INTERACTIONAL PATTERNS IN FAMILIES
OF PATIENTS WITH BREAST CANCER

DISSERTATION

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This study utilized ethnographic methodology to describe the communicative interactional patterns in families with a member who has breast cancer. Three breast cancer patients whose families were between the adolescent and launching of children developmental lifestage (McGoldrick & Carter, 1982) were chosen for the study.

Data were collected from a series of three interview sessions over a period of four weeks with a two week time lapse between each of the interview sessions. Interview sessions were conducted in the families' homes by the researcher. All interviews were video and audio tape recorded for the purpose of preserving data for transcribing and coding.

Research questions examined individual perception of meaning in regard to the disease, the structure and organization of the family in relation to the illness, and the effects of family communicative interaction on the course and management of the disease.
Findings indicated that family members' responses to the diagnosis of breast cancer were influenced by multi-generational beliefs. All three families formulated a collective belief which supported the mother's belief about the disease.

Each of the three families were mother-centered, and each mother seemed to use a metacommunicative approach to mediating family transactions. Each of the three fathers were reported as having been isolated and withdrawn within the family at various times. However, each father appeared to play a protective role in deflecting tension and stress away from the mother.

All three couples appeared to have constructed an egalitarian relationship with an implicit agreement as to who was more skilled to hold the power within a particular context. In all three families, the generational boundaries were clearly defined.

Conflict and affect were most generally expressed in an indirect manner through wit and sarcasm. However, because each of these three families were structured to allow for personal autonomous functioning of each individual member, patients were supported in seeking a modality outside of the family system to express more ambivalent feelings.
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CHAPTER I

INTRODUCTION

Within psychological research archives, many studies have indicated that emotional phenomena accompany or lead to physical phenomena. Kowall (1955) has provided a frequently cited historical synthesis of studies that point to the psychological factors that have significant influence on the etiology, course, and outcome of cancer. These studies largely focus on the individual in relation to emotionality or stress. Scant attention has been paid to the fact that emotionality and stress often evolve within a communicative interactional system of social relationships, particularly the family.

A family uses repeated transactional patterns to establish how, when and to whom each member relates. Ideally, when change occurs within the family, members will be flexible enough to generate alternative transactional patterns and accommodate the change (Minuchin, 1974).
In his study of transactional patterns within families with a diabetic child, Minuchin (1978) observed a cluster of transactional patterns he believed to be characteristic of a family process that encourages somitization in a child. From these findings, Minuchin proposed a model of the psychosomatic family.

Despite Minuchin's pioneering work, little is known about the patterns of family interaction that may have a significant influence on bodily function (Weakland, 1977), and even less is known about interactional patterns that may influence a specific disease such as metastatic cancer. One out of every 14 women in the United States will be diagnosed as having breast cancer (NCI, 1979). The breast cancer patient not only deals with the fear of recurrence of the disease, but also copes with disfigurement caused by the loss of the affected breast. The breast cancer patient's family network of interpersonal interactions may constitute an important resource for adjustment to and management of the disease. Simonton (1984) discussed the positive healthy environment of what she terms the healing family. She maintained that the cancer patient's emotional environment may be either a positive or negative force for healing.

An exploratory investigation into family interactions in relation to family members with breast cancer
could contribute to further understanding of the influence of patterns of family interactions on bodily function; and insight into interactional patterns observed within these families could provide implications for therapeutic intervention. This study has broadened the view of psychological factors influencing breast cancer by describing patterns of communicative interaction in families with a member who has breast cancer. The study has provided information that could give a theoretical impetus to future research that would attempt to discern significant relationships between interactional patterns and management of breast cancer.

A qualitative research methodology, ethnomethodology, has facilitated a flexible, in-depth study into these interactional patterns. Ethnomethodology is a relatively new approach to qualitative research (Bogdan & Biklen, 1982) with its origins in the phenomenological tradition which emphasizes the interpretive understanding of human interaction (Douglas, 1976). Phenomenologists focus on the subjective aspects of behavior within the conceptual world of their subjects (Geertz, 1973). According to phenomenologists, it is the interpretive meaning of individual conceptual experience that constitutes an individual's reality (Barker, 1968). Consequently, as individuals interact, experience is interpreted in
multiple realities. Interpretation of individual experience is influenced through interaction with others. So, the ethnographic researcher attempts to understand how people go about seeing, explaining, and describing order in the world in which they live (Bogdan & Biklen, 1982; Cock, 1979). Through examination of data gathered in the ethnographic method, regularities in the manner in which breast cancer is conceptualized and handled within families could lead to the development of an interactional theoretical model of these families.

Statement of the Problem

While there is a growing concern regarding how the family environment influences the course and management of a serious illness such as breast cancer, there is little information available to medical or counseling personnel who work with these families. This study describes the communicative interactional patterns in families with a member who has breast cancer.

Synthesis of Related Literature

Intrapersonal

From a historical perspective, the psychodynamic aspects of cancer were the subject of scientific inquiry as early as the eighteenth and nineteenth century.
Observational techniques were used to establish relationships between disease process and psychological variables (Kowall, 1955). A common theme resounding throughout these reports was a notation that frequently individuals who had experienced significant loss or extreme frustration responded to this loss with despair and helplessness. It was believed that these psychological variables contributed to the precipitation of neoplastic growth (Fox, 1976; Kowal, 1955; LeShan, 1959; Paget, 1870; Snow, 1893; Walshe, 1846).

Interest in the psychological aspects of cancer continued to be reflected during the early twentieth century through continued observation and case study. Other psychological correlates to cancer such as frequent occurrence of emotional difficulties and inability to discharge anger were noted (Bacon, Renneker, & Cutler, 1952; Miller & Jones, 1948).

Similarly, Greene (1954, 1956, 1958, 1966), through observation and interview, conducted numerous studies whose findings indicated psychological correlates of disease. One study (Green, 1966) examined three series of patients and the results indicated leukemia and lymphoma developed in a setting in which the patient was attempting to cope with significant losses, accompanied by feelings of sadness, anger, or hopelessness.
LeShan (1959), reviewed cancer research with a psychological emphasis and identified common carcinogenic personality characteristics. He noted that, typically, the cancer patient has had severe emotional disturbance in early childhood which, most frequently, has been divorce or death of a parent, or chronic friction between parents. This individual, in an attempt to form other satisfying relationships, tries continually to please others in order to feel connected. Often this person tends to maintain a facade that is too good to be true.

In the early 1960's, Kissen published seven studies that characterized certain psychological factors related to males with lung cancer (Kissen, 1963, 1964, 1966, 1967; Kissen & Brown, 1969; Kissen & Eysenck, 1962; Kissen & Rao, 1969). He noted a theme of childhood trauma resulting from death or absence of parents, or chronic friction between them. He also found that in adult life, these patients experienced interpersonal difficulties, in particular, marital difficulties. He supported LeShan's conclusions that, typically, these men utilized little or no outlet for emotional discharge.

Bahnson and Bahnson (1966) proposed that repression and denial were contributing dynamics in the etiology of cancer. The Bahnsons' view was that cancer
might be an alternative to psychosis as a somatic expression of regressed effort to substitute for significant loss.

The "helplessness-hopelessness" theory of cancer appeared in a study by Schmale and Iker (1971). Analysis of interview responses given by patients with cervical cancer indicated that women who were found to have carcinoma tended to express more helplessness and hopelessness than those who had a benign diagnosis.

As cancer research in the sixties progressed, focus was directed toward the relationship between stress and immunological responsivity. Although caution is required in attempting to generalize findings from animal studies to humans, there were several experimental studies conducted with laboratory animals that indicated the role of the central nervous system in antibody production (Labarbara, 1970; Riley, 1975; Solomon & Amkraut, 1972). Riley (1975) demonstrated, that the incidence of breast cancer in mice could be reduced from 92% under stressful conditions to 7% in a protected environment.

As a result of these animal experiments, studies began to emerge that implicated the central nervous system as a controlling factor in the pathogenesis of cancer in human subjects. Bartrop (1977), through immune
competence studies on a group of people whose spouses had died within the last year, found that the immune activity of these subjects was significantly lower than that of the control group.

Selye (1956, 1982) postulated a theoretical model based on findings by Holmes and Mastuda (1974), that related life changes, or critical incidents to subject susceptibility to illness. He theorized that stress and cancer are related in three ways: (1) cancer can produce considerable stress in a patient; (2) stress can cause and aggravate cancer; and (3) stress can inhibit or even prevent cancer.

Selye (1956, 1982) theorized that emotions accompanying stress, namely fear, anxiety, and depression, were reflected in limbic system activity which directly involved hypothalmic and pituitary function. He based his ideas on the physiological fact that all hormonal activity is regulated by the pituitary and that oversecretion of the adrenal effects the thymus and lymph nodes and eventually, the white blood cells. Because imbalances in hormonal activity have been demonstrated to be connected to increases in malignant growth, he concluded that prolonged stress influences the malignant process through increased production of abnormal cells and to decreased capability of the body to destroy these
cells. However, he found that stress was beneficial to breast cancer patients who, after diagnosis, became more assertive in actively participating in treatment of their disease.

The surveillance theory of tumor development was presented by Simonton and Simonton (1978). They determined that distorted growth of cellular structure was a frequent by-product of normal cell growth and they therefore assumed that most individuals host malignant cells. However, because the immunological system of the body is designed to protect against invasion, regardless of the presence of these cells they also contended that disease did not strike in random fashion. Rather, they suggested that disease strikes only when the body is receptive. Consequently, they stated that cancer can be viewed as a result of the depression of an immunological system by psychological factors (Achterberg & Dawlis, 1980; Achterberg, Matthews, & Simonton, 1976; Simonton & Simonton, 1978).

The Simontons (1978) related certain psychological factors to the development of malignancy. They found that, typically, cancer patients exhibited an inability to maintain meaningful relationships due to patient tendency to remain resentful. They also noted that these
patients had a poor self-image and were inclined toward self-pity.

The identification of stress as a variable in physiological functioning generated thought towards determining why some individuals responded to stress with physiological manifestation and others did not. Pelletier (1977) postulated that an individual has a baseline level of tolerable stress. When escalated to a prolonged, excessive level, stress will produce alterations in neurophysiological functioning. When this occurs, a crisis event, channeled through a specific personality type, can precipitate the onset of disease. Therefore, personality influences the manner in which an individual handles stress.

Pelletier's (1977) theory can be related to an earlier study by Rosenman and Friedman (1974). These researchers noted significant correlation between behavior and cardiovascular disease. They designated characteristics of the Type A individual personality as more prone to develop major illness. Type A persons have, what they term, "hurry sickness," in that there seems to be an ever-present sense of urgency about all that they do. Conversely, they define the Type B personality who exhibits a low stress style of behavior as being far less likely to develop major illness.
Cancer patients who significantly outlived predicted life expectancies were studied by Achterberg, Matthews, and Simonton (1976). Achterberg and Lawlis (1980) described a composite personality profile of these individuals characterized by the following traits:

1. refusal to give up
2. flexibility
3. no physical decompensation when under stress
4. rejection of the invalid role
5. nonconformity
6. aggressiveness
7. assertiveness
8. high ego-strength
9. self-reliant
10. creativeness
11. past history of success
12. limited belief that "powerful others" were in charge of their well-being
13. insightfulness. (p. 122)

In summary, these studies indicate that the emotional experience of an individual can affect bodily functions in relation to the onset, course, and treatment of the disease.
Interpersonal

As an out-growth of these studies on individuals, researchers have begun to examine ways in which individuals can draw upon natural abilities and tendencies within a particular relational context in an attempt to maintain health and well-being.

According to this social ecological perspective of psychosomatic processes, emotional experiences are influenced by the characteristics of the environment in which people live. This perspective assumes that environments have unique personalities just as people do (Moos, 1977). Research indicates that social environments can be differentiated through relationship dimensions, personal development dimensions, system maintenance, and system change dimensions (Moos, 1974, 1975). Individual perception of environmental influences accounts for differences in coping strategies which affect physiological responses to the same situation (Moos, 1977).

The cancer patient joins with other family members to form a network of human interaction in which each member reciprocally affects the others. The family environment is probably one of the most important variables related to the progress or remission of serious
disease (Moos, 1977). Weakland (1977) mentioned that emotions and stress depend upon family patterns of communicative interaction. Yet, an area that appears to be largely neglected in research literature is the interactional aspects of families with cancer.

Weisman and Worden (1977) noted the powerful influence of effective interpersonal support in families with serious illness. The importance of family resources such as role structure, flexibility, and previous experience with crisis was validated in a study by Pratt (1976). The characteristics of families that interacted effectively with the ill member were defined by Pratt in the following manner: (a) flexible role relationships, (b) shared power in decision making, (c) the functional autonomy of family members, and (d) integration of the family in the community at large.

Cohen and Wallisch (1978) observed that the more family members were able to share information and communicate with one another, the greater the likelihood that the families could reorganize and accommodate a member's sickness and death. Wallisch, Mosher, and Van Scoy (1978) found that patient expression of emotions such as fear, rage, and sadness had often been prohibited by family and friends. The rationalization made by these
individuals indicated that the prevailing belief was that if these feelings were expressed, the cancer patient could be made worse.

Some descriptive studies have addressed the issue of family reactions to the terminally ill cancer patient. Mayrowitz (1974) noted that family members experienced hostility and guilt for having been spared the disease. Research studies by Weisman and Hachett (1961) and Chandler (1965) indicated that family members tended to withdraw more from chronically ill than terminally ill patients. Krant and Johnson (1978) found that communication within the families of late stage cancer patients were frequently guarded and confused. Conspiracies of silence were observed, as was the harmful effect of denying the patient and the family the opportunity to work through anxieties, share remaining pleasures, and plan for the future.

Kubler-Ross (1969) described a web of mutual deceit involving the patient, the family, doctors, and other health care personnel. She maintained that each person, through a need to avoid facing personal death anxiety, protected others in the network by maintaining a cheerful facade. She noted that dying patients had an awareness of the seriousness of the illness condition regardless of attempts to conceal that seriousness.
Erickson and Hyerstay (1975) described the double bind hypothesis of the terminal patient. Briefly described, the double bind places the terminally ill patient in a position to receive contradictory messages. Verbally, the patient is told that all is well. However, on the nonverbal level, the message, "you will die" is communicated. The complexity of maintaining a consistent facade resulted in an elaborate deception for an audience that did not want to be deceived. The terminal patient was called upon to alter reality perception in order to protect the feelings of other significant persons.

Horrowitz (1975) referred to the treatment of the family with a dying member. He discussed the manner in which family myths regarding death influenced the way the family adapted to a dying member. Weisman (1972) described the tendency of family members to mourn the dying member of the family even though the individual was still living. The dying individual began to feel isolated, and the family felt guilt concerning the ambivalent attitude with regard to the patient continuing to live.

Peck (1974) noted that the onset of disease in one family member often intensified an unspoken, family-shared secret about death. Sometimes, the disabled person was responded to as if already dead through inter-
actional behavior within the family that designated the individual as incapable of taking care of self. Peck asserted that this interactional behavior led to the imbalance of the family's dependency style. Family members began to resent the dependent ill member and consequently, this individual began to feel isolated from the family. It is almost as though there was a cooperative strategy instigated by the disrupted family system to sabotage the rehabilitation of the sick member. The ill person was caught in a double bind of being kept ill under the guise of excessive care and helplessness.

Kerr (1981) conceptualized the family as a system of multigenerational emotional relationships which govern the adaptability and flexibility of various family segments. Kerr theorized that the more impaired or emotionally dysfunctional family segments served a function for the large multigenerational family system in that weaker subsystems were sacrificed for the stronger collective. He further contended that prognosis for the course of cancer would be different depending on whether the cancer patient was a member of the stronger or the weaker segments of a family system. He referred to four areas to be considered in the assessment of a family's vulnerability to imbalance of the emotional system: (a) level of
differentiation, (b) level of chronic anxiety, (c) emotional cut-off from the extended family, and (d) mechanisms for coping with anxiety.

Kerr (1981) referred to two family positions that were conducive to cancer. The first was one of emotional disconnectedness within a significant relationship system due to death, divorce, or a perpetuated and sustained relational build-up of anxiety. The compromised individual living within this anxious context tended to withdraw into despair. The second position is that of the individual who experienced being overwhelmed, overburdened, and locked within a relational system. Frequently, this individual felt overly responsible for the well-being of others and responded to family members by attempting to give more than was humanly possible. Family members, in turn, interacted in the process by becoming too emotionally dependent on that individual. Kerr maintained that the escalating intensity of this dependency process could, with the presence of certain physiological variables, alter a state-of-wellness into a state-of-illness.

Penn (1983), after studying 30 families with a somatic member, reported that in order to treat somatic families it is essential to understand the generational values, expectations, and meanings that illness holds within the family. She described a particular form of
binding interaction that existed in families with chronic illness. The family, due to fear of the illness, its course, and the possibility of death, anticipated only negative changes. Therefore, the family became highly resistive to any change. Rigid cross-generational coalitions such as those found in pathologic families were found in families with ill members. However, unlike families with psychotic members, these coalitions were not denied or hidden, and the family's interactions did not include hidden disqualification of meanings.

Some studies have focused on the husband-wife dyad in families with breast cancer. Spiegal, Bloom, and Gottheil (1983) proposed that the breast cancer patient's family network and interpersonal interactions constituted an important resource in that patient's overall care. They noted that this life-threatening illness forced the patient to rely more on family resources, thereby disrupting family functioning. Better adjustment was found to be predicted by more expressiveness and less conflict in the family. Consequently, they concluded that the family is a crucial factor in patient adjustment.

Punch and Mettlin (1982) reported that the extent of emotional support from spouse, family, and friends was significantly correlated with the emotional well-adjustment of breast cancer patients. Bloom (1982)
reported that two indicators of social support, perception of family cohesiveness and amount of social contact, had direct effects on the metastatic cancer patient's ability to cope.

In summary, it seems that if one is to understand how to best facilitate an individual's effective management of breast cancer, the support network within which the patient functions must be understood. The clear deficit of research regarding interactional patterns in families with breast cancer demonstrates the need for study in this particular area. Heider (1958), whose views were philosophically based in phenomenological tradition, believed that understanding of human behavior could benefit greatly by careful analysis of common everyday understanding and relationship.

The strength of ethnographic studies lies in the heavy emphasis on construct validation—the meaning of events or situations to participants (Magoon, 1977). Geertz (1973) supports this opinion and adds that a more important criteria for ethnographic research is the quality of theoretical exploration. Geertz (1973) stated that "cultural analysis is (or should be) guessing at meanings, assessing the guesses, and drawing explanatory conclusions from the better guesses" (p. 20).
CHAPTER BIBLIOGRAPHY


CHAPTER II

PROCEDURES

This chapter presents a description of the procedures utilized in this study. The research questions that were formulated for the study are listed in the first section of the chapter. In the second section, the subjects chosen for the study are described. The third section provides a rationale for the use of qualitative research methodology in the study. Following, procedures for the collection of data and for the analysis of data are presented. In the last section, a description is given of the ecological contexts in which the data was gathered.

Research Questions

Due to the exploratory nature of this study, the following research questions were posed.

1. What are the patterns of individual understanding with regard to perceived meaning of the nature, history, course, and management of the disease?
a. What are the individual perceptions of meaning with regard to the disease?

b. What are individual perceptions of other member's responses to the disease?

c. What are the family multi-generational beliefs and attitudes with regards to the illness?

2. What is the structure and organization of the family in relation to the illness? In what ways, if any, has it changed as a result of the illness?

a. What are the role functions of each member? In what ways, if any, have the role functions changed as a result of the illness?

b. What are the rules of interrelating? Who sets the rules? Have these rules changed as a result of the illness?

1. In what ways are spoken transactional sequences distributed to, through, and around certain members in the family?

2. What are the non-verbal patterns of transaction within the family?

3. In what ways is conflict managed within the family with regards to the following determinants:
a. Ability to agree or disagree
b. Ability to consider alternatives
c. Ability to make decisions
d. Ability to state issues clearly
e. Ability to deal with conflict directly

c. In what ways are alliances formed in the family?

3. What are the effects of family communicative interaction on the course and management of breast cancer within a family member?

a. In what ways do family communicative interactional patterns support the breast cancer patient?

1. Is autonomy encouraged? If so, how?

2. In what ways are feelings acknowledged and expressed within the family?

3. How are outside support systems utilized?

b. In what ways do family communicative interactional patterns facilitate adaptation to illness?

c. In what ways do family communicative
interactional patterns allow for the management of stress?
1. What are the effects of stress within the family?
2. How do individuals perceive the stress level of other members in the family?

Selection of the Sample

Three breast cancer patients and their families were selected by the researcher based upon perceived subject ability to be informative and to articulate clearly. These subjects were believed to be introspective enough to examine phenomena and describe it in a way that would be similar or typical to the manner in which other informed subjects would define the same phenomena. Each subject had been an effective and active participant in a mastectomy support group, and each had demonstrated an ability to reach out to others through the sharing of common experience. Each woman had resumed work responsibilities, and each had maintained an active, involved social position both inside and outside of the family.

Subjects were selected whose families were approximately in the same developmental lifestage. As described by McGoldrick and Carter (1982), each family developmental
stage poses a life crisis situation that must be resolved if adaptive growth is to continue. The three families chosen for this study were beginning to shift from the "family with adolescent" developmental stage to the "launching of children" developmental stage. The tasks required of these families are facilitated by increasing flexibility of boundaries to encourage autonomy of children (ages 16-20) and to allow for easy exit and entry into the family system. The family tasks appropriate to this developmental stage involve the shifting of the marital dyad from a focus on parenting issues to a refocusing on marital issues. Inherent in this shift is the development of adult to adult relationships between grown children and parents.

Difficulties encountered in task accomplishment can result in families clinging to children (Solomon, 1973). This can be an especially difficult time for women who have primarily invested their time and energies in raising the children and are left with feelings of emptiness and loss of self-worth. This stage is often complicated by the entry of spouses of the children, requiring the shifting of one generation to make room for the next. Added stressors can be a result of older parents becoming more dependent, becoming sick, or dying (McGoldrick & Carter, 1982).
The subjects of the study had been diagnosed with metastatic cancer within the last five years (1980-1985). Each of these women had exhibited efforts to become informed and knowledgeable with regard to her illness through active participation in various educative and supportive programs offered by the community and by a cancer treatment center in North Central Texas.

