ABSTRACT

THE CONSEQUENCES OF MOTHERS’ BREAST CANCER EXPERIENCES FOR THEIR ADULT DAUGHTERS’ INTIMATE RELATIONSHIP DECISIONS: A PHENOMENOLOGICAL APPROACH

By Amanda Christine Ginter

Breast cancer is far-reaching in its consequences for patient’s family members, yet there is a comparative lack of information in the field about the effect of mothers’ breast cancer experiences on their adult daughters. Thus, the purpose of the study reported here was to explore the consequences of mothers’ breast cancer experiences on their adult daughters’ intimate relationship decisions.

Ten women were interviewed for this study. Nine participants’ mothers were still alive; some still in treatment. Two women were married, four were in relationships, and four were single. In analyzing the interview data, four predominant themes were found: daughters’ perceptions of mothers, attentive fathers, partners’ reactions, and advice to other daughters. Close familial relationships and the ability to communicate prior to the diagnosis suggest greater likelihood that daughters will survive the emotional turmoil of their mothers’ treatment. Partners may not always be aware of the most appropriate or timely response, and thus should be informed. Potential implications of the findings from this study will be discussed.
THE CONSEQUENCES OF MOTHERS’ BREAST CANCER EXPERIENCES FOR THEIR ADULT DAUGHTERS’ INTIMATE RELATIONSHIP DECISIONS: A PHENOMENOLOGICAL APPROACH

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The Consequences of Mothers’ Breast Cancer Experiences
For Their Adult Daughters’ Intimate Relationship Decisions: A Phenomenological Approach

Introduction

Breast cancer is far-reaching in its consequences for families. In 2008 an estimated 182,460 new cases of breast cancer were diagnosed in American women (American Cancer Society, 2008). The diagnosis, treatment, and recovery hardly begin to tell the story of how the patient and her family members process the news of illness, prepare for a multitude of outcomes, and attempt to recover from the trauma. At any rate, the relatives’ “recovery” from watching someone so close battle a serious illness may last several years. The following literature review examines the influence that breast cancer can have on the family members of the patient in an effort to explicate the necessity for researching how patients’ daughters specifically are affected.

The relatives who are reported to be most affected by breast cancer are first degree female relatives of the patient. This is partly because they – the sisters, daughters, and mothers of women who have been diagnosed with breast cancer – are more likely to develop breast cancer themselves because of their genetic relationship to the patient. The relationship between breast cancer and its stress on first degree female relatives cannot be overemphasized. First degree female relatives are between three and four times more likely to develop breast cancer than women who do not have a close female relative with the disease (Pharoah et al., 1997). Thus, the anxiety about developing breast cancer when a first degree female relative has been diagnosed with the disease can be high (Zapka et al., 2006). Therefore, this study focused on the daughters of breast cancer patients as first degree female relatives who are likely to experience this anxiety due to being at risk of developing the disease and grappling with the stress of watching their mothers undergo the experiences of diagnosis and treatment. Specifically, the study focused on adult daughters, ages 18-30, whose mothers were diagnosed in the last seven years. The rationale for specifying this particular population is the fact that adolescent and young adult daughters who shared a household with their mother or lived near her during her treatment are likely to have been first hand witnesses to their mothers’ experiences. Exploring the impact of the mother’s breast cancer experience on the adult daughter’s intimate relationship decisions is the focus of this study.
A mother’s breast cancer diagnosis is likely to create the need for new family roles, due to her focus on treatment and recuperating. For example, due to the effects of her treatment, there may be times when a mother with breast cancer cannot fulfill her usual role as household manager as she once did and thus must take on fewer responsibilities. As a result, her family members may need to adjust their roles and have to handle more of those responsibilities. How the family reacts to these new roles is determined by how the family functioned prior to the mother’s diagnosis (Rolland, 1987). Thus, it is important to fully understand the mother-daughter relationship both prior to and following the mother’s breast cancer diagnosis in order to gain a more complete picture of how this relationship may be impacted. Given the age of the intended participant population for this study the literature regarding how adolescent and young adult women reacted to their mothers’ breast cancer is also reviewed. Phenomenology was used in approaching the interviews as a framework for understanding participants’ experiences and social locations.

**Literature Review**

The following sections explore the current literature on breast cancer’s effects on the family, and the cyclical effect of how the prior familial relationship will decide the reaction to the illness, and how the reaction to the illness will determine subsequent relationships. The purpose of this is to provide background regarding the relationship between the mother’s breast cancer experience and her adult daughter’s intimate relationships.

**First Degree Female Relatives of Breast Cancer Patients**

First Degree Female Relatives (FDFRs) of breast cancer patients are genetically related sisters, daughters, and mothers of women who have been diagnosed with breast cancer. Because of their genetic tie, these women encounter many issues that relatives of patients with other illnesses do not face. One of the biggest concerns for first degree female relatives upon finding out about their relative’s diagnosis is their own health as they are at an increased risk of developing breast cancer because of their genetic relationship to the patient. This is despite the fact that only 5%-10% of breast cancers occur in women with a family history of the disease (National Cancer Institute, 2002). This knowledge may affect their personal outlook, their relationships, and changes they might make to their health behaviors (Zapka, Fisher, Lemon, Clemow, & Fletcher, 2006), upon observing how breast cancer has impacted their relatives’ lives.
Factors that have been found to contribute to increased distress among FDFRs include being the patient’s mother, having regular contact with the patient, and reporting a close emotional relationship to the patient. On the other hand, factors that contribute to the FDFR’s healthier outlook on the situation include being of older age (and thus more independent from the family of origin), being the patient’s daughter, and reporting adequate social support (Zapka et al., 2006). However, adult daughters reported being more stressed if they served as caregivers for their mothers during their treatments and recovery rather than if they were in less contact with their mothers during their illness. This distress seems to be heightened if their mothers had died from breast cancer (Zapka et al., 2006).

