotherapy. CA- A Cancer Journal of Clinicians, 30 (5), 256-259.

Benson, M. J., & Deal, J. E. (1995). Bridging the individual and the family. Journal of Marriage and the Family, 57 (3), 561-565.

Block, K., Brandt, P., & Magyary, D. (1994). A nursing assessment standard for early intervention: Family coping. Journal of Pediatric Nursing, 10 (1), 28-39.

Bloom, J. R. (1982). Social support, accommodation to stress, and adjustment to mastectomy. Social Science and Medicine, 16, 1329-1338.

Blumer, H. (1969). Symbolic interactionism: Perspective and method. Berkeley, CA: University of California Press.

Bogdan, R., & Biklen, S. K. (1992). Qualitative research for education: An introduction to theory and methods (2nd ed.). Boston: Allyn & Bacon.

Butler, J. (1995). Introduction. In S. Benhabib, J. Butler, D. Cornell, & N. Fraser (Eds.), Feminist contentions: A philosophical exchange (pp. 1-16). New York: Routledge.

Carpenter, B. N., & Scott, S. M. (1992). Interpersonal aspects of coping. In B. N. Carpenter (Ed.), Personal coping: Theory, research and application (pp. 93-109). Westport, CT: Praeger.

Coyne, J. C., Ellard, J. H., & Smith, D. A. F. (1990). Social support, interdependence, and the dilemmas of helping. In I. G. Sarason, B. R. Sarason, & G. Pierce (Eds.), Social support: An interactional view (pp. 129-149). New York: Wiley.

Coyne, J. C., & Smith, D. A. F. (1991). Couples coping with a myocardial infarction: A contextual perspective on wives' distress. Journal of Personality and Social Psychology, 61 (3), 404-412.

Denzin, N. K. (1989). Interpretive interactionism. Newbury Park, CA: Sage Publications.

Dowling, C. G. (1994, May). Fighting back. Life, 79-88.

Dunkel-Schetter, C., Feinstein, L. G., Taylor, S. E., & Falke, R. L. (1992). Patterns of coping with cancer. Health Psychology, 11 (2), 79-87.

Dunkel-Schetter, C., & Wortman, C. (1982). The interpersonal dynamics of cancer: Problems in social relationships and their impact on the patient. In H. Friedman & M. DiMatteo (Eds.), Interpersonal issues in health care (pp. 69-100). New York: Academic Press.

Eckenrode, J. (1991). Introduction and overview. In J. Eckenrode (Ed.), The social context of coping (pp. 1-12). New York: Plenum Press.

Ewart, C. K. (1993). Marital interaction: The context for psychosomatic research. Psychosomatic Medicine, 55, 410-412.

Fawzy, F. I., Kemeny, M. E., Fawzy, N. W., Elashoff, R., Morton, D., Cousins, N., & Fahey, J. L. (1990). A structured psychiatric intervention for cancer patients: Changes over time in immunological measures. Archives of General Psychiatry, 47, 729-735.

Folkman, S. (1992). Making the case for coping. In B. N. Carpenter (Ed.), Personal coping: Theory, research and application (pp. 31-46). Westport, CT: Praeger.

Friedman, L. C., Baer, P. E., Nelson, D. V., Lane, M., Smith, F. E., & Dworkin, R. J. (1988). Women with breast cancer: Perception of family functioning and adjustment to illness. Psychosomatic Medicine, 50, 529-540.

Friedman, L. C., Nelson, D. V., Baer, P. E., Lane, M., & Smith, F. E. (1990). Adjustment to breast cancer: A replication study. Journal of Psychosocial Oncology, 8 (4), 27-40.

Germino, B. B., Fife, B. L., & Funk, S. G. (1995). Cancer and the partner relationship: What is its meaning? Seminars in Oncology Nursing, 11 (1), 43-50.

Gilgun, J., Daly, K., & Handel, G. (1992). Qualitative methods in family research. Newbury Park, CA: Sage.

Gotay, C. C. (1984). The experience of cancer during early and advanced stages: The views of patients and their mates. Social Science and Medicine, 18 (7), 605-613.