The three subjects and their families were interviewed to determine willingness to cooperate in the study. All three families consented to participate as a result of the initial approach. It is likely that the favorable response of these families to participate in the study was influenced by the fact that the researcher had worked in a counseling role with each of the three patients through a support group modality. As Wilson (1977) has pointed out, the naturalistic observer must be cautious to avoid intruding on the research setting. Because these subjects were familiar with the researcher, it is likely that intrusiveness was less of a problem.

**Ethnographic Research**

Because ethnographic research methodology differs from a quantitative approach to counseling research, it is important to provide a rationale for its use. According
to LaCompte and Goetz (1982) the following elements are characteristic of ethnographic research: (a) participant and nonparticipant observation, (b) focus on natural settings, (c) use of participant constructs to structure the research, and (d) investigator avoidance of purposive manipulation of variables.

From the ethnographical perspective, psychological events are best studied in natural settings (Wilson, 1977). Behavior and environment are mutually related systems. People are influenced not only by the physical arrangements of settings but also by individual perception with regards to what is expected and allowed (Barker, 1968).

Wilson (1977) noted that the underlying principle of ethnographic research is the assumption that individuals have meaning structure that determines much of their behavior. Indeed, if one supports this phenomenological viewpoint, then it would seem that human behavior could be understood within the framework where individuals interpret thoughts, feelings, and actions (Lewin, 1936).

In ethnographic research, prior research and theory is studied thoroughly. However, as the ethnographic researcher approaches the research setting, prior knowledge is purposefully suspended to allow for the emergence
of new theory systematically obtained from the data (Glaser & Strauss, 1967). In generating theory, concepts are generated from evidence.

Through the comparison and contrast of similarities and differences, theory can be broadened or modified so that it is more generally applicable, thereby increasing its explanatory power. Glaser and Strauss (1977) described theory as a process of evolving entity—ever changing. It is their belief that it is essential to probe continually to discover why existing theory cannot account for what is being observed. Therefore, verification of existing theory with accurate evidence is important, but only to the extent that the process provides impetus for the generation of new theory.

For comparative purposes, the ethnographic researcher may choose a particular setting because it is systematically similar in order to clarify, refine, or validate constructs (LeCompte & Goetz, 1982). Minuchin's (1978) theory of the family that encourages somitization in a child serves as a stepping stone for further verification or expansion of the theory to include families with breast cancer. However, this researcher recognizes that relevant theory discovery is the main purpose of this study even though particular aspects of the breast cancer
setting may be explained within the framework of Minuchin's (1978) theory.

The case study method lends itself to the ethnographic approach to research. As Stake (1978) noted, the characteristics of case study methodology are more suited to expansionist than reductionist pursuits. It is widely believed that case studies are useful for in-depth exploration, but they are not suitable for generalization. Indeed, single members do poorly represent whole populations. However, if the situation is one that calls for the need for generalization of a particular case to a similar case, then case study methodology can provide a basis for naturalistic generalization (Stake, 1978).

Naturalistic generalization develops from individual involvement and internal perception of experience. It adds credibility through comparison of the extent to which the researcher's perception of a data set can match another's perception of the same data set (Stake, 1978).

Theory is discovered as concepts are generated to account for relevant behavior within the boundaries of the case. A single case can indicate a general conceptualization. Additional cases confirm that indication (Glaser & Strauss, 1967). Through the use of the case study method, an in-depth understanding of interrelated
themes and events within a particular context can allow for emerging theory.

Individuals within the social world invent, organize, and act according to mutually agreed upon rules. Therefore, the insightful researcher rigorously examines how such rules are constructed and applied.

Procedure for Collection of Data

Data were collected from a series of three interview sessions over a period of four weeks with a two week time lapse between each of the interview sessions with each family. Interview sessions were conducted in the families' home by the researcher.

All family interviews and family tasks were video and audio tape recorded for the purpose of preserving data for coding and transcribing. Audio tape recording was an intended back up for the video recording to insure the preservation of data collected. Transcriptions (Appendix H) were made from the audio cassettes and verification of the dialogue was made from the video recordings. The validity of the transcriptions were verified by two individuals who were not involved in the study but who have an extensive background in research as well as skilled ability to transcribe. During the process of transcribing, repeated speech patterns such as "you know"
and "uh" were deleted and redundant conversational items were summarized for the sake of brevity and the flow of reading. Video recordings provided a documented account of non-verbal behaviors as well as a recording of the contextual setting.

The researcher conducted the initial interview with all family members present as a group. An unstructured, open-ended interview based on key questions and consequential in-depth probing questions were used (Appendix A). The key questions focused on each family member's perception and individual subjective meaning of the cancer experience. Probing questions revealed a family member's perceptions of another family member's experience. No predetermined sequence of probing questions was established so that the interviewer was free to pursue unexpected dimensions of the topic. Open-ended questions illustrative of the probing process included, "How did you see her responding?" or "What do you remember about the way Mom acted in the hospital?"

On the second visit to the home, a structured genogram (Bowen, 1976; Guerin & Pendagast, 1976) format (see Appendix B) was used by the researcher to interview only the cancer patient and her spouse. The purpose of the genogram was to provide a graphic format of family
historical information and interactional patterns. Details of past family happenings, attitudes, personalities, habits, illness, deaths, traumas, separations, and divorces were traced through three generations as best remembered. Myths, themes, rules, and secrets were explored to determine generational beliefs influencing the family.

On the third visit to the home, a series of tasks (see Appendix C) were assigned to the family while functioning as a group to provide opportunities to observe the manner in which family members interacted and organized to complete a task. The enactment of the tasks by the family provided a modality through which the researcher could observe the interactional rules for decision-making and conflict resolution within the family.

Field notes reflected the researcher perception of what was heard, seen, and experienced, in the course of observing. Field notes were recorded immediately following each interview-observation session.

The descriptive aspects of the field notes provided the following information (Bogdan & Biklen, 1982): (a) description of the subjects, (b) description of the physical setting, (c) accounts of the sequence of particular events, and (d) description of the observer's
behavior and assumptions. The reflective aspect of the field notes emphasized the observer's speculation, feelings, problems, ideas, hunches, impressions, and prejudices. These materials contained the following information (Bogdan & Biklen, 1982): (a) reflections on analysis of emerging patterns and connections between pieces of data; (b) reflections on procedures and strategies employed: (c) reflections on ethical dimensions and conflicts.

Analysis of Data

In ethnographic research, an attempt is made to balance individual interpretation of behavior with the researcher's more objective, outside view of that behavior (Wilson, 1977). Because the goal of this study was description rather than prediction or explanation, no preconceived ideas or hypotheses were formulated prior to data collection. Preconceived notions were suspended so that meaning could evolve from within the data as it was being collected.

Glaser and Strauss (1967) developed a technique for on-going, objective analysis of ethnographic data. Tension between participant data and observer reflection provided the basis for analysis. Consequently, through
constant comparison, theory was generated and altered as it was compared to subsequential data.

Employing the method suggested by Glaser and Strauss (1967), preliminary speculative ideas were generated from the data from initial interviews. These ideas were often ventilated with an experienced family counselor, and then were further developed from continued exploration and data collection in the field. For example, after the initial interview with Family #3, the researcher began theorizing that a theme, "Cancer is no big deal" seemed to reverberate throughout the family's belief system. Investigator perception evolved from the mother's report that her response upon hearing the diagnosis became the basis for the family's attitude throughout the adjustment experience:

I know that I had cancer because they had removed my right breast. Dr. B said to me, "Everything is going to be all right!" and I started smiling.... And then the next thing I remember anybody saying anything about it--and I guess this has been kind of my attitude. Well, if I smiled in the beginning I might as well smile the rest of the way, because my sister was supposed to get here the day after surgery. I had just come to my room and in walked my brother-in-law with my sister, and she said, "See I told you she'd be smiling. And so, I guess we just did that."

The theme was substantiated in subsequent data collection as it was discovered in the genogram interview.
that the family belief was multigenerational, having
been drawn from the interactional patterns of the
mother's nuclear family response to an ill grandmother
who lived in the home. The grandmother had been
treated "as if" she was not seriously ill, as the
family continued normal daily activity and behavior:

My grandmother was always sick. She had a heart
problem but it was never a downer in our house.
My mother would always just say, "Well, your
 granny isn't feeling good. Would you go in and
keep her company?" She was in bed a lot, and so
one of us would usually just always be on the
bed with granny doing whatever we had to do.
There was never any "shh-shh, somebody's sick or
granny's asleep" or anything. So, I remember
when she died that I did not realize that she
was going to die . . . . There were never
people in the corner whispering like you see in
old movies. So, my mother handled that. She
did. And she didn't let it affect the way we
were going to act . . . and now that I look
back, my grandmother was sick all the time, and
I'm not sure if I had somebody that sick in my
house— it would not be easy to run the household
as if she were a normal person. My mother,
somehow did this.

Upon completion of the transcripts, the
researcher began to search the data for repeated words,
phrases, patterns of behavior, and subjective thoughts.
Regularities and patterns were delineated and certain
words and phrases were assigned to represent these
patterns. These words or phrases developed into coding
categories.
More specifically, a coding system developed by Bogdan and Biklen (1982) served as a guideline for steps followed by the researcher in the coding process for this study.

1. The data were reviewed by the researcher for regularities, topics, and patterns.

2. Coding category were developed based upon certain words, phrases, patterns of behavior, subject's way of thinking, and events that seem to be repeated and stand out.

3. The data were numbered in chronological order according to when it was collected to facilitate locating data.

4. Numbers were assigned to the various coding categories.

5. Coding categories numbers were assigned to the original units of data that fall within a particular category.

6. The original, marked unit of data was photocopied so that the original master copy could be preserved.

7. Photocopied units of data were cut so that they could be placed in manilla folders, each labeled with one code.
8. Each manila folder contained all of the data related to a specific code and was accessible for analysis.

Coding categories that evolved during analysis were described in the following manner:

**Individual Meaning:** This category pertained to the subject's understanding of the illness experience, as well as to the subject's conceptualization of each other throughout the experience. Subcategories include the following:

1. Diagnosis and Surgery — individual recall of perception defining personal natural responses as well as responses of others during this initial stage of the cancer experience. Natural responses were conceptualized through stages of grief as a reaction to loss (Kubler-Ross, 1969). The stages were defined as denial, anger, sadness, and integration. To illustrate, the mastectomy patient in Family #1 expressed her initial denial when she heard the diagnosis and awoke from her surgery. She said, "It took a while to really sink in—to think it was serious. I didn't want to believe it." Her husband said, "There is a certain amount of shock to it. I mean, you really don't know what they're saying at the time because you've hit rock bottom." The daughter said, "It just doesn't sink in."
2. Treatment and Follow-Up — individual recall of perception defining natural responses as well as responses of others during the stage of the illness experience which includes dealing with medical personnel, side effects of treatment, and inconveniences affecting the family schedule. For example, in Family #1, this category was illustrated when the mother said the following:

Of course, with chemo, I was so sick, that I did get to the point where I thought I was losing my mind, and I had said many, many times, this is going to be the last one, and it was Mother's Day weekend that I took the last one. I was so sick. I called all of you in and I said this is it . . . I'm not taking anymore. If this gets me, then, I'll just have to take my odds. I was to that point, and the family said whatever I want to do.

The father further illustrated this category when he said, "I'd have to be half dead to go to a doctor, but if she had wanted to go to every doctor in Tarrant County, I would have supported her. The daughter said, "Shop around for your chemo doctor—don't take the first one who walks in."

3. Chronicity — referred to individual meaning attributed to the adaptive stage of the illness, as individuals conceptualize integration of the illness experience into the family style of living. The following thoughts verbalized by the daughter in Family #3 illustrated this category:
When she says she doesn't feel good. I think about it for a while. I try to just pretend I don't hear her. I think my brother does the same thing. He says, "Mom, it's just all in your mind."

4. Death — referred to an individual's response to what Weisman and Worden (1977) have termed the "existential plight." An individual is confronted with his/her own inevitable terminality so that it becomes necessary to respond in an effort to manage that realization. This category was well illustrated when one reviewed the words spoken by the daughter in Family #1:

Daddy was afraid she was going to die. Death was very much on his mind for the first two weeks. Just the thought of facing life without mother terrified him.

The father in this family further illustrated this category when he spoke openly about his struggle in responding to his personal existential confrontation.

To be honest . . . I never told her this . . . of course, the only reason I didn't was because I didn't want her to face this alone, but I thought several times about suicide.

The mother verbalized her response to her confrontation with death when she said, "Lord, I'm not ready to go home. I still have my kids and my husband."

Shared Beliefs and Attitudes: This second major category described the ways of thinking that all or some
of the members in the family share. Subcategories included the following:

1. Multigenerational beliefs -- referred to the conceptualization that results from a recreation of past generational beliefs with the assumption that unless purposefully changed, these will be repeated in following generations. The mother in Family #3 recalled her memories of the way illness was handled in her family:

   When somebody was sick, it just always appeared that my mother just would go and take care of it ... My grandmother was just old ... and she didn't treat her like a dying person.

   The following excerpt further typified the mother's multigenerational belief that mothers take care of seeing to it that life goes on, as usual.

   Well, I just couldn't bear the thought of V. having to sit out there with all these morbid adults going over this same horrible thing that had just happened, so I just told her she had to go to school, because that was just something I couldn't have on my mind ... .

   The daughter seemed to have joined the mother's multigenerational belief system as was indicated in the following excerpt:

   I remember V. saying to me, "Mama, when we go to Florida does anybody have to know you have this surgery? I mean, it gets to be a little old."

2. Themes -- referred to a belief that was often initiated by one member of the family who was joined by other members of the family in an effort to "clasp hands"
in actually perpetuating the belief. The father in Family #2 exemplified this category when he said the following:

This whole bunch -- they got their own way of doing things and you can get 'em pulling together just like team effort, I suppose, but, practically everybody in here can take care of themselves .... I think definitely it's a family that you could take and drop on the ground and each one would run a different direction.

The daughter then added, "Like a cat." The family's theme, "Land on your feet like a cat," served as an analogic description of the belief the family perpetuated. That belief was that independence and autonomy were desirable behaviors.

3. Shared understandings -- referred to agreed upon meanings or definitions within the family as assigned to events that occur within the family. An example of this category was found in Family #2 when the younger daughter said, "If you're hungry, you go in the kitchen and fix it. Everybody eats at different times of the day." The older daughter added, "I really don't think I'd like having a sit-down dinner everyday at 6:30 with the whole family. I would, but, I'd rather just eat when I want." The mother then said, "Yeh, with jobs and hours, and he never likes to eat until 9:00
The father joined in by saying, "You'd have to nail them to the floor if you got them all in here at the same time."

**Structure and Organization of Families**: referred to the preferred patterns utilized as the family interacted together to meet functional demands (Minuchin, 1974). Subcategories include the following.

1. **Rules** — the patterns of communication existent within the family interactional system. Attention was given to the manner in which spoken transactional sequences were distributed to, through, and around certain members (Minuchin, 1978). To illustrate this point, in Family #2, the father appeared to utilize various behavioral patterns to alleviate tension within the family. The following dialogue illustrated this point:

   **M**: ... when the chemotherapy started ... I'd get so sick, so really I just kind of -- I think -- backed off from the whole family and left them floundering for themselves ...

   **F**: Chemotherapy -- what time she wasn't sick, she was knocked out. She had two choices--sick or knocked out ... (father got up while talking, grabbed a fly swatter and started hitting a fly on the table where the family is gathered).

   **F**: I have missed that thing three times ... (family laughed).

2. **Boundaries** — referred to the delineation of
role function within the family. Attention was given to alliances and cross-generational coalitions, as well as to how clearly the subsystems were delineated within the family. An example of this category was found in the following dialogue:

F: Who would qualify (in the family) for being the bossiest?

D2: J.

D1: S. is the one.

D2: No, she's played Mother several times with me.

Indeed, the older daughter did appear to have occasionally assumed the mother role in the family (parental child) as has been illustrated in the case study findings.

3. Support system — referred to the family's willingness to utilize and draw upon support from outside of the family system. In Family #3, the mother's words were indicative of that family's unwillingness to share personal illness experience with friends:

M: Well, I'm in touch with my mother every week... and my sister... and I consider other than Gene... my sister is my greatest support... I don't know that we've ever talked about it -- even with our very best friends.

The father substantiated the pattern when he said, "We lived on a cul-de-sac which was very active... got to
meet a lot of people... it just became a pattern that we didn't talk about it much."

4. Power — referred to the patterns the family utilizes to manage conflict and decision-making. Attention was given to overt and covert behavior patterns and the ability to agree/disagree. The following dialogue was indicative of the implicit/explicit patterns of conflict management commonly found within the data gathered from Family #1:

I: Sounds like in your family it's O.K. to disagree.

D: If we were to agree, we'd all drop dead.

F: That's one thing we do when we disagree, we disagree abruptly and we don't stand there and jaw at one another for hours on end, and I think that's one reason marriages fail 'cause people stand there and argue and try to get the last word in.

D: I've never seen them fight.

F: We both state our cases or something like that.

D: I've never seen them fight.

F: She's never called me a name and I've never called her a name.

D: Now, that wasn't always true.

M/F: What?

D. Management of the Illness: This category referred to the family's ability to support and create a
healing environment (Simonton, 1984) for the patient. Healing environment was defined as a supportive structure in which the patient can participate in getting well by taking responsibility for choices that must be made in order to do what must be done to aid chances of recovery and to improve the quality of time left (Simonton, 1984).

1. Decisions — referred to the flexibility and support the family exhibited in allowing the patient to make her own decisions in regard to illness management. This did not imply that a family member cannot implicitly or explicitly voice an opinion contrary to the patient's opinion. It referred to the family's willingness to ultimately defer to the patient the ultimate choice. The following dialogue taken from Family #1 illustrated the point:

M: They were behind me whatever decision that I made. They were behind me and, of course, I think with E. and the kids seeing me so sick they began to have doubts, I mean, you know, and I did not know this when I made this decision. I think E. told me from the beginning she didn't like chemo, wasn't it?

D: I was against it, but I wouldn't tell her that.

M: She wouldn't tell me . . . and I think R. was against it and it was after I started he had talked to his college professors and had talked about the different medications I was on and how it would affect me -- I mean he really delved into it, you know. I didn't know any of this until I made the decision.
D: We all took care of you, you see, and you didn't know it.

F: I supported you but I didn't like the idea, too, because of what they done to R. and the time that she got down -- I don't know -- it was when they put you in the hospital for about a week . . .

2. Adaptation -- referred to the change that inevitably occurred throughout a family with a member diagnosed as having cancer. Attention was given to interactional patterns utilized in an attempt to either support change or to maintain status quo. An example of this category was illustrated in this dialogue from Family #3:

M: I don't think our routine has changed any, but I know one thing -- I thought about what if they had to do without me. You know, I've never been one to cook a lot. I like to keep house, you know, don't mind any of that, but I have relinquished responsibility after responsibility. And like, when I was growing up, my mother did a lot more things for me when I was a senior in high school than I do for V. V., I feel like, could take care of herself if she had to and do a good job of it because I've watched her, but, some things I just don't do. I just let V. do them and if they turn out well, fine; and if they don't, then we try to just work on them and do whatever things come up. And, as far as I'm concerned, you know, my mother was just here, and she can't get over the fact that he goes in the kitchen and fixes different things. And I don't even get up and go to the kitchen. I just sit in there until he brings his plate in to eat, or he does laundry. V. can do all of hers. So, I have . . . I just decided --
F: You have a lot more free time.

M: Yes, I have lots of free time to spend on myself, and I get lots of verbal abuse because of this. But, nevertheless, I'm sure if this had not happened, that right now I would be protective of V. more.

3. Stress — referred to the way the family interrelated in order to manage the effects of stressors. Special attention was given to how the family detoured stress around and through certain members within the family. The following dialogue from Family #1 was illustrative of this category:

D: One night we kind of had a discussion and I handled it differently than Daddy, and he said he wanted to die. He just couldn't live without Mama and I offered him my .38 (laughed) ... which isn't funny ... but it was funny to see ... Well, not funny ... but each one of us did handle it differently.

F: Well, she didn't have a gun there. She just said, "I've got a gun -- do you want it?"

I: What was that all about?

D: To calm him down. We are a lot alike in our emotions in that if we get nervous or worried, we go full speed and we didn't know a whole lot at first -- the test results weren't in and we didn't know what kind of chemo they were wanting to give her and there were so many different doctors -- different questions; the unknown I guess, fear of the unknown. They would come talk to you but yet you wouldn't really understand what they would say to you. You hear
one-half of it — when you're looking at your Mother — your loved one — and you know they've got cancer, that's first and foremost in your mind — anything else they throw at you, it kind of — it just doesn't sink in — isn't that right, Daddy?

**Ecological Context**

This study was conducted in the homes of each of the three families. One of the points of interest in this study was the interrelationship between environment and behavior, or ecology of behavior. In order to examine a basis for this interrelationship, it was necessary to describe the physical setting, a contextual basis for gathering the data.

Family #1 lives in what appears to be an older, lower middle-class neighborhood. Upon entering this well-kept home, the researcher observed a small, open living area that flowed into the kitchen and dining area. A sofa, two reclining rocking chairs, and tables were arranged around a T.V. that was turned off. A large grandfather clock was accompanied by what appeared to be a clock collection on the walls of the living and dining area. All clocks were synchronized to chime together so that the room was filled with soft sounds at designated times. A basket of toys for the dog was sitting on the floor by the T.V. The rooms appeared to be decorated
comfortably, suited to family patterns of living. For example, a reading lamp and reading material, including a Bible, were strategically placed next to a reclining rocker. The observer noted that it looked as if the family had prepared for interview visits. Magazines were stacked neatly on the table. There was no evidence of the fact that the family had just had dinner prior to each visit other than the sound of the dishwasher running. An afghan was always folded neatly on a bench, near the sofa. A sign was placed on the door for the second interview which read:

Do not disturb . . . live video recording being recorded 7:00-8:15 p.m. Please call after these hours. Thanks for your consideration. The Stars.