The fact that some forms of breast cancer are hereditary can have an enormous impact on the first degree female relatives of breast cancer patients. Petrisek, Campbell, and Laliberte (2000) reported that caring for a close relative with a serious illness can cause distress and “psychosocial adjustment” (p. 136). FDFRs who have observed their relatives’ diagnosis and treatment experiences have already acknowledged their increased risk of developing breast cancer, and thus have mentally prepared themselves for both receiving similar diagnoses, as well as preparing themselves for their own potential treatment. Partly this is due to the resources already at their fingertips – doctors, nurses, counselors, treatment facilities, as well as more specific knowledge about the disease.

When a daughter or other FDFR learns of a relative’s diagnosis, she is also learning of her increased susceptibility. At the same time, she must be a comfort and support to the patient (i.e., her mother) and cope with the knowledge that she is now at risk (Raveis & Pretter, 2005). There is “relatively little” information about their responses to their mothers’ illness, what the illness means to them, and the repercussions for their reactions (Raveis & Pretter, 2005, p. 50). This lack of information is problematic for physicians and family professionals alike, who may be uncertain how to offer guidance to FDFRs who are grappling with numerous questions about the patient’s health as well as their own. When a daughter learns of her mother’s illness, she must face personal livelihood questions that before she held only for her mother, such as “How long before I am diagnosed” or “What am I doing to increase or decrease my chances of getting breast cancer?” If the daughter perceived control over her breast cancer risk, she has been found more likely to improve her own physical health habits (Lemon, Zapka, & Clemow, 2004).
Sometimes the daughter’s response to her mother’s cancer is unexpected. Fletcher and colleagues (2006) discussed how distress for the mother’s breast cancer led to daughters’ increased interest in genetic testing, but not always increased frequency of breast self exams, and decreased mammography utilization (p. 413). Audrain et al. (1997) reported that daughters of mothers with breast cancer were more likely to be distressed if they were single, were pessimistic, and if they perceived themselves to be at greater risk for developing breast cancer. Daughters who reported a very close relationship to their mothers were more distressed by the diagnosis itself (Fletcher et al., 2006), but they reported less general stress.

Lindberg and Wellisch (2004) suggested that, in general, individuals who have a relative with a hereditary disease (e.g., cancer) may exhibit emotional and psychological symptoms similar to their relative. The DSM-IV, as Lindberg and Wellisch (2004) have analyzed, states that a serious illness can become a traumatic life stressor not only if it occurs to the individual, but to his family member. The term “Damocles syndrome” is used to refer to young cancer patients who feared their own looming deaths in the event of a recurrence (p. 13). Lindberg and Wellisch (2004) argued that this could also apply to the family members of cancer patients. Considering Damocles syndrome may go a long way in understanding daughters’ emotional responses to their mothers’ breast cancer. That is, if the daughters are traumatized to the point that they are constantly in fear of their mothers’ deaths, that will certainly affect how they carry out their own lives, as well as influence decisions regarding intimate relationships, such as deciding whether to move in with a partner and away from one’s mother. Currently, no research exists on how FDFR’s relatives’ experiences with breast cancer affects their relationships with others, or even how the breast cancer experience has impacted the relationship between the patient and her close female relatives. Thus, this study examined how mothers’ breast cancer affected their adult daughters’ intimate relationships within the contexts of the mother-daughter relationship prior to the diagnosis, what stage of life the daughter was in at the time of her mother’s diagnosis, her reaction to her mother’s diagnosis and treatment, and how the mother-daughter relationship has changed since the end of treatment.

**How Family Functioning is Changed by Illness**

A family member’s chronic illness can impact the entire family. New roles must be created and filled, and family members must identify their and other members’ reactions. According to Mellon and Northouse (2001), when an individual falls seriously ill, his or her
family members, who are already experiencing everyday stressors associated with work or their personal lives, will also undergo the stress of their family member’s illness. These two kinds of stressors will work together to affect the family’s quality of life.

Mellon and Northouse (2001) also pointed out that the study of the quality of life post-cancer treatment is a newer phenomenon. While a few decades ago, cancer was almost certainly a death sentence, more and more individuals are surviving longer, and thus there are more issues surrounding survivorship and its impact on the individual’s family. There is a copious amount of literature about grieving for family members who died from cancer, but not nearly as much about how familial relationships change after their relative has recovered. One of the major changes may be the family members’ personal ambitions. At the time of someone’s illness, family members may need to put aside their own aspirations for the communal good. Stetz, Lewis, and Houck (1994) reported that the patient’s family members must create goals for each other in order to ensure the health of the family flourishes. By putting one’s family first, the family system’s “developmental potential and adaptation” (Stetz et al., 1994, p. 390) will be maximized. Thus, it is necessary to study the patient’s family’s reaction to illness in general in order to infer its adaptation to breast cancer.