Gotay, C. C., & Stern, J. D. (1995). Assessment of psychological functioning in cancer patients. Journal of Psychosocial Oncology, 13 (1/2), 123-160.

Gottlieb, B. H., & Wagner, F. (1992). Stress and social support in close relationships. In J. Eckenrode (Ed.), The social context of coping (pp. 165-188). New York: Plenum Press.

Hannum, J. W., Giese-Davis, J., Harding, K., & Hatfield, A. K. (1991). Effects of individual and marital variables on coping with cancer. Journal of Psychosocial Oncology, 9 (2), 1-20.

Hansson, R. O., & Carpenter, B. N. (1990). Relational competence and adjustment in older adults: Implications for the demands of aging. In M. A. P. Stephens, J. H. Crowther, S. E. Hobfall, & D. L. Tennenbaum (Eds.), Stress and coping in later-life families (pp. 131-151). Washington, DC: Hemisphere.

Hartrick, G. A., & Lindsey, A. E. (1995). The lived experience of family: A contextual approach to family nursing practice. Journal of Family Nursing, 1 (2), 148-170.

Helgeson, V. S. (1994). Relation of agency and communion to well-being: Evidence and potential explanations. Psychological Bulletin, 116 (3), 412-428.

Herbert, T. B., & Cohen, S. (1993). Stress and immunity in humans: A meta-analytic review. Psychosomatic Medicine, 55, 364-379.

Hilton, B. A. (1996). Getting back to normal: The family experience during early stage breast cancer. Oncology Nursing Forum, 23 (4), 605-614.

Hobfall, S. E. (1986). The ecology of stress and social support among women. In S. E. Hobfall (Ed.), Stress, social support, and women (pp. 3-14). Washington, DC: Hemisphere Publishing Corporation.

Hoskins, C. N. (1995). Adjustment to breast cancer in couples. Psychological Reports, 77, 435-454.

Jack, D. C. (1991). Silencing the self: Women and depression. Cambridge, MA: Harvard University Press.

Jevne, R. F. (1991). A practical model for empowering cancer patients: Inviting patients to restory their experience. Symposium conducted at the meeting of

The National Institute for the Clinical Application of Behavioral Medicine, Orlando, Florida.

Kasper, A. S. (1989). Women with breast cancer: A feminist analysis (Doctoral dissertation, The George Washington University, 1988). Dissertation Abstracts International, 49, 11A.

Kiecolt-Glaser, J. K., Malarkey, W. B., Chee, M., & Newton, T. (1993). Negative behavior during marital conflict is associated with immunological down-regulation. Psychosomatic Medicine, 55 (5), 395-409.

Krant, M. J., & Johnston, L. (1978). Family members' perceptions of communication in late stage cancer. International Journal of Psychiatry in Medicine, 8 (2), 203-216.

LaRossa, R., & Reitzes, D. C. (1993). Symbolic interactionism and family studies. In P. G. Boss, W. J. Doherty, R. LaRossa, W. R. Schumm, & S. K. Steinmentz (Eds.), Sourcebook of family theories, and methods: A contextual approach (pp. 135-166). New York: Plenum Press.

Lazarus, R. S., & Folkman, S. (1984). Stress, appraisal, and coping. New York: Springer.

Lewis, F. M. (1983). Family level services for the cancer patient: Critical distinctions, fallacies, and assessment. Cancer Nursing, 6 (3), 193-200.

Lewis, F. M. (1986). The impact of cancer on the family: A critical analysis of the research literature. Patient Education and Counseling, 8, 269-289.

Lewis, F. M. (1993). Psychosocial transitions and the family's work in adjusting to cancer. Seminar in Oncology Nursing, 9 (2), 127-129.

Lewis, F. M., & Bloom, J. R. (1978). Psychosocial adjustment to breast cancer: A review of selected literature. International Journal of Psychiatry in Medicine, 9, 1-17.

Lewis, F. M., & Deal, L. W. (1995). Balancing our lives: A study of the married couple's experience with breast cancer recurrence. Oncology Nursing Forum, 22 (6), 943-953.