Family #2 lives in an older neighborhood that appears to indicate a socioeconomic status ranging from lower middle-class to middle-class. Upon entering the home, the researcher observed a large, open, free-flowing living area that encompassed a family room, a dining room, and a kitchen. The paneled living area appeared comfortably decorated with large reclining chairs and an oversized sofa arranged around a T.V. (which was always on), accompanied with soft lighting from lamps on side tables. Family pictures were on tables and on walls.
Most of the pictures were of the teenage daughters indicating a recording of their growth and development through the years. The home appeared to be tidy, yet the observer did not get the impression that special preparations were made for her visits. Magazines were scattered on the tables, and on the bar area in the kitchen, there were loose stacks of mail, papers, and books along with used glasses and opened containers of snack items. Pillows were tossed on the family room floor and an afghan was crumpled on the sofa from prior use. Upon one occasion the researcher found the daughters involved in decorating a Christmas tree with boxes of decorations strewn on the sofa.

Family #3 lives in a newly-built home in a neighborhood appearing to range from a middle-class to upper middle-class socioeconomic level. Upon entering the home, the observer noted a large open-spaced, paneled living area filled with large, flourishing plants. The sitting area included over-stuffed sofas and end-tables which were comfortably arranged around the fireplace. A baby grand piano stood on the other side of the softly lit room. The room presented a more formal environment and the researcher noticed tracks on the light carpet left by the vacuum cleaner. A collection of
books and memorabilia were strategically placed on the tables. The room looked as if it were used only on occasion, perhaps when there were visitors. Upon each visit, a dog barked outside the sliding glass door where the draperies were drawn.
CHAPTER BIBLIOGRAPHY


CHAPTER III

FINDINGS AND DISCUSSION

The purpose of this study was to explore and to describe the interrelatedness of individuals in a family with a member who has breast cancer. The findings that evolved from the analysis of data from this study are presented in this chapter, in sections. The first section presents case descriptions in which the questions of the study are systematically addressed. The research questions are further examined in the second section through comparison and contrast of similarities and differences among the cases. A summary, conclusion, implications, and results appear in the third section.

Case Descriptions

Family #1

This family is composed of the mother, a breast cancer patient, who is 48 years old, the father who is
49 years old, a daughter who is 29 years old, and a son who is 24 years old. The son continues to live at home while he attends a local university. The daughter, upon her divorce, moved back into the home and was living with the family at the time of the mother's surgery. The daughter is presently living away from home, but she lives nearby and regularly visits the home.

Family #1 was at the "launching of children" (Solomon, 1973) developmental stage of life. It appeared that this family has had difficulty in accomplishing this task, as both children had left home, only to return. Upon completion of high school, the son joined the Army and went to the Philippines. However, upon termination of his military service, he returned home to live in order to go to school and work part-time. The daughter expressed her perception of the mother's relationship with the son when she said, "He's her baby boy." The mother laughed and said, "He is the baby. But I don't love him any more than E. . . . He's the little boy, and I think after having lost one -- the Lord gave us another one [the mother had a miscarriage]."

The daughter has had a series of problems which escalated to such proportions that she was hospitalized for depression. Crisis experiences such as physical and
drug abuse within her marriage and her divorce have brought her in and out of the family system for the last ten years. The daughter moved back into the home six months prior to her mother's surgery, and she remained actively involved in the home throughout the diagnosis and treatment. The mother discussed the daughter's willingness to assume a key supportive role in the family. The mother said, "E. was a stronghold. I don't think I saw her cry. E. had really been through some times herself so I really felt like she was the strong one." Power (1977) has pointed out that an illness of one of the parent figures in the home can often thwart a child's attempts at individuation. Often older children feel guilty about leaving home when caretaking responsibilities are needed.

The daughter perceived her grandmother, who had lived with the family until her death, as more her parent than her natural mother. She verbalized this when she said,

When I lost her, I realized I had my real mama. Mother let that relationship develop so Big Mama would feel needed, but I look at it now that she sacrificed her firstborn -- What I'm paying to give another woman something to do -- that's the way I look at it, now.

One can surmise that the mother may have been invested in keeping the daughter tied to the family in
order to do the parenting she relinquished to the grandmother when the daughter was young. It seemed possible that it also would be difficult for the mother to let go of the son who was sent to be a replacement for the son she lost. The father seemed to conceptualize the mother's attachment, as well as his own disassociation with both children, when he said:

I don't think a man can love like a woman can. The way I understand God's love is to look at a mother's love. Sometimes, I can wonder how God can love us, and then I look at the way she loves the kids, and then I understand God's love better.

The father seemed detached in his relationship with the children at this point. He described his perception of his relationship with his daughter and son when he said:

My relationship with my mother was close. The only other relationship I have that was close was with my sister. . . . After mother died, I told C., well, that's the end. I have only one family member left and that's C. . . . I mean, my kids are a part of me, but they've got their lives. I'm not going to bother them -- let them do their thing.

As Solomon (1973) has noted, if the marital dyad is unable to solidify and renegotiate at this stage, often the children will serve as a buffer. Consequently, the family will become invested in keeping the children tied to the home. The daughter described the parent's marriage in a way that makes one question the stability of the marital dyad before the surgery when she said,
I learned one thing, I knew they loved each other or they couldn't have lived together, but I've never seen two people love each other more than these two since the surgery. I've seen it grow more -- it's been more open and obvious to us.

The daughter pointed out the fact that the couple had not always been close. The mother verified the father's distance from the family at one time when she said, "He loved his TV. But, then he said that TV was not all that important, and I need to be with my family -- and we respected him for that." The father agreed, "I got new priorities." The daughter concurred, "The respect--that changed when you changed . . . and joined the church." A metaphorical commentary on the marital dyad can be considered when the family told the story about the picture provided during the family activity interview:

D: I think they're divorced and the kids tore the parents out of the picture because the parents are fighting and they feel pulled and torn, so they just separated the parents from their lives.

M: Why didn't one kid go one way and the other one go the other?

D: Because all they had was each other without their parents.

Indeed, in a previous interview the father admitted that even though he felt he and his wife never argued, they had "fussed" over issues concerning the children.
Jackson (1966) pointed out that somatic disorders often play an unexpected role in maintaining emotional balance within the family. This mother's illness could have served a function in keeping the daughter out of a dysfunctional relationship and in the home. The father verbalized the couple's concern for the daughter's well-being:

F: I don't think we meddled. In fact, that we told you to leave him and come home -- we meant the door is open and if you want to come through it, you can take it. I don't think either one of us said "Get out of there or get away from it." I guess if we had known how bad the situation was, I would have told her that.

It appeared that the illness had provided an impetus for strengthening the marital dyad as was evidenced by what the father said, "I love her a little better everytime she goes back for check-ups every 90 days." It has provided a means for keeping the family together.

F: This lady is the one who holds the family together, right here. I'm serious. You'll have to admit that, too.

D: He came home from the hospital, Daddy did, and said if anything happened to her, that was it for this family.

Originally, all members of the family had agreed to be present during the interviews. However, the son did not attend any of the interviews. The family
initially explained his absence as due to his overloaded schedule. The son worked in the evenings and on weekends and attended school during the day. Indeed, it appeared that the son interacted little with the father in the home.

F: ... I don't see much of him. He works nights ... with his studying, he stays in that room most of the time.

D: He's a loner.

F: I'm not much of a loner, but he's more of a loner than I am. He has some friends, but he is not a warm person. You have to really get in with him.

However, when the mother was asked if she felt close to her son, she replied with a firm, "Yep!" The daughter confirmed this when she said, "... There is something about that mother/son relationship." Then the mother added:

E. shows affection ... R.—he's distant. He doesn't—I nearly fell over tonight when he left, and bent over and kissed me bye ... that is one child that really turned ... when he was little, he was more affectionate.

As the interviews progressed, the family became a little more open as to why they believed R. was unwilling to be interviewed:

D: He just grew up and practiced what you preached. Children should be seen and not heard.

M: That's right. He don't talk. What was it he said tonight? We asked him to stay for this
session and he said he didn't want people to
turn up rocks in front of his eyes.

F: We can talk about him. Maybe next time he'll
stay and defend (laughter).

In considering Research Question #1, what are the
patterns of individual understanding of perceived meaning
of the illness experience, special attention has been
given to individual perception, individual perception of
other family member's responses, and to multigenerational
beliefs in regard to this illness. The daughter verbal-
ized this family's initial response to the diagnosis of
cancer. "Cancer is a defeat...I mean to some people,
a loss." The daughter further reflected her perception
of how she viewed her father at the time of diagnosis.
"Fear of losing Mama was strong with you, Daddy...He
was afraid she was going to die...you could see it in
daddy's face...He was white--just white." The
mother further validated the daughter's perceptions when
she said, "I can remember waking up in the recovery, and
he had...he tried to hold it back...I saw Buddy
through emotion take it."

The daughter revealed her response to the father's
emotionality when she said, "I was concerned about having
to hold him up to hold her up...I felt like I had to
be strong." The mother concurred when she said, "E. was a stronghold, I don't think I saw her cry.... But, now, I'm sure when she walked out of the room she would cry." When the father was asked whether he saw the daughter as being a source of strength for him personally, he replied, "No, I can't say that I did." The daughter added, "You resented it." The father then explained that he felt the daughter's intrusiveness in his need to back away and figure things out.

When questioned as to how the family members perceived the mother's response to the diagnosis and surgery, the father said, "I don't know how she stood up under all of it, but she sure did," The daughter, however, saw her mother's response a little differently. "I saw her being strong for daddy, but I also saw her as a child -- kind of a role reversal, because I felt a need to protect her." The mother then added, "I cried a lot didn't I?" The daughter replied, "Yeah, you would when daddy wasn't around." The mother discussed her personal response to the diagnosis and surgery in the following manner:

It was a surprise. I could have sworn I did not have or I could not have had.... I said it's just.... it's not going to be me.... I think. I can truthfully say it didn't.... I didn't worry about it once I found I had it.
Because I knew that my faith was grounded so . . . that God wouldn't give me more than I could stand. I could truthfully say . . . but I think I worried about my family . . . how they would feel.

It appeared that the son's response was perceived as unemotional and controlled during the diagnosis and surgery. The father described his perception of his son's response when he said, "He didn't let down or anything like I did. He stayed up at the hospital." The mother added, "He didn't talk. He would come to that hospital to see me everyday, but he wouldn't . . . I don't think he ever really mentioned the word cancer."

However, the daughter reported a different perception when she said, "Well, we talked about it—he and I did . . . he was concerned for both of them. Of course, the few times Daddy and I had words—he keeps to himself."

Family #1 typified the stages of response to the diagnosis of a serious illness (Kubler-Ross, 1968). The initial impact of confronting the possibility of losing a member of the family often results in shock. The father discussed his response when he said, "There is a certain amount of shock to it. You really don't know what they're saying at the time because you've hit rock bottom." The daughter added, "It just doesn't sink in . . . The father agreed, "Yeah, I can't believe this is
happening to us." Individuals often question why the individual has been singled out to have the disease (Simonton, 1984). The daughter verbalized this response:

My brother and I were heavy smokers, and I knew one out of every four are stricken with cancer, but I never would have dreamed that my mother who never smoked, doesn't drink — is healthy. . . . Mama's never hurt anybody. . . . No, you haven't.

The daughter verbalized her perception of her father's fear of losing his wife, "Death was very much on his mind for the first few weeks. The thought of facing life without Mother just terrified him." The father acknowledged that he felt intense feeling of loss when he said, "It crushed me when the doctor came out of the operating room . . . that was the worst thing I've ever heard."

Family members also shared personal feelings of anger. So often, these anger feelings tend to be funneled through mistrust for medical personnel (Kubler-Ross, 1969). The father had feelings of mistrust for the medical field prior to the mother's surgery. He described his feelings and prior experiences in the following manner:

Then I really got, I guess, hostile. I was in the medical department in the service and I had a lot of respect for doctors, but after pulling four years in a medical unit, about one-half put in as a bartender in the officer's club and seeing the character of the doctors and nurses
—these were Army people—I realize. They wasn't an angel of mercy or a knight in shining armor in the whole bunch—since then I've gotten where I don't trust anyone who wears a mask except the Lone Ranger and I kind of question him running around with an Indian. That's a joke—but I don't have a lot of respect for the medical profession. We had just gone through a long ordeal where we had lost a friend with cancer and, Kathy, they had 14 doctors for this poor guy, cause we helped her fill out the insurance papers—I was the insurance representative—and I could see us going through that—and I told her—I said unless they can do some good, I don't want every doctor in Tarrant County coming in—and getting a piece of the pie.

Upon exploration into the family historical medical background, the family members reported little prior experience with serious illness. The mother remembered:

Back then, they didn't go to doctors to find out what's . . . they, of course, died at their home. I remember that we had to go—Mother had to take her turn—there were four children and Mother would have to go every fourth week and stay a week, and I was too small and I had to go with Mother and stay with Mother down there. I think perhaps it would be what we know as cancer.

It would seem that generationally, neither the mother or the father's family relied on medical care. This is further explained when the father recalled his mother's death:

Mother had . . . I don't know . . . I guess a heart attack before she died. She died . . . it was a sudden thing . . . She didn't have any medical attention when she died. My sister, they found her dead two years ago from a heart attack.
In considering Research Question #2, what is the structure and organization of the family in relation to illness, attention was given to the role functions of each family member, the patterns of interaction which include rules of interrelating as well as conflict management, and the alliances forced within the family. Attention also was given to any perceived change in role function as a result of the illness.

How the family members perceived the role of the mother was described in the following dialogue:

I: So, if I were to draw a picture of your family, it's almost as if I would put C. in the middle of the wheel.

D: That's right.

F: That's right — she's a hub — the backbone of the family.

Yet, when the mother was asked if she agreed she said, "No, 'cause I see myself as a weak person—not as strong as they think." However, she did agree with the father when he stated, "But, you hold the family together." The mother explained that she had a role model to learn from:

Yeah. Even when his mother was here—I mean, I think I helped her and she helped me. I saw Big Mama's love and how she was, and I said, well, I wanted to be like her. I had a model right here in the house.

Indeed, it appeared that the family believed that the mother was holding things together. The daughter
explained her perception when she said:

He came home from the hospital . . . Daddy did . . . and said if anything happened to her that was it for the family . . .

The daughter later commented, "Through my troubled teenage years, Mother held us together." It appeared that this mother has been the glue that had kept the family "stuck together" throughout troubled times. Consequently, a threat to her very existence in the family could result in fragmentation. The daughter commented on the mother's concern about the family's lack of cohesiveness in her absence, "That worried mother to death. She begged us all that if anything happened we would stay together and not separate. That was, I think, her main concern and still is. . . ."

The father and daughter labeled the mother as a peacemaker in the family:

F: Who was the peacemaker?

D: Mama.

F: Very definitely. Blessed are the peacemakers for they shall inherit the kingdom of God.

The father in the family presented himself as "the villain in the family . . . the guy who invented the lethal injection . . . Jack the Ripper." It appeared that his willingness to play this role enabled the mother
to remain the heroine. As the daughter explained, "She's just a walking sugar bag . . . sugar tit, or whatever you call it." In responding to her father's description of himself as a villain, the daughter revealed her perception of the father's role in the following dialogue:

D: You're just the disciplinarian, which is the same thing . . . you were the sheriff . . . the law unless we could convince Mother to convince you otherwise. Daddy's got a lot of goodness in him, he just don't let people see it, or want 'em to know it. He does a lot of things without praise or glory.

F: Like . . .

D: You do a lot of things for the church and other people, Daddy, that you don't want people to know that you do.

M: That's true.

F: What's wrong with that?

D: You keep it — there's nothing wrong, but you're not the villain. You just don't brag about what you do for people.

F: No point bragging about it.

D: That's right -- but you're not a villain . . . it's just a front.

Indeed, it appeared to the interviewer that the father utilized humor, interruption or distraction to protect the mother when he sensed her discomfort. At one point, during the first interview, the daughter was discussing the mother's concern over the fragmentation of
the family and the father became concerned about the mother's comfort level:

F: You going to start crying?

M: No (lowering head).

D: She wants you to love me -- that's what she wants you do do! (laughing).

F: (laughing). You just ain't easy to love!

D: (laughs). Like you!

At the beginning of the second interview, before the camera was turned on, the father expressed concern that the mother had cried during the first interview. At other times, the father utilized comments to the dog such as, "Hush . . . Sherri, shut up" to deflect stress. Another time, he laughingly commented, "How have we kept that telephone quiet all this time?"

It appeared that the daughter's role in the family was implicitly defined as commentator of the family. It seemed that she kept the family honest by openly expressing her viewpoint even if it was contradictory to what was being presented as a family truth. This commentator, or "gad fly" role was perhaps best described when the father talked about his relationship with his wife, "She's never called me a name, and I've never called her a name." The daughter interceded, "Now, that wasn't
always true." Both parents looked at the daughter in disbelief and were silent for an awkward moment. Then, they both said simultaneously, "What?" She did not back down. "The respect—that changed when you changed, and joined the church."

The daughter appeared to be aware that her commentator role was sometimes ineffective. She explained that at the time of her mother's surgery, her "gad fly" role was not helpful for her father.

... I was strong for Mother—I didn't approach it right with Daddy, I don't think. There are constructive ways to be critical or to give criticism and Daddy and I have a good track record of speaking quick ... 

Even though the father and daughter described the son as separate from the family—a loner—the mother described him as "present" during her diagnosis and surgery. The daughter explained her brother's role as present but uninvolved when she said, "R. was concerned for both of them—of course, he kept to himself." The mother affirmed this view when she said, "He didn't talk even though he would come to the hospital every day." The entire family appeared to value the son's role as information seeker in regard to the illness. The mother explained this role when she said, "He had talked to his college professors and had talked about the different
medications I was on and how it would affect me—I mean he really delved into it." However, again, the son's role as present but unobtrusive was commented upon when the mother said, "I didn't know he had done any of this until I made my decision. Indeed, the daughter appeared to sense her brother's presence and involvement in information-seeking when she said, "My brother, my daddy, and I tried to piece together what we had learned that day, and we each would have learned a different piece."

In examining the interactional patterns, or rules for interrelating utilized by the family, it appeared that the father and daughter both openly expressed the need for feeling in control:

F: I'm the kind of guy—kind of like being a strong disciplinarian—I guess it kind of goes along with it—if I don't have control over something I begin to get nervous and stuff like that.

D: Me, too.

F: ... I've got to have the grasp of the situation.

D: That's where I get my need to be in control. Now, I know.

The father's intended description of how he and his wife disagree actually seemed to more accurately describe what appeared to occur between he and the daughter when they disagreed. The father said, "That's one thing we do when
we disagree, we disagree abruptly and we don't stand there and jaw at one another for hours on end."

What was actually observed between the mother and father was a less open, implicit method of handling conflict. When the father became engaged in conflict with either his wife or his daughter, the mother would respond by looking at him with a strained, superficial smile. This gesture reminded the interviewer of an animal who takes the "one down" position with a more powerful animal in order to stop an escalating fight in which the weaker animal may lose. The mother, in seeing herself as the weak member of the family, engaged in conflict and got her way in less confrontational ways. The mother and father acknowledged the mother's ability to indirectly get her way in the following dialogue:

F: Who gets their way?
M: I do 'cause I cry a lot.

F: In all the times we've been married, we've had little discussions . . . not arguments . . . discussions. I've been right three times.
M: I'm usually right (strained smile).
F: Once every ten years ain't bad.

At another time, the mother said, "I'm bossy and I cry a lot. I get my way a lot." When the daughter tried to
affiliate with the mother in claiming that she also cried and was bossy, the mother repeated upon two occasions, "You don't cry like I do." So, it appeared that the mother, in her perception of herself as weak, had figured out ways to have power and control in the family in ways that did not appear to be strong—through crying, through passive, non-verbal behavior, and through disagreement on a covert level.

The mother exhibited this indirect way of indicating her displeasure about the father's behavior without openly doing so:

M: He can find humor in the worst of tragedies.

F: Who? I didn't find any humor in what you went through.

M: (strained smile). No, no, but, I mean, you know, you pester the dog, and, of course, you torment the dog, and she's going through torment and you laugh.

The daughter, at this moment, intervened to deflect stress between the mother and father. "That's how he shows affection." With the daughter's protection, the mother continued, "And he picked at the kids when they're little and they'd cry and you'd laugh." The daughter again intervened, "That's how he shows his love. He picks on them—attention." Her maneuver worked, as the tension was deflected and the father began to openly
confront his daughter when he said, "I give you attention." She then joined him to counter the escalating tension, "That's what I say, you're giving us attention."

A repeated pattern within Family #1 appeared to be one in which the mother would passively engage in sneaky conflict, while sending metacommunication such as a strained smile or a glance downward to deflect attention away from the conflict. Both the father and the daughter acted in ways to stop the conflict before the mother's behavior was exposed on an overt, confrontational level. It seemed that the mother worked in a covert way to express conflict allowing the father and daughter to engage in confrontation over her issues while she remained in the role of peacemaker.

The mother also engaged in an interrupted, unclear pattern of speaking, utilizing many phrases such as "you know" or "I mean" to modify the impact of her words. For example, when the mother was attempting to deflect the daughter's confrontational perception of the mother's sacrifice of the first born, she appeared to "tip-toe" around the issue in the following way:

Well, she, so many times, when she first came, she said she was in the way you know, and I said I was the one who invited you to live with me, you know, and so we tried to make her feel like part of the family, so,
and I realize that at a time of grief, you need something to occupy your mind, or whatever, so she loved to read, and E. would crawl up in her lap, or go to bed with her or whatever, you know, and so they became great pals, I mean, you know, like this was taking her mind away from herself.

The father came to her rescue at this point by saying, "Are we chasing rabbits here?" The interruption worked, as the interviewer joined in to slightly change the focus away from the mother-daughter conflict.

Each family member appeared comfortable in interrupting the other. Generally, interruption did not prevent a family member from making a point. The mother, in particular, seemed skilled at getting her point across, even if interrupted. She continued to reiterate the same point until she was sure her point was made, an example being the repetition of her statement, "I cry a lot," time and again throughout the interview. Another ploy used by the mother to be heard was to become very quiet and then to quit talking. The absence of her involvement was noticed by the father, as he stopped to draw her back into the conversation. At that point, the attention became, once more, focused upon the mother. An example of this interaction pattern was exhibited in the following excerpt:

D: Mama's never hurt anybody. (Turning to her mother) No, you haven't.
F: You're going to get to talk in a minute.