Rolland (1987) found that at the time of a diagnosis and treatment, families are challenged to reconcile the present and the future. While they are assisting the ill family member and possibly living from one day to the next, they must also consider the future – their fears, their expectations, and their goals. This is made especially difficult if the family member’s illness is severe, chronic, or unimproving. It may be made further confusing if it is difficult to ascertain how soon, or if, the patient will recover, and whether the family needs to change their plans temporarily or permanently. Even if temporarily, however, it may be hard for family members to regain their initial plans, before their relative was diagnosed. It is essential that health care professionals offer psychoeducation to their patients’ families, so that families are better prepared for the stress and chaos that may accompany a relative’s illness (Rolland, 1987). The results of the present study provided constructive information that might be used in this way. Regardless of the patient’s prognosis however, his or her family members will rely on previous multigenerational experiences with similar situations, as well as their family’s values, to navigate such tribulations (Rolland, 1987). How the family has reacted to illness in the past dictates how family members will respond now. Other factors include the family’s personal style of
functioning, as well as their resources (Rolland, 1987), such as outside help, doctors, clergy, or counselors they may speak to. Much also depends on where individual family members are in their life cycles when illness strikes the family – an adolescent preparing to leave for college will react to, and be affected by, a parent’s illness differently from a middle-aged adult child whose aging parents had expected news of illness.

Rolland also cautioned that a family cannot be entirely understood without the knowledge of their history, especially if a family has faced a chronic illness or condition. In order to understand their current behavior and practices, one must understand how they previously reacted to illness. If they reacted with healthy forms of coping and adaptation, such as being maintaining strong lines of communication, which will be evident in how they react now. If they responded with negativity (e.g. a lack of positive or productive communication), that too will be clear. Using a multigenerational perspective will help to garner understanding about the family’s strengths and weaknesses. At the same time, such a perspective will be useful in identifying families who are at-risk of being unable to face the trials of their family member’s illness. It is vital that the family be aware of any potential vulnerabilities and be provided with appropriate support in order to overcome them and be their most capable selves in rallying around the ill family member.

**Effects on the Marital Relationship**

Breast cancer can alter the female patient’s body (and thus her self-perception and sexuality). As a result, breast cancer can have effects on her marital relationship unique from other cancers. Treatments such as chemotherapy may also have a negative effect on the woman physically by affecting her sexual desire and functioning. These changes often lead to stress within intimate relationships (Fobair & Spiegel, 2009). Yang and Schuler (2009) found that marital stress was also associated with slower recoveries and poor results. Fang, Manne, and Pape (2001) reported that spousal stress was more likely caused by patient distress; spousal stress often leads to marital stress. Breast cancer patients and their partners must be made aware of such changes and stress, as well as coping mechanisms and methods of communication in order to overcome that strain.

It is important to know what the daughter observed of her parents’ marital relationship growing up, because as indicated by Rolland (1987), how families have reacted to illness in the past will determine how they react to illness in the present. Furthermore, if someone has only
seen her mother’s spouse or partner react negatively (becoming withdrawn, being physically or emotionally absent), this could be the schema she will then use when thinking about her own partner’s potential response to a diagnosis. How someone’s parents handled such a massive life change could influence how she thinks she and a significant other might react if she herself should be diagnosed in the future.

**Effects on Teenage Daughters**

While adult daughters may be slightly more prepared for news of illness in a parent, if only because the parent is aging, it is another matter entirely when the daughter who discovers her mother has breast cancer is an adolescent. This is due to the daughter, who is simultaneously encountering adolescent issues related to body image, sexuality, and sense of self and watching her mother struggle physically and possibly with her own body image and sexuality. This may be bewildering to the daughter. Spira and Kenemore (2000) found that the adolescent daughter is affected by her mother’s breast cancer more so than any other family member. Adolescent daughters were found to be the most distressed and to be “withdrawn, fearful, hostile, or rejecting” (p. 187). As a developmental task, daughters need to acknowledge their changing relationship with their mothers, which may be especially difficult in this context because that requires them to understand that their own futures may have changed with their mother’s present illness. Most people, especially young ones, do not anticipate such a diagnosis. Thus, while the mother-daughter relationship was already in the midst of transforming, the mother’s illness could encroach on this process or it may speed up the process. Spira and Kenemore (2000) reported that daughters often provide the most help to their mothers.

Pederson and Valanis (1988) reported a similar struggle for daughters – how they find the independence that most adolescents seek from their families when their mothers are dealing with cancer. Daughters of breast cancer patients need more attention because they are often aware that they are at higher risk for developing the disease than other girls, and that knowledge and the subsequent fear may be debilitating. Wellisch, Gritz, Schain, Wang, and Siau (1991) found that female relatives of breast cancer patients conveyed more “anxiety-laden identification” than other patient or family groups (p. 325). Stiffler, Hosei, and Haase (2008) stated that adolescent daughters whose mothers have been diagnosed with breast cancer are confused by the reversed roles with their mothers, who now require their help and attention, and that these daughters required help in discussing their needs to their mothers and other family members.
Daughters whose mothers have undergone mastectomies face another set of issues. Pederson and Valanis (1988) discovered that due to the attention society and the media have given to breasts, as well as what breasts represent — femininity, attractiveness, and sexuality, daughters of breast cancer patients are particularly at risk for confusion about sexuality and body image. This confusion increases if the daughters are aware of their increased risk of developing breast cancer. Lederberg (1998) found that daughters of mastectomy patients had increased psychosomatic problems, and some even indicated impaired sexual function. Daughters often stepped into the caregiving role, which at times was difficult for the mothers, when the daughters became overprotective and did not accept parenting behaviors from their mothers. Other daughters regressed in their behavior, and demanded attention from their mothers, even if they were very ill. Regardless of the daughters’ response to their mothers’ illness, as adults looking back to that time, universally they found it intensely traumatic.