Lewis, F. M., Ellison, E. S., & Woods, N. F. (1985). The impact of breast cancer on the family. Seminars in Oncology Nursing, 1 (3), 206-213.

Lewis, F. M., Haberman, M. R., & Wallhagen, M. I. (1986). How adults with late-stage cancer experience personal control. Journal of Psychosocial Oncology, 4 (4), 27-42.

Lewis, F. M., & Hammond, M. A. (1992). Psychosocial adjustment of the family to breast cancer: A longitudinal analysis. Journal of the American Medical Women's Association, 47, 194-200.

Lewis, F. M., & Hammond, M. (1996). The father's, mother's, and adolescent's functioning with breast cancer. Family Relations, 45, 456-465.

Lewis, F. M., Hammond, M., & Woods, N. F. (1993). The family's functioning with newly diagnosed breast cancer in the mother: The development of an explanatory model. Journal of Behavioral Medicine, 16, (4), 1-17.

Lewis, F. M., & Woods, N. F. (1995). Women with chronic illness: Their views of their families' adaptation. Health Care for Women International, 16, 135-148.

Lewis, F. M., Woods, N. F., Hough, E. E., & Bensley, L. S. (1989). The family's functioning with chronic illness in the mother: The spouse's perspective. Social Science and Medicine, 29 (11), 1261-1269.

Lincoln, Y. S., & Guba, E. G. (1985). Naturalistic inquiry. Beverly Hills, CA: Sage.

Lorde, A. (1980). The cancer journals. San Francisco: aunt lute books.

Loveys, B. J., & Klaich, K. (1991). Breast cancer: Demands of illness. Oncology Nursing Forum, 18, (1), 75-80.

McCubbin, H. I., Cauble, A. E., & Patterson, J. M. (Eds.) (1982). Family stress, coping, and social support. Springfield, IL: Charles C. Thomas.

McCubbin, H. I., & Patterson, J. M. (1982). Family adaptation to crisis. In H. I. McCubbin, A. E. Cauble, & J. M. Patterson (Eds.), Family stress, coping, and social support. Springfield, IL: Charles C. Thomas.

Miles, M. B., & Huberman, A. M. (1994). Qualitative data analysis: An expanded sourcebook. Thousand Oaks, CA: Sage.

Miller, J. B. (1976). Toward a new psychology of women. Boston: Beacon Press.

Morris, T., Greer, H. S., & White, P. (1977). Psychological and social adjustment to mastectomy: A two-year follow-up study. Cancer, 40, 2381-2387.

Northouse, L. L. (1990). A longitudinal study of the adjustment of patients and husbands to breast cancer. Oncology Nursing Forum, 17, (3), 39-43.

Northouse, L. L. (1992). Psychological impact of the diagnosis of breast cancer on the patient and her family. Journal of the American Medical Women's Association, 47 (5), 161-164.

Northouse, L. L. (1995). The impact of cancer in women on the family. Cancer Practice, 3 (3), 134-142.

Northouse, L. L., & Peters-Golden, H. (1993). Cancer and the family: Strategies to assist spouses. Seminars in Oncology Nursing, 9 (2), 74-82.

Notarius, C. I., & Herrick, L. R. (1989). The psychophysiology of dyadic interaction. In H. Wagner & A. Manstead (Eds.), Handbook of social psychophysiology (pp. 394-419). New York: John Wiley & Sons.

Olson, D. H., & McCubbin, H. I. (1982). Circumplex model of marital and family systems: Application to family stress and crisis intervention. In H. I. McCubbin,

A. E. Cauble, & J. M. Patterson (Eds.), Family stress, coping, and social support. Springfield, IL: Charles C. Thomas.

Parle, M., & Maguire, P. (1995). Exploring relationships between cancer, coping and mental health. Journal of Psychosocial Oncology, 13 (1/2), 27-50.

Pennebaker, J. W., Kiecolt-Glaser, J. K., & Glaser, R. (1988). Disclosure of traumas and immune function: Health implications for psychotherapy. Journal of Consulting and Clinical Psychology, 56 (2) 239-245.