D: Yeah -- me and Daddy need to shut up and let you talk (Mother laughed as she once more began to contribute).

So, it seemed to be important to the mother to continue to appear weak to the family, for it was through this weakness that she had access to control and power within a family where both the father and daughter openly announced their need for power. It was the researcher's perception that the family understood the mother's power in the family as all seemed to willingly participate in helping her appear "as if" she was weak so that she could maintain that power.

The family allowed the mother to masquerade her strength and power even in her decision to have chemotherapy. The other family members were against chemotherapy treatment. In order to support her decision to have chemotherapy against family members' wishes, the family acted "as if" the mother did not know about these contradictory opinions:

M: They were behind me whatever decision I made. They were behind me, and of course, I think with B. and the kids seeing me so sick they began to have doubts. I mean, you know, and I did not know this when I made this decision. I think E. told me from the beginning she didn't like chemo, wasn't it?
F: Right — I was against her, but I wouldn't tell her that.

This last sentence described the family secret that was not a secret. In other words, the daughter's reply could be interpreted, "Yes, I told you, but no, I didn't tell you."

In exploring Research Question #3, what are the effects of family interaction on the course and management of breast cancer, specific attention was paid to the manner in which the family adapted to the disease.

In Family #1, the patient's autonomy had been facilitated and supported by the family. The patient took the initiative in joining a support group and has continued to actively participate.

The ladies I've met through the group—there is a bond there. You hurt, and I think that even though I didn't know these ladies when I walked in there, it is as though we have something in common and my sister just fusses at me when I talk to those girls... Because when they cry, I cry, and she said "You're not doing anything but keeping yourself torn up," but they show concern for me—just really feel the bond. We've walked in those shoes together and as I told my sister, you're on the outside looking in and you've never been there.

The patient was supported in attending other informational groups by her husband, who attended with her. She was supported in her decision to have chemotherapy
and then she was supported in her decision to discontinue the treatment. She explained her perception of her autonomy in this decision when she said, "... I would get so sick, then I would think why did I do that? I couldn't blame anyone but myself because I was the one... I was the one who decided." However, the father expressed his personal feeling of involvement with the mother's treatment when he said, "Then we found out we had to have chemotherapy."

Feelings were sometimes openly expressed as well as openly commented upon in this family:

D: **Surprise.**

M: Yes, it was a surprise. I could have sworn I did not have it... I just said it's not going to be me.

D: **Fear.**

M: ... I worried about my family... how they would feel... I saw Buddy through emotion take it...

D: ... He was afraid she was going to die.

F: ... I'm not afraid of death but I am afraid of living by myself.

The father appeared to initially view support outside the family as intrusive:

At a time like that, I appreciate people's input, I guess, but I'm--don't know until I get this thing figured out. I didn't want anyone other than immediate family. In fact, I got so
tired of telling the same story over and over every time the phone rang—got where I would not answer the telephone . . . You just feel like you're in a looking glass, or a fish bowl, and everybody's looking in. When I go through a crisis, I may want to talk it over, but I don't want a lot of people in on it . . . that telephone—I was ready to rip it out of the wall.

The daughter, however, seemed to view things differently, "That's the outside world though, Daddy." The father described the way the family adapted when he said, "I know. In fact, ya'll done all of the telephone answering." It is important to realize the degree of adaptation in the father's response in supporting the outside intrusion of the researcher into the family experience.

In discussing other ways the family has changed, or adapted to illness, the mother said, "We had to give up going everywhere . . . we used to go somewhere every night . . . we had to cut that out." The father discussed his heightened sensitivity to and awareness of the limitation of time:

I feel older, and I feel like you realize nothing is forever. We bought cemetery lots——well, we already had cemetery lots, didn't we? We just got through last week formalizing our funeral plans.

The mother further affirmed this sense of the urgency of the moment. "We just found out there was priorities we had to keep in mind and live each day as it comes."
The father also expressed the way the family has been willing to become a resource of information for families who are just beginning to experience what the family has already experienced. He said, "I find myself counseling other people. In fact, somebody called here yesterday . . . and he was calling for a neighbor, wanted to know what radiation costs. He also commented on his willingness to draw more on the support of close friends when he said, "No man is poor if he's got a lot of friends. I think we are poor. We may be poor financially but we ain't poor with friends."

So it seemed that the marital dyad had begun to solidify separately and apart from the children to include a support structure outside of the family. The wife affirmed this observation when she said, "Now, we have four couples that we're really close to--I mean for birthdays and Christmas. Boy, we just celebrate everything we can think of." The adaptation is developmentally healthy for this family in that in the couple's willingness to accept outside support, the support of the children was less needed enabling the individuation of the children away from the family system.

The family appeared to handle the perceived stress of the illness by openly admitting and discussing its effects:
F: ... She goes back for checkups every 90 days and just this past week, I got home and she had gone to the doctor around 1:30 and I got home at 3:00 and here she had gone to the doctor at 1:15. I called down to her office to find out what the report was and she had not gotten back there. Well, boy, my mind began to race.

D: Uh-huh, we do that . . .

F: I know, like I said, I died a thousand times inside and I guess, 15 minutes after I called she called and I didn't hear the telephone. You got home at 5:00 and I was a nervous wreck . . . I could imagine everything in the world about what could have happened. Every time she goes for a physical, I'm hoping for the best, but . . .

D: Well, not even a physical, if she just gets sick, I get scared.

The daughter and father appeared to see themselves as quick-tempered under stress:

F: I guess I'll have to say I get mad.

D: Oh, I do, too.

F: I get mad and then . . .

D: We got the tempers.

F: It (the Bible) don't say you're not to get mad, it just says don't be easy to anger.

D: But we are easily angered though, Daddy.

M: Some days.

F: But I'll say this. I hope I don't carry a grudge too long . . . I get mad and it's quickly over. We don't go to bed and not speak to one another for three or four days.
M: I can remember you used to say, "Don't let the sun go down on your anger" And he'd say, "Are you going to go to bed mad?"

D: Stayed up for weeks, didn't you? (laughter).

The daughter demonstrated, in the above passage, the family's ability to laugh and to use humor in alleviating stress. Both the mother and the daughter demonstrated ability to utilize humor to alleviate tension when the father complained about some chili that was made for dinner:

F: You don't put beans in chili when you put it in the hot dogs. I know we're off the category, but that was somebody's decision to put beans on my hot dog.

D: Well, we all ate it.

M: No, the dogs ate it.

D: One bean or one bowl of chili? (laughter)

F: One bowl of chili. It was a small bowl at that. That's why I cooked that sweet potato in there.

M: Is that why you did that? You ornery outfit! (laughter).

Interestingly, often the dog, Sherri, is utilized by the family to alleviate stress. For example, the family experienced tension in relation to one of the activities they were instructed to perform. The daughter was particularly uneasy when the family was asked to tell a
story about a picture. She became uncharacteristically quiet as she let the family know that this activity reminded her too much of the time she had to respond to the Rorschach pictures when she was hospitalized:

D: You can get too far out, now Daddy. (laughter)

F: I can go way out there, if you want to.

D: Don't get too far out (laughter). You can get real vivid and get in real trouble.

F: (Looking at dog). I wish that bell would go off while she was over there (Dog is sniffing the tape recorder and the egg timer). Sherri, what are you doing? Sherri, get over here, you're just plum nosy (laughter).

**Family #2**

This family is composed of the mother, a breast cancer patient, who is 48 years old, the father, who is 48 years old, and two teenage daughters, 19 years old and 16 years old. The family is at the "family of adolescents" stage, and will soon begin the "launching children and moving on" stage as defined by McGolderick and Carter (1982). This family appeared to have flexible boundaries that allowed the two daughters to move in and out fostering autonomous experimentation. Both daughters reported that they have jobs and are active in school activities. Both daughters assumed responsibility for personal care-
taking needs at home, including the management of
necessary washing, ironing, cooking, and cleaning. The
mother's philosophy in raising her girls was perhaps best
described when she said:

... I believe in raising your children to be
independent and to take care of themselves. I
worked with one that the mother didn't, and she
can't budget her time to do a lot of things even
in the classroom. After seeing her especially,
I thought, I don't want girls raised that way,
I want them to be able to do something in life
for themselves... 

The younger daughter validated the mother's viewpoint
when she said:

Since we were probably in the fourth or fifth
grade, she taught us how to vacuum and wash
dishes and do everything on our own. If we
needed our clothes washed before she was going
to do the washing, she'd say get out there and
do it. We had to learn for ourselves.

The older daughter agreed, "This family kind of operates,
every man for himself."

All of the family agreed that after the mother's
surgery that the daughters became even more independent
and responsible for the management of the household. The
younger daughter said, "While she was in the hospital, we
did everything, didn't have her to—well, you can do it
Mom, or I'll do that later—you do it now—like that."
The mother added, "I just backed off, and I knew they
were out there, and I thought they were getting along
okay. Apparently they were. I really didn't care at the time."

So, it seemed that these daughters, having prepared for developmentally appropriate behaviors needed to leave home, had learned the necessary skills to allow for continued autonomous functioning, even in their mother's absence.

Research Question #1 asked what are the patterns of individual meaning given to personal response to illness as well as to meaning given to the response of others to the illness. When the mother went into the hospital for a biopsy, the possibility of malignancy was not discussed openly with the daughters:

D₁: Well, nobody really told us, I don't think.
M: Well, you were there, weren't you?

D₂: No, 'cause I found all of those receipt things from the doctor and you kept telling me you were going for this and for that.
M: That's what they told me. I didn't know it until later.

D₂: When you suspected something you never would tell me. I asked you. They'd have all these little boxes that you check for --it tells what they did, and I never did know what.

I: So, how did you find out?
D₂: J. told me.
D₁: I think you told me that you were going to go to the hospital and have a biopsy, you know.

M: That's what I was hoping it was ... But you were there when we saw the results.

D₁: Yeh, yes, I was.

So, it seemed that neither daughter had a clear understanding of the seriousness of the test the mother was having. The younger daughter felt even more left out as she was not at the hospital when the tests were reported.

The mother expressed her feelings of shock and her own lack of preparation in hearing the diagnosis:

I just couldn't believe it at first that it had happened that way--that it had turned out that way. I really wasn't expecting it. I had thought about it, and I had been warned, but I really didn't expect it ... it took a while to really sink in--to think that it was serious. I didn't want to believe it.

The younger daughter said, "I didn't expect to really hear about it--you know, it's on TV and stuff about other people, and you don't even think it'd happen." The elder daughter said, "It was something real simple that turned out to be complicated." The father added, "You think you're prepared until it happens, and you're not. You know I thought I was prepared for the worst, but I wasn't, and it overwhelmed me."

The older daughter talked about when she first confronted the reality of the diagnosis when she said,
"The main thing that sticks out in my memory was going in recovery and she was real pale and almost green—it hurt her." The father began, then, to discuss his method of coping, "You know, you have to put on a front, but inside you don't have a front on." The older daughter said, "I think we were all in separate cars, and we all came home in order to get some peace." The younger daughter added, "I really didn't have anything to say—like I didn't know what to say." So, it seemed that the father and the daughters could best cope with the shock of the diagnosis by distancing not only from friends outside of the family but from each other as well.

When questioned about whether the family ever discussed the diagnosis and illness experience together, as a group, the older daughter said, "Not really, because this family is not real close-knit. Really, considering it is, but it isn't." Both daughters commented upon the continued presence of relatives and friends, both at the hospital and in their home, throughout the summer months. The mother agreed, "It was just a houseful... one continuous... it almost went through the summer--too much." The older daughter commented that the company helped her mom cope:

... I wouldn't have wanted to have so many people around but I think that kept her going,
because somebody cared enough to talk to her, and to come by and see her. There was always activity going on instead of it being real quiet and restful and being boring.

The father discussed the impact of the chemotherapy treatment. "Chemotherapy, what time she wasn't sick, she was knocked out. You had two choices—sick or knocked out." The mother concurred:

I don't know if everyone is that way, but I just couldn't do a lot. Seemed like I would be tired, then when the chemotherapy started, I'd get sick, so, really, I just kind of backed off from the whole family and left them floundering, maybe, for themselves. But, they were awfully thoughtful of me. They looked after me real well. Do you need this, do you need that? Can I do this? There was no way I could keep house --there was no way I could cook. So, you know, they were old enough--they did real well.

The older daughter admitted that she wished her mother would be more open about her aftercare checkup visits to the doctor. The mother asked if she was worried about the visits. The daughter replied:

Well, I'm curious ... If I were living in another city and I said, well, I'm going to the doctor, wouldn't you kind of wonder what for? ... I mean it would be different if I really didn't care about anything medical, but I find it interesting, anyway. I mean you might think I don't know, but I might.

The younger daughter agreed, "I mean I hear it like a third person ... like the hospital--hearing it after everybody else has already heard about it." The father
replied to the younger daughter, "You can read it in the newspaper."

It appeared to this investigator that both girls felt left out because they felt information was being kept from them both at the onset and throughout treatment and aftercare. The mother, on more than one occasion, attempted to convince the girls that there simply had been nothing to tell, even when she went in for the biopsy:

I really wasn't expecting anything. It was supposed to be a simple procedure, S., and... there wasn't anything to tell. I just went in for a biopsy, and that was it.

However, the mother had privately admitted to the investigator that she was concerned about pains she had been having in her stomach, and she had just been to the doctor and was awaiting test results in regard to that matter. It appeared that neither of the girls had been told of the mother's concerns and it seemed that both girls knew on an implicit level that they were being left out. The mother had told the investigator that she did not want to concern the girls with her fears until she was sure it was necessary. So, in an effort to protect the girls, the mother had withheld information, which resulted in the girls' response of uneasiness to the "unknown but known" secret in the family. The father, in
an effort to disguise what he knew about the mother's concerns, attempted to divert the questioning and to deflect the tension by adding his humor, as he advised his younger daughter to check the newspaper for the information she wanted. Indeed, it seemed that this daughter felt that everyone else knew more than she knew about her mother's illness.

In examining multi-generational beliefs in regard to this illness, it was discovered that on the mother's side of the family "people tend to live forever."

Mother is the oldest of ten children and she's still living—all of them are. In fact, on Mother's side, there are aunts that lived to be 104. On my daddy's side, my grandparents both lived to be 97.... There just has not been a lot of illness.... In fact, it's like one girl in our group said that her family is probably saying "Thanks a lot for this."

When questioned about any other illness that might have influenced family thinking in regard to illness, the couple began to relate, in an animated and involved manner, the father's personal struggle with alcoholism. The father was actively involved, on a daily basis, with Alcoholics Anonymous. The serenity prayer, offered by Alcoholics Anonymous, has provided a theme or motto by which the couple has ascribed, "God grant me the serenity to accept the things I cannot change, courage to change the things I can, and wisdom to know the difference."
The father gathered together A.A. pamphlets and literature for the investigator and commented:

What you get in . . . these will work in any phase of your life in any situation. The principles and all that you go by in there, hell, they work no matter what. And, they work, you know, they help you, I think face any situation better. It's something, if everybody was doing it all the time, hell, no telling what kind of world we'd have. But, some people don't want to see it.

The mother added:

You can sit around and be depressed by thinking about resentment—and I know I can't get rid of some things by myself. That is my morning prayer—to get rid of those thoughts—take them away and replace it with love, and when I do, I've got a good day. We all have resentments and fears.

The mother pointed to an A.A. brochure she carries in her pocketbook with the following prayer:

Lord, make me an instrument of Thy peace. Where there is hatred, let me know love; where there is injury, pardon; where there is doubt, faith; where there is despair, hope; where there is darkness, light; and where there is sadness, joy.

She explained further:

I know I can't get rid of resentment without Him. I need that extra help, and when he takes them away, you've got to replace it with something. As long as there's love there, it goes a lot better.

The father added, "Her fear is the absence of faith and no faith is the same as calling God a liar . . . I don't
think you'll find it in there just that way. . . paraphrased." As the mother and father laughed, it appeared that each genuinely enjoyed the father's way of "telling it like it is."

In examining Research Question #2, what is the structure and organization of the family and what are the ways it has changed, notice was given to role functions within the family. The family had previously been structured in order to manage the father's withdrawal from the family as a result of his drinking. The mother referred to the father's withdrawn behavior as "his sleeping days." She then recounted:

He was out of the picture at times. I was the disciplinarian and did a lot of things on my own. That just came to an abrupt halt. . . . I think he has more control over the girls now. It just takes too much time and too much effort to argue and fuss if something comes up. I just kind of back off and let him handle it.

At another time she restated her perception that the role of disciplinarian had switched to the father:

Really, our family has changed because when they were younger, he was in that chair dropped off to sleep. I really raised the girls myself so many years, and then (three years ago) after he got into the program, he began to open his eyes and see what reality was and . . . they began to get some of his benefit, rather than always just Mother's. So, it really has been a blessing. Then, this past year (since the surgery), it has been more so because, I think, they have gone to him for things where they normally have come to
me. Because they knew that Mother didn't need that extra added stress—so I'll ask Daddy, and I think you have enjoyed getting to be closer to them and knowing them better through this.

The father agreed in a noncomitted way, "Probably." At that time, the younger daughter confirmed her perception of the father's increased involvement with them when she said, "Do you feel any meaner, crueler?" Everyone laughed and the father replied, "The devil can't get any meaner."

So, it appeared that at one time, during the father's absence due to alcoholism, the mother took a leadership role in the family, assuming caretaking responsibility for the girls and the functioning of the home. This leadership role appeared to continue until the time of her surgery when she began to defer leadership to the father and to the older daughter. The mother, at one point, appeared to be trying to convince the family of the older daughter's capacity to lead.

Her kindergarten teacher said that she was a leader in her class. And, I said, "Do you mean bossy?" So, that's been evident from day one. So, I think J. definitely has the most, leads the most. Leadership.

The older daughter replied, "But, I'm not bossy." The younger daughter countered, "Yes, you are bossy. She's played Mother several times with me." The mother asked, "Is it bossy or being a leader?" The father added,
"Let's just say being a leader and being bossy is just a matter of degree."

At this point, the family began to identify who seemed to play the role of peacemaker. The daughters "clasped hands" in conclusion that the mother played the role of mediator:

M: Who is the peacemaker?
D₁: You're the peacemaker.
M: Am I?
D₁: Um hum, neutral ground mediator.
D₂: Because you can't take sides.
D₁: Because usually, it's me and her fighting, and you're the mediator.
D₂: You don't want to show how you really feel—that you'd really take my side, so you have to (laughter)... 
M: To be neutral. I don't want to show it in front of J., but I'm neutral.

It did appear that the mother often mediated within the family in order to give each member equally deserved credit. For example, when the father asked, "Who laughs the most?" the mother replied, "I would... S. has a good sense of humor. B. has a good sense of humor. J. likes to laugh." It appeared, however, that often the mother mediated or facilitated in behalf of the older daughter rather than the younger daughter. It seemed
that the mother was continually attempting to convince
the family of the older daughter's capabilities as if she
were trying to prepare the daughter to assume more of a
leadership role in the family.

J. is one of action when there's something to be
done—when there's a problem, J. gets it out in
the open and does something. You act... I
think J. analyzes the problem and sets out for a
solution... gets the solution going in a
hurry.

Family members then began to identify their perception
of the younger daughter:

M: I think S. is definitely the scrapper of
the family, in the family and outside the
family.

D₂: I don’t fight—I just defend myself.

D₁: S. just keeps griping—no action.

F: Lots of mouth action—griping.

M: Yea—S. tells the problem a lot.

F: If problems could be solved by talking,
shed have 'em all solved.

The younger daughter seemed to take the family's
commentary on her behavior with good humor which con-
formed what the mother had said earlier about her. "S.
has a good sense of humor—a capacity for saying things
in a funny way. She keeps the pot stirred—she can
always come in and stir it up—I mean, stirs good when
things get quiet—she laughs."
The family then began to tease S.:

M: We don't have any pouters in the family, do we? (looking at younger daughter)

D₁: I don't know, no, we don't have any pouters (whole family is looking at younger daughter).

M: Every once-in-a-while, S. has a breathing problem.

F: S. just swells up like a toad frog (laughter).

D₂: Well, you know the upper respiratory problems are inherited, I imagine (laughter).

It seemed that the family enjoyed the younger daughter's scrappiness and depended on her to liven things up. She responded favorably to the teasing and admitted that she and her dad use sarcasm and wit to comment on family experience:

M: S. has a capacity for saying things in a funny way.

D₁: Kind of smart aleck, huh?

D₂: Sarcasm runs in the blood (looking at the father).

M: No, she's always said things in a funny way . . . she laughs a lot.

F: How about laughable?

The younger daughter appeared to enjoy the bantering back and forth with her father. At one time, the father got up from the table to get a glass of water as he was talking. The younger daughter picked up the recorder
and followed him with it. Everyone was amused. Indeed, she seemed to keep things happening—"to liven up the place." The family appeared to enjoy the wit and sarcastic commentary of both the father and the daughter. This pattern enabled the family to be open in their comments to one another as the tension was generally lightened through funny, sarcastic remarks or funny gestures.

The father revealed that he had been the information source for the family in regard to the illness:

> Since this has come about, I guess I've read 10 or 15 books on cancer. You know, we've had the contact with it and I feel I know a whole lot more about it now than what the doctor's going to tell you—they don't tell you anything. They figure it's two things. One, you don't want to hear about it, and two, they don't want to explain it to an imbecile. They give you half of a story—or a third, and they don't finish telling it because they don't think it's any of your business.

The mother agreed, "He has taken the responsibility to read a book on that and interpret it, where I couldn't, or I wouldn't. So, he's told me a lot and has kept me informed on a lot of this." The father added:

> Well, I think they could spend more time with you if they wanted to, and tell you more, but again, that's looking in the mirror at their side of the fence because I don't like to explain something to somebody when I know full well that when I get through telling them, they'll know just about as much as they did when they started. You know, it goes over their head.
The younger daughter added, "He's been a talking Webster's Dictionary on cancer." The family seemed to value the father's willingness to inform them about the disease.