Adult daughters who were in their adolescent years during their mothers’ diagnoses have been reported to be profoundly affected (Wellisch, Gritz, Schain, Wang, & Siau, 1991). Compared to a control group whose mothers were healthy during their adolescence, daughters whose mothers had been diagnosed with breast cancer when the daughters were teenagers had considerably less frequent sexual intercourse (2-3 times per month compared to 3-4 times per month), and they scored far lower in the areas of sexual behavior and communication about sex.

**Parent-Child Communication**

Another significant factor with regard to the daughter’s reaction to her mother’s breast cancer is how the mother communicated her illness to her daughter. In deciding how to talk to her, much depended on the daughter’s age and maturity level at the time of her mother’s diagnosis (Gould, Grassau, Manthorne, Gray, & Fitch, 2006). Norris et al. (2008) reported that children accepted such information best if it was given to them a few pieces at a time and in age-appropriate ways.

Bradbury et al. (2009) found that parents were more likely to detain telling their female offspring than male offspring about their BCRA mutation and mothers were more likely than fathers to share this information. Reasons for waiting to talk to their daughters included wanting the daughters to be at a more mature age and thus better able to understand the medical information. Of offspring who had not received written materials about the disease, the majority felt that this would have been helpful. These results are concurrent to Gould et al. (2006), who
reported that mothers of older children found it more appropriate for an expert to deliver medical information about breast cancer. Bradbury et al. (2009) found that daughters were most concerned about developing breast cancer. The majority of offspring reported that being told about their risk for developing cancer was beneficial in understanding the familial risk and aided them in making decisions (or contemplating making decisions) about their personal health.

**Mother-Daughter Relationships**

Mothers and daughters exhibit a very unique and specific relationship. This is based on several factors, both biological and sociological. Lye (1996) examined the “kinkeeper” phenomenon among women; namely, that in families women are more likely to oversee communication matters, particularly keeping in touch with family members who have moved away from home. Thus, relationships between mothers and daughters are often strongest, since both people in the relationship are likely well versed in communicating. Compared to father-daughter and mother-son dyads, mother-daughter relationships are usually strongest in a family. The mother is used to ensuring that her children are conveying their wants, needs, and thoughts. Similarly, adult daughters report contacting their parents more often than adult sons do, and in general, adult children report more contact with their mothers than with their fathers (Lye, 1996).

It must be acknowledged that the mother-daughter relationship, despite being depicted as emotionally closer than other parent-child dyads, is not always so. Lye (1996) found that mothers are more likely to report arguments with their adult children, and daughters are more likely than sons to report tension in relationships with their parents. This may be related to the fact that adult daughters are more in contact with their parents than adult sons are, so there are more opportunities for contention to arise. Rastogi and Wampler’s (1999) cross-cultural study reported that the adult daughter-mother relationship is both a source of support and difficulty. Factors such as personal relationships with people outside the family and various stressors (both intrinsic and extrinsic to the relationship) also play a role. Outside relationships have a significant impact on the mother-daughter relationship, and thus they too must be examined when studying a mother-daughter dyad.

Like other relationships, what exists between a mother-daughter dyad is constantly in flux, partly due to life course transitions. Fischer (1981) examined the transition periods in a mother-daughter relationship, which include “the daughter’s adolescent years, the daughter’s transition to marriage and motherhood, and the mother’s old age and infirmity” (1981, p. 613).
Rossi (1980) referred to this shift as the “winding up daughter and winding down mother” (p. 142). As the daughter grows in experience and opportunity, the mother may find herself settling down in life. This is a time for both mothers and daughters to reexamine the relationship they share, and acknowledge how it is being altered. The daughter’s marriage is a particularly trying time for the mother-daughter relationship, especially if the mother is lonely, ill, or unhappy (Wallerstein & Blakeslee, 1995). She may be more reluctant to part from her adult daughter, and may even go so far as to resent the new role into which her daughter is entering.

**Contexts of Health and Illness.**

Allen (1992) found that the elderly mother prioritizes having her life preserved. The adult daughter may serve as a support for this by protecting her mother’s health, “prevent[ing] new health losses, and help[ing] her to compensate for earlier ones” (p. 286). If the mother becomes ill when the daughter is younger (e.g., during her adolescent years, during her transition to marriage), both women may have to delve into new roles (e.g., caregiver, care recipient) prematurely, which may be unsettling for both of them: the daughter who still looks to her mother for guidance, and the mother who had expected several more years of good health and strength.

Illness and eventual death are inevitable parts of the life course. Kaufman and Uhlenberg (1998) found that one’s failing health was a significant stressor on his or her relationships with family members. A family member’s illness may necessitate that other members fill his or her role, temporarily or permanently, which can be extremely stressful if the role is unlike their own. Since adult daughters are usually more involved with parents than adult sons, especially with dependent parents, this leaves the burden to them, and thus, the stress. Kaufman and Uhlenberg (1998) also found that the “linkages across generations” (p. 924) created a sort of trickle-down effect, where the parent’s illness would have large consequences on the adult children, especially daughters. A parent’s illness often worsens the quality of the relationship with his or her adult child, but improvements in health also improve the quality of the relationship.