Personal Narratives Group. (1989). Conditions not of her own making. In Personal Narratives Group (Eds.), Interpreting women's lives: Feminist theory and personal narratives (pp. 19-23). Bloomington, IN: Indiana University Press.

Peters-Golden, H. (1982). Breast cancer: Varied perceptions of social support in the illness experience. Social Science and Medicine,16, (4), 483-491.

Pistrang, N., & Barker, C. (1995). The partner relationship in psychological response to breast cancer. Social Science and Medicine, 40 (6), 789-797.

Predeger, E. (1996). Woman spirit: A journey into healing through art in breast cancer. Advances in Nursing Science, 18 (3), 48-58.

Ptacek, J. T. (1992). Gender differences in coping with stress: When stressor and appraisal do not differ. Unpublished doctoral dissertation. University of Washington.

Quint, J. Q. (1963). The impact of mastectomy. American Journal of Nursing, 63, 88-92.

Reiss, D., Gonzales, S., & Kramer, N. (1986). Family process, chronic illness, and death: On the weakness of strong bonds. Archives of General Psychiatry, 43, 795-804.

Rosenblatt, P. C., & Fischer, L. R. (1993). Qualitative family research. In P. G. Boss, W. J. Doherty, R. LaRossa, W. R. Schumm, & S. K. Steinmentz (Eds.), Sourcebook of family theories, and methods: A contextual approach (pp. 167-177). New York: Plenum Press.

Rosser, J. E. (1981). The interpretation of women's experience: A critical appraisal of the literature on breast cancer. Social Science and Medicine, 15, 257-265.

Somerfield, M., & Curbow, B. (1992). Methodological issues and research strategies in the study of coping with cancer. Social Science in Medicine, 34 (11), 1203-1216.

Spiegel, D. (1995). Commentary. Journal of Psychosocial Oncology, 13 (1/2), 115-121.

Stetz, K. M., Lewis, F. M., & Primomo, J. (1986). Family coping strategies and chronic illness in the mother. Family Relations, 35, 515-522.

Strauss, A. L. (1987). Qualitative analysis for social scientists. Cambridge, UK: Cambridge University Press.

Strauss, A. L., & Corbin, J. (1990). Basics of qualitative research: Grounded theory procedures and techniques. Newbury Park, CA: Sage.

Streubert, H. J., & Carpenter, D. R. (1995). Qualitative research in nursing: Advancing the humanistic imperative. Philadelphia, PA: Lippincott.

Surrey, J. L. (1991). The "self-in-relation": A theory of women's development. In J. V. Jordan, A. G. Kaplan, J. B. Miller, I. P. Stiver, & J. L. Surrey (Eds.), Women's growth in connection. New York: The Guilford Press.

Taylor, S. E., Lichtman, R. R., & Wood, J. V. (1984). Attributions, beliefs about control, and adjustment to breast cancer. Journal of Personality and Social Psychology, 46 (3), 489-502.

Thompson, L., & Walker, A. J. (1982). The dyad as the unit of analysis: Conceptual and methodological issues. Journal of Marriage and the Family, 44, 889-900.

Vachon, M. L., Freedman, K., Formo, A., Rogers, J., Lyall, W. A., & Freeman, S. J. (1977). The final illness in cancer: The widow's perspective. Canadian Medical Association Journal, 117, 1151-1154.

Webster's New World Dictionary (1968). Cleveland: World Publishing Company.

Wellisch, D. (1981). Family relationships of the mastectomy patient: Interactions with the spouse and children. Israel Journal of Medical Science, 17, 993-996.

Wellisch, D. K., Jamison, K. R., & Pasnau, R. O. (1978). Psychosocial aspects of the mastectomy II: The man's experience. American Journal of Psychiatry, 135, (5), 543-546.

Zahlis, E. H., & Shands, M. E. (1991). Breast cancer: Demands of illness on the patient's partner. Journal of Psychosocial Oncology, 9 (1), 75-93.