The older daughter was also interested in the scientific informational aspect of the disease, as she plans to become a nurse.

I thought it was kind of interesting because I want to be a nurse—I got to see what actually happens, you know, the chemicals—the side effects. I didn't feel put out or obligated—it was interesting.

She reported that part of her frustration in being left out during doctor's visits resulted from her desire to learn more from a medical perspective about her mother's disease. In becoming more scientifically knowledgeable about her mother's disease, the daughter could utilize that knowledge to be more included in the decision making process in regards to the treatment of her mother's illness.

In examining the ways in which the family had structured and utilized patterns or rules of interrelation, attention was given to how conflict was managed and to the manner in which decisions were made. One of the most noticeable patterns of communicating within the family focused upon the mother's tendency to frequently
utilize the sound, "uh-hum," when she was making a point. It appeared that, at times, when the mother punctuated in this manner, that she was communicating on an implicit level, "I am saying this, but I am not saying it." It seemed that "uh-hum" metaphorically could stand for a white flag being raised in truce for making a confronting comment:

My theory is, too, that B. was and is the apple of his mother's eye, and, I think, she probably has guilt feelings about leaving him (when he was a young child) . . . for a couple of years . . . uh hum . . . that's my theory. And I think B. has spent many a year trying to prove to his mother that he is worthy of her to this day, but I think he has finally put me first. That's the way I feel. Uh hum. It may be all wrong, but anyway, uh-hum.

In using this indirect method of confronting, the mother appeared to control the direction of flow of conversation. It was as though her "uh-hum" either punctuated the flow of the dialogue to continue along with her viewpoint, or it signaled the family to discontinue pursuit of that particular viewpoint. It appeared that when the family utilized sarcasm and wit to discuss family issues that the mother did not interfere when the focus was on the youngest daughter. The youngest daughter not only seemed to handle the teasing well, but she also seemed to enjoy it. However, when the focus turned to the oldest daughter, the mother tended to begin softening
the tone of the sarcasm and to run interference for this daughter who generally looked down and became quiet. Consequently, it often appeared that the mother tended to be in alliance with the oldest daughter and to defend her against the wit and sarcasm of the younger daughter and the father.

M: J. is definitely more one to -- when there is a problem, to . . .

D1: Think it over.

M: To think it over, think it out, and express it and find a solution.

D2: She comes to a conclusion . . . she comes to an hypothesis.

F: Like, how would we best keep water out of the car? By leaving all the windows down or rolling them up?

D2: Or, what's the best way to leave them down?

M: Is this an . . .

D2: Or, leave the windows down and the doors unlocked at all times.

F: That way, there is no danger of breaking windows out to get in the car.

D2: That way she doesn't have to replace the door.

M: Now, is this the time to accuse people of things that . . .

The family repeatedly chose a seating arrangement during the interviews in which the father and younger daughter
were seated together, followed by the older daughter and mother.

The father appeared to utilize humor, sarcasm, or what appeared to be nervous activity to deflect tension or stress away from the mother. For example, at one point, when the mother was discussing how difficult her chemotherapy treatment had been for her, the father left the table and grabbed the fly swatter as the mother was talking.

M: That was the first time around—the second time around, I was much better, but that first one—and I'm sure it was not as rough as some people have it (whole family laughs as father swats fly).

F: I have missed that thing three times.

D2: You just realize that it rolled right on the table.

F: I'm sure she's seen people kill flies before.

The family, and in particular, the younger daughter, appeared to recognize the value of the father's use of humor and sarcasm to alleviate tension.

M: ... Around here, things can get pretty hectic and everybody knows if something bothers him, they love to pull his string ... and he takes the bait ... 

D2: Well, not everyone has a great, wonderful sense of humor like Dad.
I: Seems like you do have good times laughing together. Would you say that your home as a lot of laughter?

D2: A lot of sarcasm in this family (laughter). Nobody else has a dad that picks up crickets and throws them at the wall in my front bedroom... and we sit there and laugh at my dad and say "What are you doing?"

D1: Or he talks to your cat like it's your brother.

M: He's been noted for his sense of humor.

D2: Yes, it's pretty much like a role in everyone's daily life.

F: Yes... people used to think of me as cynical, but I like to think of myself as being realistic.

M: He has mellowed on his sarcasm.

F: I bite my tongue.

D2: When?

From the mother's perspective, the father is presently more in control of making decisions and running the family.

M: ... I think we're to the point where we've got our rules, we know how things are run, uh hum, and if things come up, I think he handles it, now... I don't want to hassle. I don't want to thingslike that—it drains on me, now, where before, you know, I used to could handle it.

However, the father did not agree with the mother that he was the decision-maker in the family now.

Everybody is still... while they're dependent... no, we are interdependent to a certain
extent, but still, like we were talking the other day, everybody can function as their own person to a certain extent. And around here, there's not, this deal that I had of not asking anybody, because around here, everybody asks everybody and I don't think the kids are reluctant to ask. They probably go to LaRue more than they go to me, but still, I get called in for my thoughts, so it's not completely . . .

This father appeared to be uncomfortable with being thought of as the "powerful one" in the family:

F: Some of these families . . . not ours, necessarily, . . . one person has all the damn power and other's can't say "boo" without getting clearance on it first.

But, I don't want to be that way, and I'm not that way. And so, LaRue and I talk—anything that needs talking over—we talk it over and over and reach a decision and that's what we'll go by.

I: Sometimes, now, you're the one who carries it through?

F: Oh yeh. You know, I'm not going to let the wolves run off with the sheep while my back's turned . . .

The entire family commented on the loosely structured rules for functioning in the family.

D₂: I mean, if you're hungry, you want to go in the kitchen and fix, I mean, everybody eats at a different time of the day.

D₁: We're not real formal.

F: You might say unstructured.

I: Do you structure time to talk—or do you just talk informally, for example, as someone is cooking?

D₁: Or walking out the door . . .
D₂: Or, go from room to room ... beating on the wall.

M: We leave long notes.

F: Have a lot of written communication around here. If somebody wants any messages passed, they better write them down because that's the only way they are going to get passed.

D₁: 'Cause even if you do tell them what you do tell them, half the time they won't remember it anyway.

D₂: The note can lay on the counter for days.

M: Terrible, terrible this summer.

It was apparent that decisions made in regard to managing family issues were now discussed by the mother and father and more often than not, executed by the father. The family was open in acknowledging that this was not the case when the father was drinking. It appeared that even before the surgery, the family had begun to restructure so as to better include the father who described himself as "ostracized in my own house." The father seemed to enjoy his newly recognized position in the family and the family enjoyed teasing him about his new role:

F: And who is the most level-headed and keeps his head in any type of problem?

D₁: We don't have but one in this family, either (smiles and looks at the father).
P: I don't think we are talking about you (laughter).

D₂: He, you are talking generalization, you know.

F: How many he's we got—me and the cat's the only two around here.

D₂: Well, he's not considered a he . . . since he doesn't have a girlfriend by now then he might as well give it up (laughter).

M: Well, sometimes we remain cool, sometimes we don't.

D₁: That wasn't a question.

F: I think it's a good one.

When examining Research Question #3, what are the effects of the illness on the family, attention was given to the flexibility of the family to allow for autonomous functioning of the patient in her right to express feelings and to make decisions. Attention was further given to the family's ability to adapt and to manage stress. The family's willingness to draw upon support outside the family was also examined.

It is apparent that within this family, the mother's perception is that she has always functioned autonomously.

I think, while he was in his sleeping days in the chair, he could make things miserable, and I thought if he wants to be miserable, that's fine. But I'm not going to sit around here and be miserable. So, you know, I had friends, I'd do things,
and we'd do things with the girls, and I thought if he doesn't want to, that doesn't mean that I'm going to sit here and be miserable with him or let him be miserable. He can be miserable by himself . . . I didn't hassle him, and he didn't hassle me, because it didn't do any good. I thought, I have a life, too. This is my life.

The mother seemed to continue her autonomous functioning, as was illustrated in her discussion concerning her church affiliation. "I'm in the process of going to another church, if I can ever get myself there on Sunday morning . . . I'm Methodist and suppose he would be, if I could get him to go with me."

As has been previously discussed, the family adapted in ways so as to allow the mother to virtually drop out of the family during the summer after the surgery. From the mother's point of view, she described this time when she said, "In fact, you did it, you did it all, because I didn't do anything. The mother seemed concerned about the impact of her withdrawal from her involvement in the household. She asked the daughters, "Did you feel obligated, or, not obligated, but put upon, that you were having to do that? Did you feel it wasn't your place to do that?" Both daughters replied that they were "glad to do it." The younger daughter added a witty remark when she said, "... like when you said the dust settled, it settled."
The mother commented upon the daughter's willingness to continue special consideration of her:

I think both girls are more considerate of me, more thoughtful, willing to help when they leave. S. will always say "Mother, do you need anything?" And if I ask them to do anything for me, they are more than willing to. They may have been that way before, but maybe I just didn't ask them.

She also perceived the father as being more considerate of her. "I feel he places me first, now, uh-hum, in his life . . . ." The father commented on his willingness to become more flexible since the surgery:

It's probably affected me now in that I'm more into wild things like going to different places to eat rather than one place. I'm not very adventuresome . . . you know, it gives you back some humility to see these things that you don't have any damn control over, and lets you realize these things, more than somebody who gets set in their ways--like everything's got to be--to have an answer. You get in a situation like this, and you find that's not necessarily so.

The mother and father discussed their perception of the effects of the illness and their management of it in the following dialogue:

F: Acceptance is all you can do when you can't change it. You have two choices, you can either accept it or fight it, and if you don't know what you're fighting, all you're going to do is get frustrated even more so, but you go ahead and accept it for what it is--but you're powerless.

M: Kind of goes back to the serenity prayer, "Help me to accept the things that I cannot change and change the things I can."

F: And the wisdom to know the difference.
M: The wisdom to know the difference—can't change it. Well, we've never had illness in our family, and I don't know, I think we've had a positive outlook on this, this episode.

F: You've got to meet it head on—not necessarily take it on its own terms. You have to to a certain extent, but you can still be either positive or negative about it.

I: So, you're saying you have a choice, about how to respond?

F: That's the only choice you've got. That is the only, I think, weapon you've got against it. It just made the choice and the choice is how you react to it, so that's the key.

The family discussed the personal frustration with responses from others outside of the family to the illness.

M: I know, J. and I have talked about it and people would say, "Well, you look so good." Finally, one day you said, "Well how in hell are you supposed to look?"

D1: I remember her saying, "Golly, your mom looks so good." You know, like she's supposed to be on her death bed.

D2: Or, "How's she looking these days?"

M: Looks the same . . .

D2: Everybody said, "God, I can't believe . . ."

M: Does that bother you to have people say that?"

D2: They make it like it's . . .

D1: Something that's not here in [our town].
D2: Like her head got screwed on backwards or something—deformed you, or something.

D2: I just think that cancer is just a word...

D1: They really meant it in a different way other than...

D2: Yeh, they meant it that she really did look good. I guess they expected her to be looking like she was on her death bed—not able to move or something.

D1: Because none of them have ever had any experience with cancer.

D1: Well, I just look at them as, they are so dumb. They don't know what cancer is, you know.

D2: They could say "She looks like she is recovering well," but not "She looks good."

The father explained that he viewed other's attempts to be supportive in a different way:

I think a lot of people are hesitant to even mention it... ask about her. They just don't want to mention it because they are not sure about how to approach it. And, I'm the same way. Because you never know if you're going to say the right thing or the wrong thing, or what. And I think it puts people, you know, you've got to open the door for them, because it's like they're not gonna interfere, and they're not going to mention it unless you say something about it. In the same way, I don't like to jump in... because a lot of people take it like they're being nosey... you can't say that evidently they don't care because they didn't say anything, but I think in most cases it's not that they didn't say anything, they just don't know what to say.
Family #3

In this family, the breast cancer patient, is 44 years old. The father is 46 years old, the son is 22 years old, and the daughter is 17 years old. Developmentally, this family is classified in between the "family of adolescents" stage and the "launching of children" stage (McGoldrick & Carter, 1982). The son is in college and appeared to be successfully individuating from the family. The mother related that the son was told to stay at school when she went to the hospital for her surgery:

I talked to H.G. before I went to the hospital and I said, "Now, I don't want you to come home. I am not sick, so don't come home. So he didn't. After the surgery, I was concerned about him being by himself and hearing that his mother had cancer but he had a real close friend... I did worry about him only because Gene told me that... I remember, I said "Now, did you call H.G.? What did you tell him?" He said, "I told him the truth."

At another time, the mother discussed the son's autonomy when he came home for a visit:

My mother was just here and she can't get over the fact that he goes into the kitchen and he fixes different things. I don't even get up and go to the kitchen. I just sit in there until he brings his plate in to eat, or he does his laundry.

Indeed, when the family discussed perceptions of other's responses to the illness, it seemed that the son was removed from the illness experience. The son was home,
visiting from school when one of the interviews took place. He chose not to participate in the interview, and the family seemed comfortable with this as they really did not see him as having been involved in the experience.

It appeared that since the mother's illness, the daughter had been encouraged to become more independent:

I know one thing—I thought about what if they had to do without me. I have relinquished responsibility after responsibility. When I was growing up, my mother did a lot more things for me when I was a senior in high school than I do for V. V., I feel like, could take care of herself if she had to and do a good job of it because I've watched her—some things I just don't do. I just let V. do them and if they turn out well, fine; and if they don't then we try to work on them and do whatever things come up.

The daughter expressed her agreement with the mother's perception of her autonomy. "I just walk out the door and Dad goes, 'N. you just let her run wild (laughter). They never sit down and have dinner with us.' Well, she doesn't cook anyway so what does it matter." The father laughed and agreed, "N.'s only goal is to have a house without a kitchen." The mother laughed and said, "Somehow we haven't managed that yet." The mother's view of the daughter is described in the following passage:

She's like me by nature anyway. She is independent. She is going to do what she thinks is right and what is best at the time, as far as her judg-
ment goes. Even if you say to her, "You are not going to do that," she's got a pretty strong will and, I was much more protective of our son -- I did much more, many more things for him than I do for V., but that was before this. Now, he had to learn a little later in life, and because V. is out -- I trust her to do things and to have better judgment, and I don't always try to tell her everything. Then G. says, "Well, N., you haven't tried as hard with her" (laughter).

So, it seemed that the illness experience has served a function for the family in that the mother has certainly encouraged the autonomy and individuation of her children. As the mother pointed out, her tendency was to be protective of her children, and it seemed that after the diagnosis and surgery, it became a priority for her to teach these developmentally appropriate behaviors.

In examining Research Question #1, what is individual meaning of personal response to the illness, as well as what is personal meaning ascribed to other family members' responses, the mother discussed her initial response to hearing the diagnosis:

I sort of knew that I had cancer from what they had -- they had removed my breast, but because Dr. B. said to me, "Everything is going to be alright," I started smiling, and G. didn't say anything... When V. came we just smiled and I figured well, if you smiled through part of it, you know... this would be the way I would approach it as far as people knowing that I had it or whatever... that I wouldn't really get own and drag along with it. So, I chose to sort of control it myself. I just knew that by the mood that I presented, which I am sure kept a lot of people from talking about it... then every-
body else did the same thing I did—she's doing alright—this is what I wanted them to say, which was either fair or not fair to them, but this is the way we could handle it if we all just didn't sit down and just mull over it... So, my reaction was when somebody said, "Well, she is smiling" well, I thought if that works one time, I'll just grin through the rest of it.

The father agreed with the mother's perceptions. "I don't know, I guess I really didn't talk about it a lot. It was there, but I didn't talk about it much... I didn't say too much about it... I just kind of avoided it." The father further explained his discomfort with the hospital environment:

I'm not very, I don't particularly like hospitals and I, you know, even I guess they serve a purpose but I spend very little time in 'em, so I just... I did spend a lot of time there, you know, and I'd walk back and forth from the waiting room.

The daughter commented on the mother's response when she said, "Mom kind of seemed fake at first... 'cause I expected when I went in to see her, for her to be upset, which I had pictured in my mind for her to do... I thought it was weird." The daughter admitted that she felt left out during the surgery. She commented, "I didn't see her 'till Saturday. I went on like nothing had happened. Well, one day she had surgery... I was kinda mad at her because she didn't invite me to go to the hospital." The mother then explained that she was trying to protect the daughter:
I did that on purpose because right before I had my surgery, about six months before that, one of V.'s friend's mother had the same surgery, and I was volunteering up there and M. was up there, and they came out and told her daddy that it was cancer and they would have to do the surgery—little M. went to pieces. And then, she had to sit there for four or five hours with just all these people going over and over this. Well, I just couldn't stand the thought of V. having to sit out there with all these morbid adults going over this same horrible thing that had just happened, so I told her she had to go to school, because that was just something I couldn't have on my mind—wheeling into surgery and waving goodbye to her the way I had seen M. do with her mother. Even if it was terrible for her, I had to do it for myself.

The father added, "I guess I wasn't with V. a lot . . . at night and to see her off to school. I think she was not changed in her routine very much . . . her grandmother and her aunt were around." So, it seemed that it was expected of the daughter to act as if things were normal throughout the surgery experience.

Indeed, to hear the family describe the experience, it seemed as if the diagnosis and surgery were something like one big happy party:

F: My first reaction to N.'s surgery was, you know, after I talked to Dr. B. and then he told me it was cancer, I was a little shocked then. But, I got over that in a few minutes, and there were a lot of people there—her family was not there at the time, but five or six of her lady friends were there and a couple of my friends . . . so, there were around 12 people in the waiting room. So, we were drinking cokes and coffee and just chatted. I think I spoke to you briefly when you came out of surgery . . .
M: We were laughing because two of my friends had both come in as my sisters and had told them—first one came in and she said when she got to the bed—she said, I am your sister so don't act any different. So, we laughed about that. I don't guess there was anything else to say. We're pretty blunt. If you say it once and then . . .

F: N. got a lot of flowers . . . seemed like . . .

D: Someone died . . .

F: Yea.

When the family was questioned as to what it was like in their home when the mother returned from the hospital the daughter replied, "Well, it seemed like the party continued." The mother explained:

Well, it was a long time before we were ever in the house by ourselves together, I think. I mean, yeh at least two weeks. I will have to say this with my family, I think if I had died they still would have had a pretty good time because my sister—it's kind of hard not to have a pretty good time. I really had one of the nicest times in my life when I got home. I didn't feel bad and people came to see me that I have not seen forever.

The daughter told a story about an intended shopping trip with her aunt on the day that her mother was told she could come home:

The doctor came in and said my mom could go home and we laughed and said she was trying to spoil our shopping day. When she got home, the school called because my aunt didn't call in to excuse me and it was like I was skipping school. Mother gets on the phone and says "Mr. H., V. didn't go
to school today because I've been in surgery all week." That's what she said—all week. Well, by this time, my aunt is on the floor dying laughing. My mom was saying all week instead of saying that she needed me to come stay with her. He said "I am so sorry" (laughter) ... It was funny—hilarious.

This family appeared to utilize humor and levity to manage and cope with this crisis. It seemed that there were several recurrent themes adopted by the family in response to this illness experience—"Cancer can be just one big party," and "Cancer is no big deal."

Indeed, in the mother's family, illness and dying had traditionally been treated as if it were a natural and normal part of the process of living. "Business as usual" was generally the accepted attitude the mother's family employed when the grandmother was ill and dying in the mother's childhood home. The mother described her family's attitude toward her grandmother's serious illness. "She was just old, but we didn't treat her like a dying person."

The mother discussed the modeling her mother provided for her:

My mother is a real role model. She's had a lot of hardships in her life which I didn't realize until I was, maybe, 40. And G. will tell you, my mother—her house—she had an abounding amount of faith—she has a very stubborn attitude that she will not give in to anything that would—you know, not make things pleasant for
the rest of the world to run along... She is a come through-er. Isn't she, G.? I mean, she doesn't complain about anything.

When the mother discussed her memories of her husband's father, who had diabetes, it appeared that once more, she seemed to see him as a role model for keeping personal suffering a private experience:

I didn't know him until he lost his eyesight. He never--he never said a word about it. But he would talk about everything else and when people had to do things for him, he just accepted it and took it, but he never did say how bad I feel, or wish I had done something different. He just--he was pretty well satisfied that he had lived...

G.'s daddy tended to live and live to the fullest.

So, it seemed that the mother's role of a "real trooper" throughout the illness experience had been reinforced throughout the mother's recollections multigenerationally. The mother mentioned that because she did not allow cancer to "run her life" that others "wouldn't notice anything different about her:"

I've tried to run it and have some control over it because I want to be in control of what I could do and that was one part I could be in control of--that is, how it affected my house.

In examining Research Question #2, what is the structure and organization of the family, the mother's belief system has influenced the role she plays within the family. Indeed, it appeared that the mother perceived her role as being protector or guardian to insure
that the illness would not significantly affect or impact other family member's lives. The mother appeared to have invested in seeing to it that the family ran as smoothly as possible with as little discomfort as is possible.

The family discussed her role in the following excerpt:

M: I am the peacemaker.

F: Well, there is no question about that—we all agree on that.

D: Who is the easiest to get along with?

F: Me.

M: Me.

D: I knew there would be fighting between them. I knew it, because I was the one that they say, oh, you just don't want to get along with anybody. So, I knew that I wouldn't win on that one.

F: Who makes the most sacrifices—you know it's me on that.

D: Dad, you'd better watch it—

F: That's right, it's me on that.

D: No, we have to discuss who is the easiest to get along with.

F: Who do you think it is?

D: It depends on what the situation is.

M: Who makes life the easiest for you? Your father or I?

D: I think Mom does on that one.

M: Who is the easiest to please, and I believe that's your dad.
D: Oh yeah, by far... dad is easy compared to you.

The father and daughter also labeled the mother as the bossiest in the family:

D: ... You seem to be the bossiest.
F: We all agree, she's the bossiest.
M: She has a name.
F: Mama is the bossiest.
M: And I'm not your mother. You can refer to me as N.
F: Okay, N. is the bossiest; right, V.
D: Yeah.