**Theoretical Family Frameworks**

In order to fully understand the mother-daughter relationship and how it, in the context of the mother’s breast cancer, may have influenced the daughter’s interpersonal relationships, it is necessary to utilize theories that illuminate familial relationships. Theories are practical when trying to understand the phenomena of family interactions because they offer a larger
explanation for individuals’ actions and rationalizations, and when a topic has little existing information, theories may be used to supplement what is already known. This is especially true in the present case in which no empirical attention has thus far been paid to this particular familial situation. The following theories are especially beneficial for understanding the mother–daughter relationship and how breast cancer could affect both the relationship and the daughter’s subsequent intimate relationships.

**Family Systems Theory.**

Systems theory, as explained by White and Klein (2008), is the “assumption of interconnectedness in a system,” and that it is only possible to understand something by “viewing the whole” (p. 156). For this research, “she” (i.e., the woman whose mother has been diagnosed with breast cancer) is not just a partner contemplating marriage. She is also a daughter, a sister, a friend, and an individual, and these roles all influence her and each other. Moreover, she and her roles will affect the other people in her life or system, and they in turn will affect her. The participant will be best understood if we know about her various roles; relationships with friends, family, and partners; how these roles have changed since her mother’s diagnosis and how those role changes have altered her relationships. Such a holistic view will be greater than “the sum of their parts,” or roles.

Systems theory also looks at the environment in which an individual exists. When her mother is diagnosed with breast cancer, this disease and the treatment for it will become very much a part of the daughter’s environment: hospital visits, doctor’s appointments, medical jargon, and discussions of survivorship will permeate her life because they are now a part of her mother’s life.

**Social Learning Theory.**

Aside from systems theory, there are varying premises about the nature of the mother–daughter relationship. Psychoanalytic theorists stress the concepts of “unconscious internalization” (Boyd, 1989). Social learning theories are more apt to emphasize modeling. Young girls first look to their mothers (if there is one present) as role models for wives, mothers, and capable adults. Women learn how to mother by watching and then imitating their mothers (Boyd, 1989). Gilligan (1982) explains that women learn how to create and preserve relationships by understanding how they identify to their mothers.
Rationale and Research Question

The mother-daughter relationship is unique due to the special familial roles that mothers and daughters each undertake. There are several factors that can shape the relationship, including the life transitions of the daughter moving away, marrying, and starting her own family, as well as maternal illness. If the daughter was younger and still living at home when her mother was diagnosed with breast cancer, she will likely be required to fill new roles prematurely, which can cause stress to her relationship with her mother. Several family theories may help to better comprehend this relationship, as well as how the relationship will influence the daughter’s future intimate relationships. According to family systems theory, the family is interconnected and one person’s illness will affect other family members. Thus, a mother’s illness will shape her daughter’s roles as a daughter, friend, and current or future partner. At the same time, social learning theory may be used to suggest daughters learn how to be women by watching and imitating their mothers. For daughters who have watched their mothers undergo the diagnosis, treatment, and recovery of breast cancer, this too will be incorporated into their schemes of womanhood.

Understanding the mother-daughter relationship is intrinsic to further learning how adult daughters perceive their mothers’ breast cancer to affect their own relationship decisions. The study fully examined the mother-daughter relationship in all of its intricacies and through the perspectives of social learning theory and systems theory, as well as within the context of illness, potential marital discord, and the daughter’s current relationships. To date, academic literature concerning breast cancer and the family has primarily focused on consequences for the entire family. What is left is a lack of empirical understanding of how individual family members, specifically the daughters, take their experiences and apply them, consciously or not, to their own lives and to their intimate relationships. There was a consistent message among the current literature that points to a serious lack of information regarding how young adult daughters fare after their mothers are diagnosed. What is known is that female first degree relatives are most at risk for developing breast cancer as well as for rising stress levels and they are commonly daughters. Also, daughters are affected by their mothers’ breast cancer. The next step is to research how the daughters’ experiences determine any decisions they do or do not make about their intimate relationships. This will allow for beginnings of understanding of how mothers’ breast cancer experiences affect their adult daughters’ intimate relationships. Thus, the purpose
of the study was to analyze how mothers’ breast cancer experiences affect their adult daughters’ intimate relationship decisions.

Methods

This study involved the recruitment of ten participants who took part in semi-structured, in-depth interviews. These interviews were transcribed and analyzed using thematic analysis. This section describes recruitment processes; procedures and materials used in data collection; how human subject protection was achieved; and how the data were analyzed. In addition, a description of the final sample of participants is provided.

Participants and Recruitment

Daughters of female breast cancer patients were recruited using fliers (Appendix D) posted on the Miami University Oxford campus and by posting announcements (Appendix E) on discussion boards and through electronic mailing lists on internet-based organizations that act as support groups for family members of breast cancer patients. Such online organizations include breastcancer.org and the Susan G. Komen page on Facebook. To be eligible for participation, individuals needed to be the biological daughters of women who have been diagnosed with breast cancer. The rationale for this inclusion criterion was that in having a genetic relationship to their mothers, these women are at an increased risk for developing breast cancer themselves. This knowledge may create unique anxieties and concerns that non-biological family members do not experience.