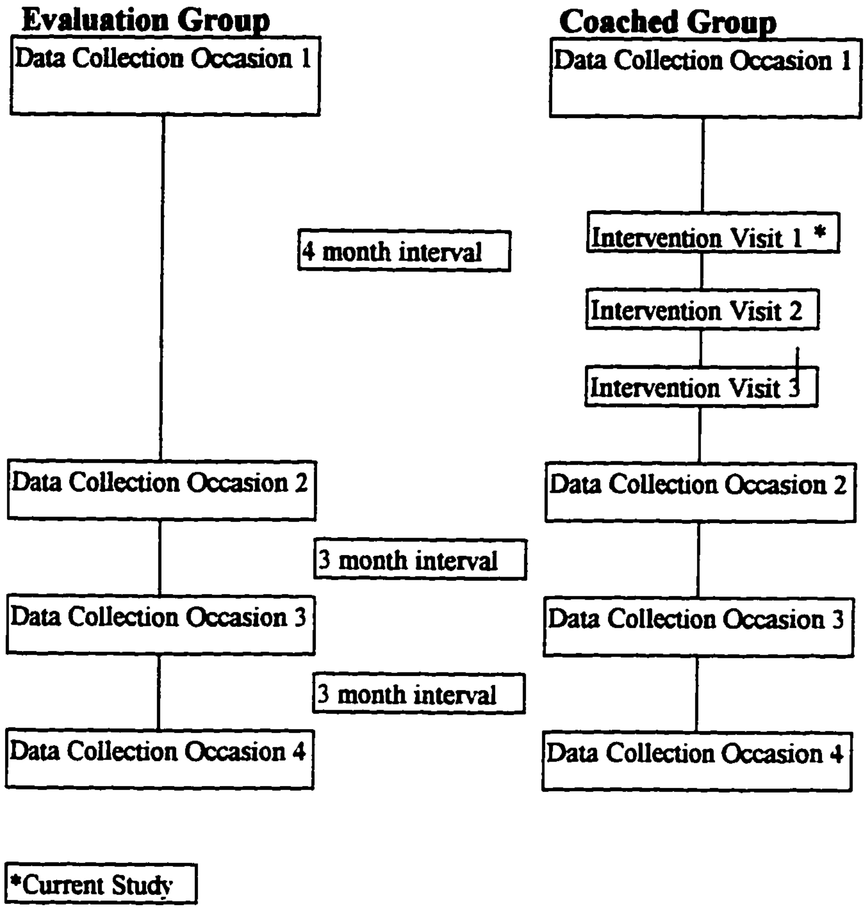
APPENDIX A

Study Design for Family Home Visitation Study

The Family Home Visitation Program:

The Nurse as Coach

Study Design



APPENDIX B

Interview Questions for Family Visitation

First Couple Interview (Sequence 1)

Some couples appreciate having the opportunity to discuss issues they are experiencing with an objective listener. We hope we can be that for you. We want to give you the opportunity to talk about the ways the breast cancer is affecting your lives.

1. Can you tell us how the breast cancer is affecting the two of you now?
2. How have things changed for you as a couple (couple issue is a common issue or something you both have feelings about) since the breast cancer was diagnosed?
3. Are there issues or concerns you have as a couple about the breast cancer?

Transition from Sequence 1 to Sequence 2A/2B

Now we would like to spend about 20 minutes with each of you separately to talk about similar issues. We've found with other couples that they appreciate having private time with us. Then we will get back together and spend the last block of time with you together.

Woman's Interview (Sequence 2A)

Some women find that after they are diagnosed with breast cancer their lives change in some ways.

1. What parts of your daily life have changed since your breast cancer?
   (PROBE: What sorts of changes have you had to make in your daily life?)
2. What kind of things have been particularly difficult for you?
3. What things have you felt unprepared for?
4. Is there anything more you would like to tell me about your experience?

Transition from Sequence 2A/2B to Sequence 3

This next session will be an opportunity for you and your partner to choose what will be discussed. It might be that in talking, some things have come up for you that you would like to discuss further in the next session.