The mother seemed to assume leadership in the family. She appeared to be aware of her leadership role as she talked very openly about her awareness that the family would key off of her attitude in response to the illness. She commented, "I just knew that the mood I presented... everybody else would do the same thing I did." At another time, she discussed how she sees herself like her mother:

We both are very opinionated, and if we think something is one way, that's the way it is. And we don't hesitate to say so. I realize that she thought that those things that she said, that this is the way it will be, she believed them so firmly, and it was her responsibility to tell us. And, I'm sorta the same way--whatever the cost that it costs me, I will go ahead and say if I think something is wrong that is going on or that doesn't meet up to what should be.
The father mentioned that the mother generally was the focal point in the family. He said, "I think in most cases, N. is a very vocal person and she talks a lot in a room." He added, "N. says that I'm the one that can't hold friends and if it hadn't been for her, I wouldn't have any friends" (laughter). At another time, the father acknowledged the mother's leadership role when he said, "You always get pretty much control in what changes."

It appeared that the father often was uninvolved in the family, as well as with friends. The daughter described the father's pattern of noninvolvement when she said, "In the sense that she tends to get radical, he just kind-of lays back and goes to sleep" (laughter). At another time, the daughter said, "Who could just not pay attention when being spoken to? Who gets that award? Think about it, Dad." The father laughed and said, "Well, I only hear what I want to hear." The daughter added, "That's right, and you never want to hear us. You like listening to yourself rattling the newspaper all the time." So, it appeared that when the mother expressed her opinions the father often backed away and let her talk, seeming to pay little attention to her words. The mother commented on the father's tendency to withdraw from the family when there was a problem:
M: The kids always say if Dad has a problem, he just goes to the bathroom and shuts the door. He might stay in the bathroom for a long time.

I: So, somehow G. would cope.

M: Somehow, G. would make it . . .

D: Or, sleep through it.

The family seemed to describe an image of the mother running the family, and the father leaning back and watching (or not watching) her do that. Occasionally, he seemed to comment on the way things were going, but the family tended to dismiss his comments with laughter or sarcasm.

The father did appear to have assumed the role of financial supervisor in the family. Both the father and mother appeared comfortable with the fact that the father handled the finances. The couple described his management of money in the following way:

M: I spend it, but G. handles it. G. does all of our money things. I carry the checkbook. But G. pays all the bills.

F: I have to juggle it so we can pay them.

M: He does. He pays all the bills. We don't have a budget. We've just always known how much we had and how much we didn't.

F: If I'm real good, I get a blank check once-in-a-while.

I: So, who would you say controls the money?
F: Probably N.

M: This is one place where we'd have to . . .

F: Well, probably I do. Well, everything is joint so it doesn't make any difference.

At another time, the mother discussed the way the father shielded her by taking care of the financial management of the disease.

G. is wonderful. G. takes care of every bit of that. I have yet to fill out an insurance form. I know a lot of people who've had cancer and they have not only the burden of that but the burden of seeing that everything's paid or sending in everything. G. has always done every bit of that. That's a big burden as far as I'm concerned that I don't have to handle. I just rely on him to do all that. He does it all . . . it really relieves my mind. Probably, if I knew how much all this costs, it would flabbergast me, but I just see one or two little things at a time. I never see the pile of it.

The father admitted, "Some things I try to shield her on—wouldn't be right . . . N. was in ERA before there was ERA so I have not much to say about anything . . ." (laughter). In other words, the father was expressing his desire to shield the mother without calling it shielding. He allowed the mother to be independent and to be overtly expressive of that independence. To acknowledge that he protected her would be in contrast to the mother's image in the family. The mother too, acknowledged that she deferred to the father to handle money matters, and she felt that worked well for her.
The daughter appeared to act as commentator on the family, keeping the family honest during the interviews. She appeared to have integrated her mother's tendency to "tell it like it is," and she seemed to feel free to reflect openly on any member of the family. When the family was discussing the impact of the mother's check-up visits to the doctor, the daughter chose a teasing, witty way to relate what happened in the family:

D: When she says she doesn't feel good, that is when it sets us all off . . . But, she said a lot, even before she had her surgery. Now, when she says it, we kind-of wonder if it's psychological or if she doesn't feel good.

I: So, that was sort-of a pattern Mom had before all this happened?

D: She always had these little aches, you know. The older she gets--I think it just comes psychological that when she says she doesn't feel good, I think about it for awhile . . . but I just pretend I don't hear her (laughter). I think my brother does the same thing. He says, "Mom, it's just all in your mind." Dad . . . it is in his mind . . . (laughter).

At another time, when the mother was discussing her need to foster her children's independence, the following dialogue demonstrated the daughter's ability to comment on function within the family:

M: They wanted to do their own thing, anyway. I was not one to . . .
D: Dad's the one you had to control... Dad doesn't say much... It's just "Go ask your mother"... and Mom just laughs. And then, Dad would say, "You just let her run wild" (laughter).

The family appeared to enjoy the daughter's "tongue-in cheek" commentaries, and they acknowledged her viewpoint as viable.

In examining Research Question #3, what are the rules and patterns of interrelating, it appeared that the family had established a policy that reflected the mother's "no big deal" attitude:

Well, we handle everything in our house—not to the bottom of the depths. None of us can handle anything to wallow in it. There are just a few moments that you can allow that and we have to, you know, like they say, well, so what if you had to drink two quarts of Gatorade (for the tests). Hope you can make it to the bathroom. That's the only way we can handle it. I can't the night before say, "Oh, if this isn't good, what in the world will we do?" And they can't say, "Mom, if this test isn't good. We just can't do that."

The mother further explained that the family often was involved in discussing outside topics unrelated to personal issues:

So, we don't labor the point, but when we sit down to talk, like we've been talking a lot of politics for several months now. We'll thrash that out and stand up in the floor and shout, or if it's a ball game we've been to—we'll pick an outside interest that we bring in. We do a lot of talking and sometimes disagreeing. If there had been four political parties in the last race, each of us would have had a different one.
Each individual member in the family utilizes humor in a unique way. The mother often utilized humor, including laughter, witty comments, and sarcasm, to discuss sensitive matters:

D: People that haven't seen her in a long time and know that she's had this surgery say to me like you should be so thankful that she looks this good. I mean she doesn't look any different to me than—

M: Except that, V. says my eyelids are sagging and I'm looking bad to her. My cellulites really look bad and when people say that she wants to say, "Look, you have lost your eyesight . . . the old bag . . ."

D: It's like they keep telling me that even though she's had it, she really looks good, like nothing has happened. Like they're expecting her to look like she's dead or something—I don't know.

The father used humor, particularly laughter, to confront the mother. When discussing the way the mother had managed her illness, the following dialogue ensued:

M: I've tried to run it and have some control over it because I want to be in control of what I can do . . .

I: Would you agree with that, G.?

F: I would think so . . . you always got pretty much control over what changes (laughter) . . . now don't tell anyone that it's not true (laughter).

He also used joke-telling to relieve tension or discomfort in the family. Often, while the interviewer was
setting up video and audio recording equipment to begin interview sessions, the father would entertain the group with jokes, helping to alleviate the tension of "getting started." At one time, when the family was feeling awkward towards the end of the task interview, the father once more began to break the tension with a joke. However, the mother stopped him and attempted to put the family back to the task:

F: Okay, what is the next question?
M: Maybe we should repeat the question.
F: Well, I think it said something about . . .
D: Dad, you're adding questions to the ones she asked.
F: Well, it was a long question. We should have a copy of it to read.
D: The picture was awful, there wasn't enough money and now the question was too long.
F: It's really hard to do.
D: She told us that the third session would be so much fun and now--look at it--boy, it's the pits.
M: We can't even remember the question.
F: Well, we'll think about it a little more . . . Did you hear about the two black guys that . . . (looks at Mother) . . . Well, this is good (laughter).
M: No, we're trying to be serious. This is taking up a lot of space on the tape . . .
Father (laughter).
D: She'll think you're the most humorous.

The father and daughter appeared to openly confront one another without the use of humor, as was demonstrated in the following dialogue:

M: If there was any way for me to go for my tests and not tell anybody, but, from one time to another, they'll say "When do you go again?" Last week, people started calling me about when I was having my—they said, "I thought you said it was the end of October." Well, I chose to have it this week because my mother was visiting me. Well, that threw all of them off, you know. And I appreciate this, but if there was some way I could sneak in and have my test and slip out and nobody know it—but they've got the pattern down and if in six months, I haven't reported, you know it's supposed to be in six months. So, then, you go through all this and then they ask you questions.

F: You would probably be upset if they weren't asking.

M: Oh, I'd be upset if they didn't care but it just means that you have to go over it—tell the story over and over. I could tell V. to just tell them but she gets irritated.

D: It's the retelling. Just when they call, just say "This is a recording"... Mom's okay... the test were fine.

F: You joke about it... obviously... if the tests weren't great, weren't good, you probably wouldn't be feeling that way about it.

D: Dad, what I'm saying is—it's kind of like repetitious that Mom has to go through that. If it wasn't okay, we wouldn't be joking like we are now—-it's not a joke.

F: It's just humor.
The mother had related to this interviewer right before this session that on the last series of tests, the doctors were concerned about indicators on her X-ray photographs of possible activity, or growth of lesions in the bone. Consequently, the father was unable to join in the humor and sarcasm which was the usual manner utilized by the family to cope with the disease. The daughter was not privy to the information about the past tests and was able to join the mother in her use of humor to maintain the conspiracy of silence in regard to the matter. In fact, the mother went for her tests the following day after this interview, and luckily, the tests indicated no new activity. Consequently, the family was given a reprieve for six more months, left with the haunting question as to what might appear next.

As was demonstrated by the before-mentioned dialogue, the father was sometimes unwilling to join in the humorous treatment of managing the disease. The daughter also seemed to resist joining her mother when it seemed inappropriate. Both the father and daughter appeared to feel comfortable in openly resisting:

D: I think she has been more religious. (Mother laughed—daughter looked at her and appeared irritated). It's not funny.

M: I know it, but it sounds funny, like I didn't have any before.
D: No, she did before, but I just, I don't know, she says she doesn't preach but it sounds a little bit like she does every once in a while. You didn't see that in her before . . . Sometimes I get mad about it, but that's just her. Sometimes she quotes something that she's just read or something that she said was on TV and I don't know where it comes from—and it's really the Bible . . . that makes me mad.

At another time, the mother was discussing a mutual friend who had died several months previously, and she began to laugh. Both the father and daughter confronted her with the inappropriateness of her laughter with looks that communicated disgust and surprise. She responded to their looks in the same manner as above—making an effort to clarify her more light-hearted perspective. It appeared that the mother tended to view difficult situations in a way that helps her laugh at herself and others. Generally, when she explained her laughter, which at the time seemed inappropriate, one could begin to understand her ability to respond to the most somber event in an alternative, less serious manner. Her tendency to help perpetuate her motto, "We don't waller" enabled her to look at the more optimistic perspective of each experience. The father and daughter seemed to serve as a reality check for her, and she responded by clarifying her viewpoint.
The daughter used witty remarks and sarcasm to comment on the family and to join her mother and father in a more light-hearted approach to managing conflict and tension within the family:

F: So alright, what is the next thing we're talking about--crying and bossing.

D: Laughing.

M: I probably laugh the most.

D: No, you don't. Dad, you don't get that one either. If you get mad, we always laugh at you.

F: Okay. Who laughs the most—you, V.?

D: I probably laugh a lot and pick on people when you think about it.

F: Well, we agree--yeah.

D: Mom wanted to laugh the most. She's mad now.

F: You can't win them all (laughter).

The daughter appeared to openly confront both parents and during the interviews she did not hesitate to add her perspective on things. In an effort to get a glimpse of what the family was like with the son present, the interviewer asked how the family perceived management of conflict with all members present:

I: How would I see people disagreeing and sharing opinions? Is anyone afraid to do that?

M: I don't think anybody's afraid.
F: We probably don't—I don't know who N. voted for—she doesn't know who I voted for. We don't discuss that part of it.

M: See, this is another thing we wouldn't discuss, now. It would be just better.

I: But you do discuss the issues—you allow one another space and privacy, though.

M: And, H.G., we don't know who he voted for. He probably told V. Now, they tell each other things more. I mean probably more personal things—the things they think we don't approve of ... and they want to certainly shield their daddy from ... 

I: So during the surgery, with H.G. at school, you didn't get to use him as somebody to gripe to about all those things, did you?

D: No. But I don't think I could have griped at him. At that time of our lives he would still hit me. There is no need to get upset with him. So, now he doesn't hit me—he just calls me names (laughter).

I: I can tell you have come a long way in that relationship. When it comes to needing to team up to get something done with Mom and Dad, then you are getting pretty good at that.

D: We're pretty good about it.

It appeared that the daughter knew her limits in confronting her brother. She seemed to value her affiliation with him, and the coalition in the brother-sister relationship appeared to be openly acknowledged and accepted.

The daughter commented on her inability to get attention from people outside of the nuclear family, when
she was ill:

D: Still, when anybody calls long distance, if I answer the phone, it's just habit—I could really sound terrible and I hear, "How's your mother?" I told my grandmother I was really sick and she said, "Well, how's your momma doing?" She acted like she didn't hear me. She calls back later and she says, "I asked V. how you were doing but I just remembered V. said she was sick" (laughter). It's funny.

I: Seems like you don't get any billing for being sick in this family.

M: Like, if you don't have cancer, it hardly counts.

D: What's a bad cold?

Indeed, during the course of the data gathering for this study, the daughter was ill and home from school on several occasions. When a phone call was made to the family by the interviewer, the daughter would answer the phone with a rather pitiful, weakened voice. The interviewer was careful to give the daughter focused attention on her own illness, inquiring about her well-being. It seemed that as the daughter received this recognition for being ill that her voice perked up as she began to make remarks in her witty, charming manner. So, while the mother had invested in an identity separate and apart from the illness, the daughter appeared to strive for her right to be sometimes recognized as ill. The mother explained this issue in the following manner:
M: My closest friends tell me that just acquaintances, mutual acquaintances, mine and my closest friends are always saying to them, "Is she really doing that well?" M.C. was telling me that the volunteers at the hospital because I hadn't gone back this year because I'm busy doing other things, they'd say, "Are you sure she's alright?" You know, she's kind of like V. She's real fed up with the attention that I get because I have cancer. I mean who wants attention because they have cancer. Any other way you can get it is wonderful.

The mother and father discussed the way affection is expressed in the family in the following dialogue:

M: I don't think that we're a real hugging, kissing group. We perform all this well when we get with the relatives because we don't have much choice. But, as far as the four of us are concerned, we might give each other a pat but we don't make a scene. We sit together a lot. If we're watching TV or if we're doing something, we sit a lot together. Of course, if somebody's in the bedroom, you look around and all four people will be in the bedroom sitting on the bed, but I don't think that we do a lot of hugging, do you?

F: Probably not enough (laughter).

M: Sounds like a man (laughter). We don't have any places in our house that only belong to that person. If that person's here, we all feel free . . . our kids have always kind-of gotten in on our bed . . . no locked doors or anything.

When observing the family sitting together in the interviews, the family always chose a seating pattern that placed the mother in the middle of the father and
daughter. The mother and father seemed to lean into each other, and indeed, occasionally, the mother or the father would lean over and pat the other, often in an appeasing manner.

The family seemed to make an effort to encourage the autonomy of each individual member. A point in illustration was when the family attempted to decide on the best way to spend $10.00 so that all members could enjoy the money. After a lengthy discussion, it was finally decided to just divide the money by four so that each member could spend the money in the manner preferred. During the course of the decision-making process, the daughter critically analyzed and questioned suggestions, and in typical teenage fashion, immediately thought of a way to spend the money on herself. However, the mother and father seemed to team up so that all family members were considered:

D: Well, how would you spend it? I'd go out and buy tapes.

M: But that won't satisfy the whole family. What if we all went to a movie?

D: You can't go to a movie--four people.

M: Well, say we went to that twilight movie.

F: You still can't do it.

D: I don't want to go to a movie.
M: Well, we'll just go down to Luby's Cafeteria and all eat that little plate that they have got.

D: The deli plate.

M: The deli plate.

F: The Luan plate.

M: Or whatever it is.

F: We've only got $10.00 and you can't do a heck of a lot with $10.00. I'll do something that we all agree on--let's get on with it.

D: Well, why would you want to go eat?

F: Your mother wants to eat.

M: Well, we could give it to the church.

D: No, we don't want to do that.

F: Why not? We can let them argue (laughter).

The mother appeared to take the responsibility for thinking of alternative suggestions. The father, who seemed to be impatient with the discussion, tended to align with the mother, perhaps in order to get the decision made. The mother, who often acted as the appeaser during the task, finally came up with the idea to divide the money. The daughter joined her decision immediately. The father appeared to be removed from the task at that point. It seemed that the daughter's description of the way the father steps back and allows the mother to handle
responsibility was acted out throughout this interactional sequence:

M: We'll divide it by four.

D: Yeah, and each of us could do what we want to do with our own $2.50. There's our answer. Put that on there, Dad.

F: What shall I say?

D: Put it on that thing.

F: It's already there (laughter).

D: I thought it said stop the machine.

F: It stopped.

D: Oh, the question machine stopped but the video is still going strong.

F: The other one is still playing. Is that the end of that question—we're going to buy a plant.

D: No, we're not going to buy a plant, we're going to divide it by four and we're going to take $2.50 and do whatever we want because nobody in this house can ever decide on anything. So, we can take our $2.50 and Mom can eat and you can go to the game . . .

F: Or whatever . . . Is that it, now? We have just divided it up.

Even though the mother appeared to take responsibility for leadership in the family, the investigator's perception was that there was an implicit agreement between the mother and father that it would be that way. During the course of the final interview, the father
seemed impatient and frustrated with the tasks the family were instructed to do. He did not hesitate to voice his frustration, and the mother and daughter responded by appeasing him:

F: Go ahead, next subject.
M: I don't know what it was.
F: You don't listen very well. Back that thing up.
M: And who doesn't listen at all?
D: Who could just not pay attention when being spoken to? Who gets that award? Think about it, Dad . . .
F: (laughter) Well, I only hear what I want to hear.
D: That's right and you never want to hear us. You like listening to yourself rattling the paper all the time.
F: I play Trivia all day, why should I play it here? You know what I'm saying?
M: Yes, I know.
F: Have we finished these questions?
D: Who would know?
F: I think we have finished them. I can't remember, but I think we've covered all the subjects.
M: Probably more. Okay.
D: Turn it off.

The family responded to the father's irritation by joining him in giving him what he wanted. It seemed that
there was a point at which the father ceased to give in to the sarcasm and wit of the mother and daughter, as he insisted on having his way. They respond by giving in to him.

In considering Research Question #3, what is the manner in which the family has organized to manage the effects of the mother's illness, special consideration was given to the ability of the family to encourage the patient to be autonomous and to express her feelings. The family's response to outside support has been discussed, and the family's ability to restructure in order to adapt and manage stress has been examined.

The mother decided upon her adaptive response to the illness when she first awoke from her surgery. Her adaptive theme, "Smile and laugh as if cancer is no big deal," became the theme for the family. Soon after her surgery, the family moved to Florida. This move enabled the family to enter into a conspiracy of silence about the mother's illness:

M: In fact, we moved a few months after that (the surgery)—we moved to Florida. And I remember V. saying to me, "Momma, when we go to Florida, does anybody have to know you have this surgery?" I mean, it gets a little old for somebody who wants to talk about fun things. "How's your mother?" My mother is just fine. You all are just killing me."
F: We left town about, I guess it was around the first of June or so that we left—remember?

M: You did—we left in August.

F: We went down to Florida—Tampa—we lived down there a little over a year and came back here. So, maybe that—because we developed a whole new set of friends—that might of had—we never did talk about it much, though. N., you know, seemed to be real healthy, and we spent a lot of time on the beach. We lived on a cul-de-sac—very active. We got to meet a lot of people—it just became a pattern that we didn't talk about it much. They were all very friendly. We just sort-of fell in with them, I guess. Some sort of social life. She may have talked about it with some of her neighbors, but I don't think we talked about it much in a group and I don't think we ever talked about (in the family).

M: I don't know that we've ever talked about it—even with our very best friends.

The mother's desire to have an identity apart from cancer made it necessary for the family to avoid mentioning the illness either inside or outside of the family system. However, the continued follow-up tests every six months served as an unavoidable reminder of the illness to the family. It was interesting to note the way in which the family managed these tests:

F: I think things shifted back into pretty much of a normal pattern. I noticed N's had a lot of tests since then. She's been very up on them. She takes the test and has stayed very on top of the tests, but other than
that, there's probably never been much conversation about it, otherwise.

D: I usually don't think about it until her results. She comes back and we ask about her results. I usually don't say, "Are you going to the doctor today?" Either I ask about the results or I overhear on the phone and if I hear her on the phone tell someone that she is okay then I feel I don't have to ask.

I: So, one thing you don't do is get into that pattern of asking those questions that everybody else is asking.

D: Yeah, because she kind of gets tired of it. Because if you listen to her enough, the story gets shorter each time... like everything's fine... I've got to go.

I: G., how about you? When she is getting ready to go for the tests, do you even acknowledge it between the two of you?

F: I have to acknowledge the tests.

M: I always have to get the insurance number—I never know any of that.

The family's move to Florida for a year facilitated the mother's need to keep cancer a secret. Old friends and extended family have continued to call after checkups inquiring about the results of tests. These phone calls have served as a reminder to the family who has had so much invested in "no big deal" that Mom had cancer.

It seemed that friends were able to support the mother's need for silence except when test results were
back. Friends took responsibility for keeping up with scheduled tests, as the mother gave no indicator of approaching checkups. Friends also seemed to talk among themselves to avoid having to ask the mother for results:

M: The husband of a friend of mine really got mad at her because she was on the phone for like 70 minutes talking long distance to San Antonio to another friend of mine, and this was after I had the tests done one time, and when her husband fussed at her about the telephone bill, she said, "Yes, but we were talking about N." So, it is alright to run up a big bill if we're discussing N.

I: Such a good cause.

M: Such a good cause. Let's talk about her for an hour.