Because this was a pilot study, the participant’s mother could be in any state in her treatment, which included that she might have been as yet untreated or have completed treatment, or that she had died. Participants had not been diagnosed with breast cancer themselves, but there was no preference for their own health status for the purpose of this study. Participants received a $10 gift card to Starbucks Company for their participation in this study. Interested participants were asked to contact the researcher either via e-mail or telephone. At that time, participants were screened for eligibility; the researcher asked if the potential participant was over the age of 18 and whether her biological mother was diagnosed with breast cancer in the last seven years. If the participant met the criteria, she was invited to participate.

The original objective was to find 10 women between the ages of 18 and 25 whose biological mothers were diagnosed with and treated for breast cancer in the last five years. An insufficient number of qualified women emerged, so I consulted with my chair and decided to
reapply to the IRB, asking that the criteria be changed to participants between the ages of 18 and 30 and whose biological mothers had been diagnosed with breast cancer in the last seven years. Upon IRB approval of this revision, I was able to recruit sufficient participants.

**Procedure**

Participants took part in one-time face-to-face or telephone interviews conducted by the researcher. The interviews were semi-structured with regard to content (Appendix C). The interviews were conversational in nature and the interviewer allowed the participant to guide the interview. In the event that the participant did not initiate all topics outlined in the interview guide, the interviewer had questions from the guide to ensure that these topics were addressed. These interviews lasted between 20 and 60 minutes. Each interview was digitally recorded and transcribed by the researcher prior to data analysis.

**Materials**

In writing the interview guide, it became clear that the first questions (after documenting the participants’ demographic information) should be far less structured in order to allow the participants to speak freely about their experiences: “To begin, tell me a little bit about your mother’s breast cancer experience [e.g., staging, treatment, age at diagnosis, current health status, troubles/triumphs].” These grand tour questions are necessary to obtain a “big picture” idea of the participant’s experience, which facilitates further discussion. After participants discussed their experiences and observations in depth, they were questioned on more specific issues: perceptions of family quality of life both before and after diagnosis (i.e. perceived quality of the mother’s relationship with her spouse/partner if one was present, general family functioning since the diagnosis): “Describe for me what your family quality of life was like before/after your mother’s diagnosis of breast cancer.” Next I asked about the fears and personal beliefs of the participant, and relationship issues and decisions: “Were you in a serious relationship at the time of your mother’s diagnosis,” “What are some similarities or differences between your intimate relationships before your mother’s diagnosis and after your mother’s diagnosis? To what do you attribute those differences?”

Additionally, participants were also asked to provide demographic information that included age, current marital status, racial/ethnic background, occupation, and years of formal education. The same demographic information was asked about the participants’ mothers as well as information about their mothers’ breast cancer (e.g., years since diagnosis).
**Human Subject Protection**

Institutional Review Board approval was obtained for this study. Prior to participation, individuals were provided with written or oral consent information. Each participant consented to participate in this study. If the interview was face-to-face, then the researcher gave the participant two consent forms to sign; the participant kept one and the researcher kept the other. If the interview was conducted over the telephone, then the researcher read aloud the consent form and asked that if the participant agreed, then to verbally state her consent. A copy of the consent form was also mailed to participants. Any topics relating to health and wellness might have caused discomfort to the participant while sharing with me and it was absolutely essential that as the researcher, I made certain that participant’s identity was protected and that her thoughts and feelings were respected. In this study, all demographic data, recordings, and transcriptions were identified using code numbers (the researcher’s first and last initials along with the date of the interview). Audio files were retained to allow for their use in data analysis. Transcribed files were stored, password protected, on the researcher’s computer. This information will be destroyed upon publication of all findings from these data.

**The Researcher**

It is imperative in qualitative research that the researcher(s) acknowledge any personal biases that may be relevant to the work. This is done in order to best represent the collection and analysis of data with regard to the understanding that the researcher is the research instrument. Thus, I have provided a brief description of my personal experiences with issues related to breast cancer and family illness in order to best represent myself as the research instrument.

My paternal grandmother was diagnosed with breast cancer when I was thirteen years old. I am aware of my slightly heightened risk for developing breast cancer, and since beginning my breast cancer research, I have thought more about my grandmother’s experience, and I need to be open to those personal thoughts. Having researched how an individual’s chronic illness affects family members, I am aware of decisions and changes I have made based on this information.

**Trustworthiness**

In acknowledging that no research is value-free (Morrow, 2005), below I discuss potential threats to the trustworthiness of my findings as well as procedures that I employed to ensure these data and findings meet appropriate standards of quality and rigor. For this I have
followed the standards most often aligned with postpositivist qualitative research. These standards are considered equivalent in many ways to the standards set out in quantitative research: objectivity, internal and external validity, and reliability (Guba & Lincoln, 1994).

The first criterion of trustworthiness is confirmability (i.e., objectivity). This criterion is associated with the view that while research is never objective, the research findings should convey adequate measures to attempt neutrality. When working with qualitative data, it is imperative that the researcher maintains as much objectivity as possible. As the principal investigator, I filter all data through my experiences, and I must remain aware of the fact that all research, including this project, is subjective and that my personal experiences may influence my participants and findings (Morrow, 2005). To keep my personal experiences from influencing my research, and specifically, my analyses of my interviews, I maintained a “researcher’s memo,” or a journal detailing my thoughts and perceptions, as I conducted my research and wrote my thesis. It was a way to acknowledge how I was feeling and to track those feelings. I was open to the possibility that I might become subjective and I was prepared to talk with my chair to devise ways of maintaining objectivity, although that issue never arose. Journaling was also an effective way to discuss any preconceived notions that I might have had about my research. By writing out my thoughts, I was able to confront biases.