Partner's Interview (Sequence 2B)

Some men find that after their wives/partners are diagnosed with breast cancer their lives change in some ways.

1. What parts of your daily life have changed since your wife/partner was diagnosed with breast cancer? (PROBE: What sorts of changes have you experienced in your daily life?)

2. What kinds of things have been particularly difficult for you?

3. What things have you felt unprepared for?

4. Is there anything more you would like to tell me about your experience?

Transition from Sequence 2A/2B to Sequence 3

This next session will be an opportunity for you and your partner to choose what will be discussed.. It might be that in talking, some things have come up for you that you would like to discuss further in the next session.

Second Couple Interview (Sequence 3)

You've had time together and time individually talking with us about the breast cancer. In the course of these discussions some things may have surfaced, been clarified, or crystallized for you that you would like to work on and talk more about.

1A. What would you like to spend some time talking about further?
(Allow listing of more than one concern.)

1B. Of all these, which one are you currently dealing with that you would want to spend time on now?

(Alternative: Is there one issue or concern which stands out as the most important one we might spend time now working on together?)

APPENDIX C

Researcher Background

I have been a research assistant with family and women's research projects including the Family Home Visitation Study (Principal Investigator- Dr. Frances M. Lewis, 1992); Family Health Study (Principal Investigator- Dr. Clarann Weinart, Dr. Marci Catanzaro and Dr. Patricia Brandt, 1990); The University of Washington Parenting Clinic (Principal Investigator- Dr. Carolyn Webster-Stratton, 1992); and the Women's Irritable Bowel Syndrome Study (Principal Investigator- Dr. Margaret Heitkemper and Dr. Monica Jarrett, 1991). I participated in the design and implementation of two psychoeducational intervention programs. One is an ongoing project for couples, a preventative intervention for transition to parenthood that emphasizes marital communication (Principal Investigator - Dr. Pamela Jordan and Dr. Kathryn Barnard, 1992) and is based on the Premarital Relationship Enhancement Program (PREP). The other one, also ongoing, is a Breast Cancer Awareness Program for women emphasizing skill building and coping strategies for dealing with the risk of breast cancer. I am certified as a Clinical Specialist in Psychiatric and Mental Health Nursing by the American Nurses Association and am licensed as a Nurse Practitioner in the State of Washington. My training and experience working with families, couples, and women provided a foundation for this data analysis.

APPENDIX D

Demographic Data

Family #	Age of Woman	Age of Man	Years of Relation	Number of Children	Age of Children	Length of Diagnosis (in months)	Type of Treatment *
003	44	41	21	2	15, 12	3	M
007	42	42	24	2	6, 6	1	M
010	43	42	23	2	19, 14	3	M, C
019	49	54	31	1	18	3	M, C
023	42	40	10	2	7, 2	2	M
035	41	41	19	2	12, 9	5	L, R
049	44	52	3	1	19	5	M
055	40	37	4	1	20	4	L, R
066	51	49	21	2	11, 9	4	M, C
090	42	43	22	6	15, 14, 12, 10, 8, 6	11	M, C, R
092	45	44	22	1	1	6	M, C
120	39	41	13	2	5, 1	5	L, C, R
133	48	54	25	1	17	7	M, C
147	29	30	8	2	4, 3	3	M, C
159	42	48	18	2	10, 7	9	M, C
SD	5.06	6.56	8.19	1.22	5.53	2.65	
Mean	42.73	43.87	17.6	1.93	10.65	4.73	
Median	42	42	21	2	10.5	4	
Sum				29			

* M= mastectomy

L= lumpectomy

C= chemotherapy

R= radiation therapy

Vita

Name: Gretchen M. Zunkel

Education: University of Colorado, Denver: Bachelor of Science in Nursing, 1972

University of California, Los Angeles: Master of Nursing (Cardiovascular Nursing and Nursing Education), 1977

University of Washington, Seattle: Master of Nursing (Psychosocial and Community Health Nursing), 1995

University of Washington, Seattle: Doctor of Philosophy (major in Family Adaptation to Health and Illness, minor in Clinical Therapeutics, cognate in Psychology), 1996