The family joined together in laughing at friends and extended family whom they labeled as overresponding. They expressed frustration with this slight flaw in an otherwise effective and workable plan:

M: We went to a wedding not long ago, and we hadn't seen the people in a long time. G., when we got back to the hotel that night, said, "M. said you really do look good." He wanted to know how we were doing. Well, you know that means more than just saying, "Well, how's N.?" He would, you know, he was stating a point and making a point with G.

D: This is their favorite comment--everybody says it and I don't understand why but they say it--"Your mom looks the best I have ever seen her look!"
Similarities and Differences Among Families

In the following section, a comparison and contrast has been made across cases to establish similarities and differences among the families studied. In addition, findings have been compared to variables characteristic of healthy families. Research questions have been systematically examined throughout the comparative process.

Research Question #1 examined the patterns the individual understanding with regard to perceived meaning of the illness. Perception of personal response, as well as perception of other family members' responses were examined. Multi-generational beliefs and attitudes towards illness were analyzed.

A family faced with the diagnosis of breast cancer is often influenced by the culturally reinforced belief that cancer and death are synonymous (Simonton, 1984). This cultural belief contributes significantly to the shock and feeling of fear the family experiences upon hearing the diagnosis. In addition, the family often encounters the existential issue of confronting the mortality of its individual members for the first time (Weisman & Worden, 1977). In spite of the fact that early detection in breast cancer can result in a good prognosis, the patient and her family must contend with
the proverbial question mark associated with the possible recurrence of this potentially life-threatening disease (Simonton, 1984).

When examining the initial responses of these three families to hearing the diagnosis, both Family #1 and Family #2 openly discussed initial individual responses of denial or disbelief upon hearing the diagnosis. In both families, members reported a tendency to withdraw into isolation in response to the initial shock of hearing the diagnosis. The fathers in these two families discussed their feelings of irritation with what they perceived as the intrusiveness of outside support when they first heard the diagnosis. Kubler Ross (1968) identified the responses reported by these family members as being normal, adaptive responses to shock.

As Kubler Ross pointed out, individuality in response to shock prevents unilateral categorization (1968). Family #3 typified an "exception-to-the-rule" response in that none of its members reported a response of disbelief. The mother said that upon her awakening, she knew the diagnosis before the doctor told her because she could tell her breast had been removed. The father reported that he felt "a little shocked" at first, but his perception was that the shock lasted only "for a few minutes."
He perceived the mother's response as positive, and he saw her in great spirits so consequently, he just settled into visiting with friends at the hospital. So, it appeared that both the husband and wife utilized their involvement with friends present at the hospital to create distance from the impact of the diagnosis. This was in contrast to the other two families who reported the desire to distance themselves from others in order to manage the shock. Distance from the diagnosis and surgery was purposefully structured for the daughter who was kept from visiting her mother in the hospital until the mother could regain her healthy appearance.

As was pointed out in the case descriptions, each family adopted a theme, or a collective belief about cancer. In Family #1, the theme "cancer kills" or "cancer is a defeat" was initially adopted. This family had little perceived experience with serious illness, because multigenerationally, medical aid had rarely been utilized.

Simonton (1984) discussed the importance of a shared belief of hope in the family. The old adage, "What you do speaks so loudly I can't hear what you are saying," is applicable to families with breast cancer, as a secret attitude of despair and hopelessness can impede a patient's attitude toward positive expectation for
recovery. Often, individuals believe that a "think positive" attitude is thwarted if one experiences the more difficult feelings such as anger or fear. Individuals mistakenly believe that if they directly encounter their fear and acknowledge it, their think-positive attitude will crumble at the foundation. In reality, once fear is expressed and acknowledged, it generally dissipates, leaving an individual energized to continue on with a hopeful attitude (Simonton, 1984).

The individuals in Family #1 were willing to openly express a whole range of feelings among members in response to this illness. This family's ability to openly deal with fear facilitated an effective teamwork approach in examining the options open to them. The family continued to create an open forum in which feelings were expressed and plans were generated based upon acquired knowledge. Consequently, the family was able to reformulate a realistic, yet hopeful, belief about the disease.

In Family #2, the theme "cancer is scary and out of our control" was conceptualized in much the same way as the father's alcoholism. "Replace fear with God's love" was the mother's theme in responding, and both the mother and father talked about acceptance of things beyond human
control and belief in a "Higher Power" to help them manage the illness one-day-at-a-time.

This family had the advantage of having already established a very workable plan to manage the father's disease. It seemed apparent that the family had experience with an ill member as the plan seemed to be quickly and easily implemented. There was no self-pity or "poor me" response from any member. Once the shock of the diagnosis was contended with, the plan was automatically implemented without discussion.

The theme, "cancer is a curiosity" occasionally was precipitated by the older daughter in Family #2 who expressed interest in becoming a nurse. This theme resonated throughout the mother's side of the family, who looked on with curiosity and caution, because multigenerationally, the belief system had been that in this family, people live forever. Consequently, the mother's illness became a threat to her family's multigenerational belief about life and death.

In Family #3, the theme "cancer is an inconvenience" or "cancer is no big deal" was chosen by the mother and was based upon the mother's multigenerational belief that business continues as usual when people in the family are ill. "Let's have a party" was the response the
extended family chose in order to help precipitate the theme. The mother's report that she had the time of her life as she laughed her way through the diagnosis and surgery was initially labeled as "fake" by the daughter. The father saw the mother's response as positive and applauded her brave soldier attitude. The son joined the mother's conceptualization, "I am not sick," and honored her request for him to stay away at school. The mother's sister seemed to have played a role in aligning the daughter with the family response, "Let's have a party," by allowing her to skip school and go on a shopping trip while her mother was in the hospital.

In examining Research Question #2, the structure and organization of the three families were compared and contrasted. Attention was given to the role function of individual members. Communicative interactional patterns, including verbal and nonverbal transactions were examined across the cases. The parental dyad was examined to determine the degree of complementarity and the distribution of power within the dyad. The family's method of handling conflict was analyzed and then compared among the cases. These findings were equated to normative data indicative of healthy families studied by Lewis, Beavers, Gossett, and Phillips (1976).
In each of the families, the role of the mother perhaps has best been described as "keeper of the family." All three families perceived the mother's role before the surgery as the "hub of the family wheel." However, family members agreed that the mother had moved a little "left-from-center" in the family wheel since the surgery. All three mothers appeared to have stepped aside to allow other family members to assume responsibility for management tasks of individual and collective functioning.

The mother's movement from the center of family functioning appeared to have provided an effective impetus for encouraging and fostering the autonomy and independence of the children. Consequently, all three families seemed to have begun to move toward effectively managing the developmental task of preparing the children to leave (McGoldrick and Carter, 1982). This movement away from the children and back into the marital dyad was particularly significant for Family #1. Before the surgery, the children seemed to have been experiencing difficulty in moving away from the home as there seemed to be a "tidal pull toward oneness" (Lewis, Beavers, Gossett, and Phillips, 1976) within the family. After the diagnosis and surgery, the couple reported their intensified feeling of closeness with one another which could have resulted in
enabling the older daughter to subsequently move away from the home. The son also appeared to have begun to use his parent's home more for room and board than for affiliation.

In each of the three families, the mother was perceived as the mediator or peacemaker, and indeed, this behavior was repeatedly demonstrated throughout the interview sessions. So, it seemed that the mother in each of the three families was willing to step aside to support accomplishment of everyday tasks by other members, but she was unwilling to encourage family interaction without her direction. Each mother utilized a metacommunication to signal the family to change the course or flow of communication. The mother in Family #1 used a strained, accentuated smile to signal her family. The mother in Family #2 used her tendency to repeatedly say "Uh-hum" to signal her family that she was punctuating a viewpoint. The mother in Family #3 used laughter, a smile, and sometimes a pat to signal her family. Each family seemed to openly acknowledge and accept the mother's role. In studying optimally functioning families, Lewis, Beavers, Gossett, and Phillips (1976) found that these families had no need to rely on a family referee. Each of the three mothers seemed less willing to consider the subjective viewpoints
of others in the family than did the mothers in healthy families.

It seemed that at one time or another, each of the three fathers had been uninvolved with or withdrawn from other members of the family. Family #1 attributed Christianity and the surgery to enabling the father to affiliate more closely now. Family #2 attributed the father's continued sobriety and the surgery to enable his closer affiliation. In Family #3, jokes continued to be made in reference to that father's tendency to withdraw and isolate himself within the family. This behavior was exhibited by the father's lack of involvement at one point in the task interview.

This father in Family #3 played a protective role for the mother in that he functioned as the financial advisor and manager for the family, shielding the mother from the cost of her continued follow-up treatment. There seemed to be an implicit agreement as to how and when the father could protect and the father expressed caution in overstepping the contextual limits of that agreement. It seemed that this father played "the silent partner" role with the mother in fostering her leadership and managerial position in the home.

Like the father in Family #3, the father in Family #2 also played a protective role for the mother. He took
responsibility for gathering information and reading available materials to inform himself and other family members about the mother's illness. The father appeared to be a master at alleviating tension or deflecting stress from his wife with his humorous comments and antics. This father could also be named "Poet Laureate" of the family as he appeared to have an ability to comment on the family using metaphors and analogies that seemed to be enjoyed by all.

In Family #1, the father played a protective role by selling himself as the "bad guy." The father had been responsible for discipline when the children were growing up in the home. In assuming this "bad guy" role, the mother was able to assume a more angelic role within the family. However, the daughter was not fooled, as she discussed all of the good her father was able to do undercover.

In Family #1, the daughter acted as the commentator of the family, keeping the family honest in the recounting of events. Her approach to telling it like it is was straightforward and witty, very much like the younger daughters in Family #2 and Family #3. In Family #2, the younger daughter was described as "scrappy" because she kept things "stirred up." Indeed, this
description seemed to fit the younger daughter in Family #3, as well. Her wit and sarcasm provided an entertaining, yet seemingly accurate portrayal of family functioning and adaptation.

The older daughter in Family #2 appeared to have the role of apprentice-in-training to assume more of a leadership and managerial position in the family. As she begins to pursue her nursing career, it is plausible that she could achieve more of an authority role within the family in regard to her mother's illness. This could further elevate her to a matriarchal position within the family.

Both sons in Family #1 and Family #3 appeared to have the role of occasional visitor within the family. From the family's perspective, these sons were removed from daily family functioning. The son in Family #3 was not present during the diagnosis and treatment, and the family saw him as uninvolved at that time. The son in Family #1 was described as present but uninvolved during his mother's surgery and treatment. It seemed that these sons emulated the traditional withdrawn, uninvolved role of men in these families.

In examining family structure and organization, it was considered important to assess functionality of the
parental coalition. In considering the parental dyad, attention was paid to power within the dyad, complementarity of the dyad, and whether the boundaries appeared clear between the child and parental coalitions.

In all three families, it appeared that the parental dyad functioned with a reciprocity or a fit between individuals, as there seemed to be an implicit agreement about who would do what. More often than not, leadership and managerial matters were executed by the mother. Yet, in all three families, the fathers appeared to function in designated contextual tasks within the family. In all three families, the fathers joked about the mother's ability to always get her way. The mothers responded with lighthearted affirmation; yet each mother seemed to sense when to back away from pressing the father too far.

Caputo (1963) pointed out that in assessing families, it was not as important to note with whom the power was held within the parental dyad as it was to note whether the power could be shared without conflict. Lewis, Beavers, Gossett, and Phillips (1976) saw that in healthy families, leadership was generally shared, but that more often than not, the father was seen as more powerful.
In Family #1 and Family #2, these fathers had been, at one time, withdrawn and reportedly less involved with the family than at the present time. It would seem logical, then, that during the absence of these fathers, the mothers would have had to assume more of a leadership role. Both families exhibited more of a shift toward egalitarianism with the more involved affiliation of the fathers.

In Family #3, the mother and father seemed to negotiate the managerial tasks in that the father openly commented upon his view of things while leaving it to the mother to actually execute the tasks. All three couples said that they discussed matters involving major issues apart from the children, and then one spouse subsequently carried through with the task. Each couple appeared to cooperate in utilizing the varying degree of individual skills within the dyad as functions were generally executed by the most skilled person. Lewis, Beavers, Gossett, and Phillips (1976) found a high degree of complementarity between the parents of healthy families. Tyler (1970) described the mutual participation of a healthy parental dyad in task accomplishment.

Within all three families, there generally appeared to be a clear boundary between the parental and
child coalitions. Children seemed to have formed closer affiliations with one another as a result of the illness experience. In Family #3, the daughter appeared to occasionally overstep the boundary with the mother's support, but the younger daughter openly confronted her on playing the role of parental child. Perhaps this mother has prepared this daughter just in case her illness takes a turn for the worse or the father relapses. Consequently, on occasion, she has allowed this daughter to practice.

Lewis, Beavers, Gossett, and Phillips (1976) found that in healthy families, a high degree of initiative in responding to input was evident in each family member's ability to be involved in communication in an animated and spontaneous manner. In all three families, family members appeared comfortable in spontaneously contributing to the discussions with humor, sarcasm, and wit. Family members appeared to interrupt one another without hesitation. This characteristic, the spontaneity of interruptions, was observed in healthy families studied by Lewis, Beavers, Gossett, and Phillips (1976).

Family members in Family #1 and Family #2 seemed actively involved and interested during all interview sessions, each contributing in a personal style of interaction that seemed to be valued and accepted within the
family. The interviewer experienced the father in Family #3 as restless and, at times, uninvolved throughout the course of the last interview, only. At one time, a decision supposedly made by the entire family had to be clarified for the father. It was as if he had simply checked out of the family to allow them to deal with what he labeled as trivia. The father's behavior was openly commented upon, generally with sarcastic remarks, and all three family members appeared to accept and honor this father's need to withdraw from what he viewed as an unimportant matter.

Another characteristic evident in the healthy families studied by Lewis, Beavers, Gossett, and Phillips (1976) was that communication was delivered in a clear, concise manner so that there was little or no doubt as to what individuals within the family were thinking and feeling. In Family #1, the mother's tendency to talk with frequent interrupters such as "you know" and "I mean" made it difficult, at times, to have a clear understanding of what she was saying. This pattern was punctuated with the mother's strained artificial smile and it was most often exhibited when the mother was discussing sensitive issues. Interestingly, when the mother discussed her illness, her speech pattern became clear and concise, and there seemed
to be little or no doubt as to what she was thinking or feeling.

In Family #2, the mother's pattern of punctuating her statements, as well as other family member's statements, with "uh-hum" often left this investigator with the impression that sensitive issues were more often than not dealt with in this manner. Interestingly, this mother's pattern of speaking became noticeably more clear and concise as she joined the father in an animated discussion of their philosophical beliefs grounded on AA principles. It was as if this was an issue in which each could affiliate wholeheartedly so there was no need for guarded response.

In Family #3, the mother's tendency to laugh inappropriately, at times, was perceived by this investigator as this mother's efforts to disguise her real feelings when she was discussing the more sensitive issues of her illness. The father joined the mother in guarding his true thoughts and feelings concerning the illness by talking in an interrupted pattern and by failing to complete sentences. This mother demonstrated an ability to communicate in a straightforward, clear, and concise manner when she was discussing her philosophical views in handling her illness. It was as if there was no questioning this firm belief foundation.
Lewis, Beavers, Gossett, and Phillips (1976) assessed congruency within families and found that healthy families generally see themselves as others see them. It seemed that in these three families there was evidence of what seemed like incongruent myths. In Family #1, the myth that the mother was the strong one in the family who held the family together seemed incongruent in that the mother appeared to have held the family together in the past through her weakness. The rule in the family that placed the father in the role of disciplinarian and executioner enabled the mother to meekly stand by in order to patch things up once he had completed the task. The mother's weakness through her illness again enabled the mother to glue the family back together after the fragmentation experienced by the family as a result of the daughter's hospitalization for depression and her dysfunctional, abusive marriage.

In Family #2, the myth that the father was inadequate during his "sleeping days" appeared incongruent in that this father proudly reported that during this time, he never missed a day of work and had held the same job for 21 years. It seemed logical to assume, then, that the family belief, "Father is inadequate," enabled his inadequate behavior at home while the systemic belief at work facilitated his adequacy.
In Family #3, the myth, "cancer is no threat," appeared incongruent in that the family had to contend with the repeated reminder of uncertainty associated with the mother's 90-day follow-up visits to the doctor for tests. Had friends and relatives been unaware of these scheduled tests, it is conceivable that the family could have masked the critical nature of these tests to the point that they would never be acknowledged, much less discussed. Phone calls from friends and relatives have kept the family reporting as to the mother's progress, even though the report, "everything is just fine" had been given even when there had been cause for concern.

Lewis, Beavers, Gossett, and Phillips (1976) found that healthy families had loosely structured or flexible patterns of functioning. In Families #2 and #3, the theme, "Every man for himself," had been implemented to facilitate the mother's desire to back away from the work load. The mother in Family #3 reported that some things were just left undone as a result of her need to carry less of the work responsibility of the home. Family structure enabled the mothers in these families to carry less of the work load without jeopardizing family functionality.

The rule, "Get it said quickly, and then let it go," seemed to guide the families in this study through
conflictual issues. Another rule more commonly used, "Soften the blow with humor," seemed to facilitate members' ability to disagree with one another without open confrontation. Family members appeared to sense each other's limits, and there was a point of mutual reciprocity and respectful negotiation when these limits were reached. Lewis, Beavers, Gossett, and Phillips (1976) discussed this ability of members in healthy families to define where "one's skin ends and another's begins" (p. 212).

In examining Research Question #3, what are the effects of family interactional patterns on the course and management of breast cancer, special consideration was given to the ability of the family to support the patient's autonomous functioning. Attention was also given to the ability of the family to openly and freely express feelings. Adaptive patterns, including the utilization of outside support systems were examined and compared. Methods of managing stress as a result of the disease was also considered.

Simonton (1984) maintained that the continued autonomous functioning of each individual family member is essential to a healing family environment. Within our culture, often patients are cast into passive, child-like
roles as family members respond with overprotective behaviors. As family members protect, a patient tends to respond with increasingly helpless behavior which thwarts the mobilization of personal resources toward healing.

In each of these three families, the patients were supported in backing away from family duties for healing from the surgery and chemotherapy treatment. Family members facilitated continued family functioning by pitching in to cover for the mother. However, the expectation appeared to be that the mother would resume her fully functioning position within the family. Adaptation, as defined by Simonton (1984) referred to the ability of family members to be supportive of the patient while maintaining personal satisfactions that are necessary to individual well-being. Each of the supportive members in these three families were able to quickly resume and continue individual autonomous functioning in work and social activities. The patients in Families #1 and #2 were able to resume work responsibilities inside and outside of the home once chemotherapy treatment was terminated. The patient in Family #3 was given a two week recuperative party with friends and relatives present, then the family expectation was that everything would settle back into normalcy.
As was indicated in the studies of healthy families by Lewis, Beavers, Gossett, and Phillips (1976), optimally functioning families had the ability to express a whole range of feelings including joy, sadness, fear, anger, and love. In these families, feelings were not labeled right or wrong; they were just accepted as what was.

In all three families, feelings in response to the illness were more commonly expressed as individuals interacted in dyads. In Family #1, the three family members interviewed exhibited an ability to openly discuss these thoughts and feelings with one another as a group. However, a formal group meeting had never been organized to discuss thoughts and feelings resulting from the illness experience. The family's perception of the son was that he had been unable to express his affect with the family as a whole, but he had communicated these feelings in a guarded way with his sister.

In Family #2, family members reported that like Family #1, thoughts and feelings about the illness had never been discussed in the family as a group. However, like Family #1, family members exhibited within the group setting, an ability to freely contribute personal thoughts and feelings in response to the illness.
In family #3, affect was reported to have been expressed between the mother and father and between the daughter and son. The family had never discussed the illness experience as a group. The mother and father remained guarded in their expression of affect but free in their expression of thought when the family met as a group. However, the daughter appeared to utilize this group forum to express her feelings as well as her ideas.

It is interesting to note that in all three families, family members expressed gratitude for having had a forum to share their perceptions of others' responses in the family. These interviews enabled family members to explain and clarify behaviors and to openly express feelings that had not been expressed to the family group as a whole.

Lewis, Beavers, Gossett, and Phillips (1976) reported that healthy families demonstrated the expectation that affiliative encounters would be caring and so, consequently, family members reached out to others in an involved way. All three families appeared to be actively involved in community and church groups, and the family members in Families #2 and #3 comment on the perceived tendencies of friends to overdo at the time of diagnosis and surgery. The family members in Family #1 expressed
gratitude and relief in receiving this outside support during the mother's recuperation, perhaps because this family had little or no extended family to help.

The family members in Families #1 and #2 have been able to include friends in their personal response to the illness experience. Family #1 has found that their experiences have been helpful to others who have been newly confronted with the diagnosis of cancer. Family #2 expressed sincere gratitude for close friends with whom they have shared personal feelings and experiences. Family #3 has maintained a strong affiliative connection with the outside world, but the illness experience has remained highly personal and individual responses have remained guarded with even the closest of friends.

In each of the three families, effective adaptive strategies have facilitated the management of the stress of the chronicity of the disease. In Family #1, members discussed a heightened sensitivity to the passage of time, and their tendency, now, to enjoy and value the moment. In Family #2 the AA motto, "One day at a time" facilitated the family's adaptive process as members began to settle in to a new normalcy. In Family #3, the belief that nothing is gained by exploring the depths of what cannot be changed has provided the impetus for this family to
deal with the here now. Lewis, Beavers, Gossett, and Phillips (1976) said that their findings indicate that optimally functioning families are more clearly aware of the passage of time.

In all three families, humor alleviated tension and facilitated the management of the stressors associated with the illness. Family members teased one another with a pervading tone of tenderness and empathy. Supportive friends who continued to attempt to relate to the patient in an overzealous or protective manner were commented upon in a tongue-in-cheek manner within Family #2 and Family #3. Consequently, these family members facilitated and supported the movement of the mother from a sick role to a well role and protected her from friends who tended to view her as sick.