Credibility (e.g., internal validity) is ensuring that the researcher has portrayed the multiple realities of the participants’ experiences (Morrow, 2005). Morrow stated: “Credibility can be achieved by prolonged engagement with participants; persistent observation in the field; the use of peer debriefers or peer researchers; negative case analysis; researcher reflexivity; and participant checks, validation, or coanalysis” (Morrow, 2005, p. 252). I achieved credibility by establishing rapport with the participants prior to the interview, by keeping a journal of my experiences and thoughts throughout collecting and analyzing my data (researcher reflexivity), and finally by having my thesis chair and a second colleague serve in the roles of peer debriefers and coanalysts.

Transferability (e.g., external validity) refers to the extent of generalizability of findings from one study to other contexts or situations by the reader of the study (Morrow, 2005). Unlike more positivist standards of rigor that focus on the researchers offering generalization from their findings (Hoepfl, 1997), transferability in qualitative research refers to the reader’s ability to make generalizations from the findings. According to qualitative research philosophy, it is not
the role of the researcher in qualitative studies to tell future researchers whether or not the findings could transfer to his or her own research. Thus, in qualitative research, the goal of transferability is to provide a description detailed enough so that they may decide for themselves. At the same time, the description cannot be so detailed that it breaches confidentiality. This thick description has been provided here regarding research procedures, participants, and sufficient evidence of themes and sub-themes through presentation of exemplar quotes found within the data.

Dependability (e.g., reliability) refers to the consistency with which the data were collected throughout the study (Morrow, 2005). To demonstrate this, researcher maintained journals, logs, or auditable records so that the specific research processes can be held up to scrutiny. The aforementioned journal of experiences and thoughts regarding data collection and analysis also served as a record of my research procedures. I met regularly with my thesis chair who served as peer debriefer and auditor regarding the dependability of my research processes.

Analysis

**Phenomenology and Experiences of the Daughters of Breast Cancer Patients.**

Phenomenology enhanced my understanding of how adult daughters of women with breast cancer coped with the simultaneous experiences of their mothers’ diagnoses, their families’ reactions to the illness, and any intimate relationships they were in during or after this tumultuous time. Such a framework allows the researcher to learn about the participants’ “lived experience” (Schram, 2006, p. 98). As stated by Schram: “phenomenological studies investigate the meaning of the lived experience of a small group of people from the standpoint of a concept or phenomenon” (2006, p. 98). The researcher met with participants and learned how they experience, have been affected by, and discuss their mothers’ breast cancer experiences and what those experiences have meant for their own relationships. The researcher found meaning in the participants’ experiences. These actions which the researcher took comprise the “basic tenets” (meeting, learning, discussing and understanding; p. 100) of phenomenology.

**Thematic Analysis.**

Since I was uncertain of the themes that I would find, it was necessary to use a flexible analysis technique initially. After transcribing an interview, I read it entirely and coded line-by-line (i.e., open coding; Strauss and Corbin, 1998), making note of recurrent themes, and highlighted quotes that demonstrated these themes. This thematic analysis is often used in
phenomenological research in order to find common threads as indicated by the data. Braun and Clark (2006) define thematic analysis as: “A method for identifying, analyzing and reporting patterns (themes) within data. It minimally organizes and describes your data set in (rich) detail. However, frequently it goes further than this, and interprets various aspects of the research topic” (79). There is some debate about the use of the term “thematic analysis,” although for me, this process began with open coding and ended with themes based on their strength and prevalence throughout my data.

Moving from open coding to the development of themes was an intriguing process. As Braun and Clarke (2006) point out, a “prevalent theme” is not necessarily one that shows up in over 50% of the transcripts or data sets. Moreover, “the ‘keyness’ of a theme is not necessarily dependent on quantifiable measures – but rather on whether it captures something important in relation to the overall research question” (p. 82). Not everyone in my sample reported the same kind of mother-daughter relationship or intimate partnership. However, there were consistent responses that could not be overlooked and which reflected my research questions.

Next I discussed with my chair and advisor, as well as a second colleague, the data set and my perceptions of recurrent themes. My chair acted as an auditor and read outlines of my analysis that I provided her along with my transcriptions. She advised me to distinguish between my themes and sub-themes, and to clarify my sub-themes. This often meant rewriting my descriptions of themes, or even reconsidering how I had categorized certain themes. As a result, my code book was far more comprehensible and my themes were better organized. After this step, I gave my data set and code book to a colleague, who read the transcripts with my code book to determine whether my codes (and perceptions of recurrent themes) were clear. After she determined that they were, I returned to the data set to clarify those themes by identifying evidence that both supported and did not support the existence of the themes. The following is an example of my coding method and subsequent thematic analysis.