All three women utilized a mastectomy support group format to manage the stressors of the disease through the ventilation of feelings and through the sharing of personal issues with others who have had similar experiences. The mothers in Families #1 and #2 cried in the group, as neither felt comfortable with crying at home while the mother in Family #3 seemed to utilize the group setting more to voice her anger and fear. In all three families, members supported the mother's attendance to the
meetings that were held weekly for an eight-week period. In each of the families, members expressed gratitude for the perceived support resulting from the mother's participation in the group. So the family's flexibility in functioning allowed for the mother's participation and involvement in an outside support system, facilitating the mother's expression of ambivalent feelings in response to the uncertainty of the illness. Simonton (1984) identified this ability to express these debilitating feelings as essential to alleviating the stress associated with managing cancer.

Summary

In-depth descriptive analysis of data is an essential element of Ethnographic Research. This section is included in order to provide a relatively brief, more concise overview of the descriptive analysis of data. In order to facilitate summarization, research questions have been addressed within cases, as well as across cases.

In examining Research Question #1, individual perception of meaning in regard to the disease was examined with focused attention given to multigenerational beliefs influencing perception. In Family #1, members reported disbelief in hearing the diagnosis and responded, initially, by withdrawing into isolation from each other
as well as from significant others outside the family system. The father continued to view the inclusion of others into his experience as intrusive while the daughter shifted to involve herself with others, reporting the results to the outside world. The mother reported that her major concern at the time of diagnosis was that the family appeared to be fragmented, and she responded by pleading with family members to pull together.

Family members responded to the mother's plea by reformulating their initial collective belief, "cancer and death are synonymous" to a more hopeful belief, "cancer is scary but manageable." Because of a multigenerational belief that medical personnel were not essential to care and because of the father's belief that medical personnel were not to be trusted, family members had to alter perception in order to support the mother's decision to consider treatment alternatives prescribed by her doctors.

In Family #2, the mother reported that she had failed to prepare herself, as well as her family, for the diagnosis as she was convinced that she did not have cancer. This belief was reinforced by the mother's multigenerational belief that members in her family live long lives. Each family member reported a response of disbelief and shock, and each responded by distancing from
each other as well as others. The mother continued to isolate herself and withdraw from family members throughout her chemotherapy treatments.

As other family members began to accept the reality of the diagnosis, responses were influenced by the father's belief that some things cannot be changed and therefore must be accepted. This belief was philosophically founded in the principles of Alcoholics Anonymous, and it provided the impetus for family members to reestablish involvement with each other, as well as with others, in order to assess and determine what could be changed in relation to the illness.

In Family #3, the mother's belief, "Smile and the whole world smiles with you," was perceived as a "positive attitude" by the father and as "fake" by the daughter. Family members appeared to be strongly influenced by a multigenerational belief that serious illness is a natural part of the normal process of living and is not just cause for disruption of normal family functioning. The mother's determination to have an identity separate and apart from cancer resulted in family member's responses to shield her from reminders of the illness.

The mother's decision to have her other breast removed as a preventative measure was treated as an inconvenience to be contended with so that normal functioning
could be resumed. This mother's belief in enjoying the moment resulted in her ability to adapt to the diagnosis and surgery experience quickly and to avoid, as she said, "wallowing in self-pity." She responded by using her humor and wit to create a party environment for friends and family as she recuperated. Individual meaning of these supportive family members appeared to be influenced and altered to adjust to the patient's conceptualization of the illness.

In examining patterns of individual perception of meaning of the disease across cases, individual responses of the patients in these three families as they approached biopsy to determine diagnosis were similar. "It will not happen to me" was the belief that all three patients embraced as they prepared for the procedure. Once the diagnosis was made, family members reported varying responses to shock, including distancing from others through isolation as well as through active involvement with others.

After the reality of the diagnosis was accepted, family members reported varying responses that were influenced by individual multigenerational belief systems. In all three families, a collective belief was formulated to support the mother's belief about the disease. All
three patients reported an acceptance of what could not be
changed and a hopeful attitude, as preventative measures
were taken to manage the disease.

In Research Question #2, the structure and
organization of the family in relation to the illness was
examined in reference to the role function of members,
interactional patterns among members, and management of
conflict among members. In Family #1, the mother was
symbolic of the glue that held the family together. The
father was the protector of the mother, and the daughter
was the gadfly, or social commentator. The son appeared
to be the quiet and withdrawn observer in the family.

The couple appeared to have an implicit, comple-
mentary agreement which allowed the wife to more-often-
than-not, get her way. Each boasted that there was little
disagreement between them and, indeed, conflict within the
dyad appeared to be handled indirectly with metacommunica-
tion and humor. When the family met as a group, conflict
was sometimes dealt with in a quick, direct, and open
manner, even though indirect confrontation appeared to be
more the rule.

In Family #2, the mother appeared to be the
director and negotiator. The father was the protector and
the informer. The oldest daughter was the apprentice-in-
training for parental substitute and for medical expert. The younger daughter was the scrapper in the family who stirred things up.

The couple has functioned more in an egalitarian manner since the mother's surgery, as the mother has seemed intent on abdicating an increasing number of her duties as director. However, the mother continued to direct transactional patterns among family members through metacommunication, especially when the family dealt with sensitive issues. Indirect confrontation through humor and sarcasm appeared to be the family's preferred mode of dealing with conflict even though the family did occasionally exhibit the ability to openly and directly disagree.

In Family #3, the mother played the role of emissary and manager of everyday family functioning while the father remained aloof and uninterested. However, the father became involved and assumed a protector role as manager of the finances. The daughter played the role of social critic, and the son appeared to maintain a peripheral position.

The dyadic relationship appeared to be complementary supported by an implicit agreement as to who would manage in a particular context. Conflict was more often
dealt with implicitly through sarcasm and wit, even though members also appeared comfortable with open and direct disagreement. When sensitive issues were discussed, the mother utilized a metacommunication approach in directing transaction.

Across cases it appeared that in all three families, the mothers were seen as peacemakers and keepers of the family, even though these mothers reported they were now less willing to assume caretaking responsibilities in the home. Each of these three fathers were seen as having been isolated and withdrawn within the home at various times. It was observed that each of the three fathers played a protective role in deflecting tension and stress away from the mother. The older daughters in families #2 and #3 acted as commentators on the family in order to keep the family congruent and honest. Their ability to "stir things up" kept family members involved in animated transactions. The older daughters in Family #1 and in Family #2 were able to step in as a parent substitute on occasion when the father was tired and the mother was uninvolved or withdrawn due to illness.

In examining the parental coalition across the families, it was found that there was a complementarity, a reciprocity, or fit within the dyad. Even though the
couples admitted the mother's tendency to get her way, all three dyads appeared to have negotiated an implicit agreement as to who was more skilled to hold the power within a particular context. Consequently, all three couples appeared to have constructed an egalitarian relationship which allowed for a mutual respect for the strengths and limitations of the other person. In all three families, the generational boundaries appeared to be clearly defined. The older daughter in families #1 and #2 seemed to occasionally function in a parental child role, especially when both the mother and father were unable to function effectively in that role.

In all three families, the mothers used a meta-communicative approach to mediating family transactions. In discussing sensitive and guarded issues, these patterns appeared to be utilized in order to mask conflict. When conflict was expressed openly and directly, it was negotiated quickly without apparent harboring of resentment. More often, an indirect manner of using wit and sarcasm to handle conflict was utilized within these families.

In examining Research Question #3, cases were studied to determine the effects of family interactional patterns on the autonomy of individual members, on members' abilities to express and acknowledge feelings, and
on members' inclusion of support outside of the family. Adaptive patterns were also examined, particularly in relation to the management of stressors associated with the chronicity of this disease.

In Family #1, family members had resumed work and social activities, as each appeared to be functioning effectively inside and outside of the family system. Members interviewed exhibited an ability to express affect openly with one another even though a pattern of indirect expression of affect through humor seemed to be more commonly utilized. The mother seemed more guarded in her affective responses than did the father or daughter. Both the mother and father reported that outside support systems were more included and valued as a result of the illness. Stress and tension were alleviated through humor and through adaptive restructuring.

In Family #2, the extended withdrawal of the mother during chemotherapy treatment did not impede other family members from continued and involved functioning inside and outside of the family system. Adaptive restructuring facilitated the mother's movement away from and then back into the system without disruption. Affect was more often expressed with humor or sarcasm and rarely expressed in a direct manner. Outside support was util-
ized, and personal experience was shared with valued others.

In Family #3, personal autonomy of individual members was unaffected by the illness, as members were expected to carry on as usual. Outside support systems were utilized to create continued normalcy and were cautiously monitored enabling the mother to maintain a well-and-healthy role. Affect was expressed most often through humor. Stress and tension were alleviated through adaptive restructuring patterns enabling the mother to maintain her identity apart from cancer.

Each of these three families had been structured to allow for the personal autonomous functioning of each individual member. Structure appeared to be more flexible in Families #2 and #3, perhaps in order to accommodate the schedules of older adolescent children who moved freely in and out of the home in order to work, go to school, and to engage in a busy social life. In fact, in these families, interviews had to be scheduled at the one specific time during the week when all members could be present. In Family #3, the structure appeared less flexible and was adapted to the father's unusual work hours and the mother's need for restful evenings after work.

All three families were able to endorse an adaptive strategy based on the realization that in living, one
must ultimately die. Consequently, these families were able to create a new normalcy of functioning, buoyed with a hopeful attitude and balanced with the awareness and appreciation for the gift of time. It seemed that family members tended to laugh at themselves and with each other in their efforts to take life less seriously.

Perhaps because affect was less comfortably expressed in these family settings, members encouraged and supported patients to actively participate in a support group. This modality for expressing feelings, enabled patients to identify and express ambivalent feelings that might otherwise have gone unexpressed. Consequently, even though the family did not always organize in ways to facilitate the patients' direct expression of difficult feelings within the family setting, the structure was flexible enough to support the patients' utilization of an outside support system to alleviate the stress associated with these feelings.

Family members expressed gratitude for the formalized interview setting structured for the purposes of this study. Members appeared interested in hearing other members' perspectives of the illness. This format enabled younger members, in particular, to voice concerns and feelings.
Conclusions

The data in this descriptive, exploratory study of the patterns of interpersonal interactions in family networks of three breast cancer patients indicated the following conclusions:

1. Individual beliefs of family members about breast cancer appeared to have been altered to formulate a broader, collective belief about breast cancer.

2. The family's collective belief seemed to be influenced by the family's multi-generational beliefs about serious illness.

3. Common understandings which seemed to most effectively influence the family's management of the illness experience included the following:
   a. Cancer is scary but manageable.
   b. Accept what cannot be changed and make the best of it.
   c. Control is gained through understanding the complexities of the disease.
   d. Understanding is best gained through active information seeking from reliable and trusted sources.
   e. Decisions regarding treatment are left to the patient.
f. Create and establish a new normalcy based on necessary adaptive changes.
g. Resume normal functioning as quickly as possible.
h. Share the responsibility of managing the illness.
i. Rely on outside support or extended family to help alleviate the stress.
j. Expect the patient to get well.

4. These families appeared to be mother-centered, and each mother appeared to be shielded and protected by other family members.

5. The mothers in each family appeared to act as referees in mediating family interaction concerning sensitive issues. Often the mother appeared to detour conflict around the father or a child by using a metacommunicative pattern to direct the flow of transactions.

6. Conflict within these families seemed to be generally dealt with in an indirect manner through sarcasm and wit.

7. When conflict was openly and directly expressed and acknowledged, it appeared to be negotiated quickly and with little or no resentment.

8. Even though the mothers in each of the three families appeared to assume more of a leadership role in
the family, power seemed to have been negotiated on an implicit level and to have been shared on a contextual basis according to individual strengths and limitations. Consequently, the parental coalition appeared to be covertly egalitarian.

9. There appeared to be clear generational boundaries between the parent-child coalitions, with one exception. It appeared that an adaptive response to the mother's illness enabled the older daughter in two of the families to occasionally act in a parental-child role in order to relieve the father.

10. Autonomous functioning of family members appeared to be facilitated by the loose, flexible structure appropriate to the developmental stage of the families studied. Each member appeared to successfully resume healthy functioning inside and outside of the family system.

11. The illness of the mother may have facilitated the restructuring and reorganization necessary to encourage the autonomous functioning of children. Consequently, the flexible structure also may have facilitated and encouraged the autonomous functioning of the patient.

12. Outside support systems seemed to have been utilized by family members to bring relief to the already stressed family system.
13. Families did not appear to be organized in ways that encouraged or facilitated frequent expression of ambivalent feelings within the family as a group in an open and direct way.

14. Humor and sarcasm appeared to be an acceptable indirect method of expressing affect within all three families.

15. Family organization seemed to support the patient in seeking a modality through which ambivalent feelings could be directly and honestly expressed. Consequently, these feelings, which could have otherwise been debilitating, were expressed and acknowledged by others who had shared in a similar experience.

16. Family members may have been excluded from the patient's affective responses because these women believed that true understanding comes only from directly experiencing the diagnosis and surgery.

Implications and Recommendations

The descriptive findings in this study suggest implications for therapeutic intervention in families with a member who has breast cancer. First, assessment of individual multi-generational family beliefs concerning serious illness seemed to be essential in understanding
the family's collective belief concerning breast cancer. The genogram format (Guerin & Pendagist, 1976; Rogers & Durkin, 1984) utilized in this study appeared to be an effective tool for assessment of multi-generational beliefs.

Second, a shared understanding of individual meanings attributed to this illness could facilitate a family's awareness of how a collective belief was formulated. Because an effective plan-of-action is founded on a hopeful and optimistic attitude (Simonton, 1984) and is embraced wholeheartedly by each family member, awareness of individual meanings which are contrary to the collective meaning could clarify and expose any contradictory behavior.

If one supports the studies of healthy families by Lewis, Beavers, Gossett, and Phillips (1976), then it would seem important to move the breast cancer patient away from the stressful role of mediator or referee within the family in order to allow for the open and direct expression of conflicting subjective views. Perhaps, if the mother could be removed from this stressful job, other family members could respond with less protection and shielding, therefore enabling the mother to continue her autonomous functioning in a less guarded way.
It would also seem important to strengthen the parental dyad and to explicitly negotiate an egalitarian relationship in which there could exist a complementarity and reciprocity based upon individual strengths and limitations. In moving the breast cancer patient toward a more shared balance of leadership and managerial functions, the patient could develop and implement more self-nurturance, a seemingly essential ingredient in a healing environment (Simonton, 1984).

In clearly defining generational boundaries between the parent-child coalitions, it seems important to structure a format to clearly and honestly inform children about the diagnosis, surgery, and follow-up treatment and tests throughout the illness experience. Failure to do so appears to result in children feeling frustrated and left out. It would seem important that the family view the crossing of generational line by an older child as an adaptive strategy to be used when all other resources have failed. This crossover would be best negotiated in an open, direct manner.

Family members, other than the patient, need to be encouraged to continue personal autonomous functioning in an effort to fulfill needs and to self-nurture. This idea is supported by Simonton (1984) who maintained that the
healing family is composed of autonomously functioning individuals who are willing to take responsibility for self-care.

It would seem that family members should be encouraged and supported in affiliating with outside support systems to help alleviate the stressors associated with the disease. As the family becomes more flexibly structured, individual members could be encouraged to move in and out of the family system to draw upon other support networks for shared involvement in the illness experience.

Simonton (1984) has pointed out that it is essential for individual members to feel comfortable in expressing a whole range of feelings to one another in response to this illness. The family could be taught direct and effective communication skills to express feelings openly. A structured format designed for the expression of subjective views and feelings could insure family members the opportunity to empathize with other members' responses.

Humor and wit appeared to be effective tools in alleviating stress in these families. Therapists could join the family with humor and wit in an effort to support the family when this response seems appropriate. Affiliation in this manner would help facilitate the different-ness of the therapist who may never have had a direct
experience with serious illness either as a patient or as a family member.

In hopes of providing an impetus for further research in this area, recommendations have been made based upon the descriptive findings and conclusions of this study. Because the data in this study was descriptive and the sample studied was small, the behavior in these three families may not be considered representative, therefore extrapolations must be approached with caution.

The findings in this study could provide future researchers a data-based standard against which differentness and sameness may be measured and toward which intervention efforts may be aimed. The studies of healthy families by Lewis, Beavers, Gossett, and Phillips (1976) provided comparative data for this study. It would be interesting to compare cases of families of breast cancer patients with families of physically healthy subjects.

Minuchin, Rosman, & Baker (1978) have worked extensively in studying dysfunctional families. The study of the interactions among these mastectomy patients and their family members has contributed insights that the study of the breast cancer patient, alone, could not have rendered. It would be interesting to study the interactional behavior patterns of the breast cancer patient
within a support group setting and compare the similarities and differences of that same patient's interactional behavior in the family setting.

Recommendations for improving the rigor of study through replication include first, the suggestion that multiple researchers be utilized in providing expert opinion as interactional behavior patterns are observed and analyzed. Second, it is suggested that a larger, multi-site sample be chosen in order to render more representative results. Third, it is advised that during the task interview, the researcher should be excluded from the task accomplishment setting except at the beginning and end of the session when audio and video equipment must be turned on and off. It may be that investigator presence in the room to directly observe may have influenced the family interactional patterns during this interview. Members appeared to glance uneasily at the observer, and often, family members expressed concern that tasks were not being approached in a correct manner.
CHAPTER BIBLIOGRAPHY


APPENDIX A

INTERVIEW
1. If a book were going to be written about your family's experiences since you found out Mom had cancer, what would the story be like?

2. Chances are that life in your family has changed since it was discovered that Mom had cancer. I wonder if you could talk together about the ways you see things have changed.

3. All families are alike in some ways and different in other ways. What words would you use to describe your family? How do you think your family is different from other families?
APPENDIX B

GENOGRAM
These symbols are utilized to show relationship and positions for each family member:

- □ = male
- ○ = female
- △ = child in utero

- △ with a line through it = abortion or stillbirth
- Horizontal line = marriage
- Vertical line = offspring
- \( \frac{D}{\_} \) = divorce
- \( \times \) = death
GENOGRAM INTERVIEW*

Demographic Data:
- Names of family members by generation
- Date of birth, and if applicable, death for each family member
- Ages of each family member
- Place of residence of each member
- Marital status of each member

Specific Questions:
- Is there anyone in your family who has or has had a chronic illness?
- Is anyone in your family unable to do daily activities because of physical illness?
- A mental illness?
- Does anyone in the family drink too much?
- Smoke too much?
- Have a drug related problem?
- Is any family member having a problem at work or school?
- Has anyone shown a major change in behavior within the last year?
- Do you follow a particular religious belief? Has it changed generationally?
- How would you describe your ethnic background?
- How important is this heritage to you?
- How has your family influenced your plans and ambitions?
- How is your present household different from the family in which you grew up?
- What adjectives would best describe the family in which you grew up (e.g., strict, supportive, affectionate, distant, active, close).
- How is your present household?

Supplemental Questions:
- With whom do you stay in close contact?
- Is there one family member who seems to facilitate the communication of family news?
- With whom do you gather on important holidays ... at whose home?
- How is money handled in the marriage? Who makes it? Who controls it?
- Which side of the family has the most, and how is it passed on from generation to generation?
- Are difficult issues discussed openly in the family, or is there a conspiracy of silence? (death of a family member, onset of physical illness, premature death of parent or child).
- Does your family have a pet?
- Who is closest to your family pet? How has that changed since your family discovered Mom had cancer?

*Adapted from Guerin & Pendagast (1976); Rogers & Durkin (1984).
APPENDIX C

FAMILY TASKS
FAMILY TASKS*

The purpose of the family task procedure is to provide a method for observation of overt behavior of family participants in a relatively natural, semi-structured situation which does not include the counselor.

Preparation:

1. Family members are asked to seat themselves as they wish at the table. Care is taken to assure that all are facing the camera, full or profile.

2. On the table is placed the tape recorder containing the Family Task cassette.

Verbal Instructions:

1. Videotape procedure is explained.

2. Family is told that instructions are on the tape recorder.

3. Family members are told to listen to instructions. Instructions for the first task are played. Then, the family shuts the recorder off, and the family proceeds with the task. The recorder is then turned on for a second task, and so on.

Recorded Instructions:

1. In every family different people have different ways about them. How about in your family? Consider the following questions:

   a. Who is the most bossy?
   b. Who gets angry the most?
   c. Who is the one who is easiest to get along with?
   d. Who fights the most?
   e. Who is the peacemaker?
   f. Who cries the most?
   g. Who laughs the most?
Just talk about as many of these things as you can remember. Now turn off the machine and go ahead.

2. Let's pretend. Please pretend that somebody gave your family $10.00 to spend together, but there's one thing: all of you must agree on how the money is to be spent--what you will do with it so that everyone is satisfied. Talk it over and decide together how you would spend the $10.00 so that all of you agree. Turn the machine off, now, and go ahead.

3. On the table, you will find a folder with two picture cards in it. Each one of these cards shows a family scene. Please choose one of the pictures and make up a story about the picture. Tell what is happening in the picture. What led up to the scene in the picture and what people are thinking or feeling. Then make up an ending for the story. Now, turn off the machine and go ahead.

*Adapted from Minuchin (1967, 1982).
NOTICE OF CONSENT

I understand that I am participating in a research project and that I am assured anonymity in the report of the findings of this study. I agree to cooperate fully in three one-hour interview sessions with the researcher. I understand that audio and video tape recordings will be made to be used by the researcher for analysis of data. I also understand that these recordings will be held in strictest confidence by the researcher.

NAME:__________________________

________________________________

________________________________

________________________________

DATE:__________________________
APPENDIX E

GENOGRAM — FAMILY #1

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FAMILY #1
APPENDIX F

GENOGRAM -- FAMILY #2
FAMILY #2
FAMILY #3

M b.10/2/20
F b.8/24/05 d.6/28/61
Heart
D2 b.6/4/49
S b.11/13/43

M b.6/23/14
F b.4/20/14 d.4/25/61
Diabetes
S1 b.3/17/36
S3 b.11/14/40
S4 b.12/28/44

M b.1/17/40
F b.8/28/38
S b.8/16/62
D b.6/8/67
APPENDIX H

TRANSCRIPTS
Transcripts of all three interviews and task accomplishment sessions are on file and are available for review. Video and audio tapes of the sessions are also on file and available upon request. Coded data has been categorized and filed for preservation and is available for analysis.
REFERENCES