One of my codes was for mother-daughter relationships. All ten participants were asked about the qualities of their relationships with their mothers. I created a spreadsheet that listed all responses to all questions that were asked. Below is a sample table containing participants’ responses about their mother-daughter relationships:

<table>
<thead>
<tr>
<th>ID Numbers</th>
<th>Relationship with Mother</th>
<th>Qualities of Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>AG0119D</td>
<td>My mom and I have always had a really</td>
<td>Um… just always being there for each other. Just always having someone to talk to, that kind of</td>
</tr>
<tr>
<td>ID</td>
<td>Quote</td>
<td>Annotation</td>
</tr>
<tr>
<td>----------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>AG0121D</td>
<td>Um, I’ve always been super close with my mom. She is definitely my best friend and, yeah, definitely a good relationship.</td>
<td>Um, just that she’s somebody that I can talk to about anything. She’s really, um, comforting, and just there for me, um, no matter what. Just anything that I’ve ever gone through in my life, she’s been there 100% for me and my sister, and she’s just – she’s more than a mom, she’s a friend, too.</td>
</tr>
<tr>
<td>AG0122D</td>
<td>Um, it was pretty close. I consider her one of my good friends. I mean, I don’t know… we hang out together, go shopping.</td>
<td>Um, I just know that my mom is very accepting and tolerant, so I never felt that I had to keep things from her or that she’d be upset with things I was doing.</td>
</tr>
<tr>
<td>AG0129D</td>
<td>My mom and I talked about everything all the time. We used to drive around the city, used to talk in the car… um, we were really close and we like, love spending time together and doing things together.</td>
<td>Mmhmm. Yeah, I definitely felt like I could go to my mom with anything, which I think a lot of my friends didn’t have at the time, and I know, like, teenage years can be stressful and stuff like that, and I knew I could talk to her about anything and knew she’d be willing to help.</td>
</tr>
<tr>
<td>AG1011D</td>
<td>Um, we’re like best friends, practically talk on the phone at least every day, um, really close – we can pretty much talk about everything together, so we had a really close relationship.</td>
<td>Yeah, I think it’s our open communication, and I think we understand each other really well… those are both probably strengths.</td>
</tr>
</tbody>
</table>

After reading over these responses several times, I took notes on themes I had identified. Braun and Clarke (2006) state: “An account of themes ‘emerging’ or being ‘discovered’ is a passive account of the process of analysis, and it denies the active role the researcher always plays in identifying patterns/themes, selecting which are of interest, and reporting them to the readers” (p. 82). These themes did not appear suddenly; it took time and studying the data sets to understand the patterns I had found. I recognized the varying nuances in every participant’s voice; the words she chose to explain her relationship (“best friend,” “very close,” “more than a mom”), and what she deemed important. The following section from my code book explicates this theme:

Sub-theme: Close Mother-Daughter Relationships
Definition: Prior to mothers’ diagnoses, participants mostly described very close relationships to their mothers. Characteristics of a close relationship included spending time together, often just talking, and the ability to confide in their mothers almost anything. Following the diagnosis, daughters wanted to spend even more time with their mothers – and if they were at school, wanted to come home more often to spend especial time with them. Moreover, participants frequently reported that their mothers were a large part of their support systems (in coping with the diagnosis itself).

Example: “My mom and I are super close. We spend as much time together as possible, and I don’t like it when I can’t see her often.”

Non-example: “We see each other regularly and our family has dinner together every night.”

By creating the table based on actual responses, I had a clearer method for examining my data and determining how I was identifying these themes. By having my chair and a second colleague read my code book and attempt to find quotes that applied to these themes, I ensured that my code book was comprehensible. After ensuring that, I went back and selected quotes that evinced my four themes (daughters’ perceptions of mothers, attentive fathers, participants’ partners’ responses, and advice to other daughters).

Results

Ten women were interviewed for this study. The age range was 18 to 29. All ten reported being Caucasian. All were American except one was from the United Kingdom. Nine of the participants’ mothers were still alive, and in a variety of diagnosis, treatment, and post-treatment statuses (one woman reported that her mother had passed away two years prior to this study). Two women were married, four were in relationships, and four were single. All ten were heterosexual.

In analyzing these data, four predominant themes were found: daughters’ perceptions of mothers, attentive fathers, partners’ reactions, and advice to other daughters.

Daughters’ Perceptions of Mothers

In the first theme, daughters’ perceptions of mothers, daughters discussed how perceiving their mothers’ characteristics and reactions to their diagnoses influenced their own behaviors and perspectives. The two primary perceptions, close relationships with their mothers and recognizing their mothers’ fortitude, are described below as distinct sub-themes. While close
mother-daughter relationships and references to strong mothers often co-occurred, these two things are still separate and participants did not necessarily make connections between them.

**Close Mother-Daughter Relationships.**

When thinking about their relationships with their mothers prior to diagnosis, participants mostly described very close relationships to their mothers, and four of them referred to their mothers as their “best friend” or a “very close friend.” When asked about the strengths of her relationship with her mother, Melissa (22, server, in a relationship) reported, “She’s really, um, comforting, and just there for me, um, no matter what. Just anything that I’ve ever gone through in my life, she’s been there one hundred percent for me and my sister, and she’s just – she’s more than a mom, she’s a friend, too.”

Characteristics of a close mother-daughter relationship included spending time together, often just talking, and confiding in their mothers almost anything. Carolyn (19, college freshman, single), commented that before she left for college, “My mom and I talked about everything all the time. We used to drive around the city, used to talk in the car... um, we were really close and we like, love spending time together and doing things together.”

Following the diagnosis, most daughters wanted to spend even more time with their mothers, and if they were away at school, they wanted to come home more often to spend special time with them. Moreover, participants frequently reported that their mothers were a large part of their own support systems in coping with the diagnosis. For example, Carolyn (19, first year college student, single) explained,

> Um, it kind of sounds weird, but my mom was part of my support, because she was really, like, factual in what she was telling me, and like, “These are the options and these are the treatment we’re going through,” “This is what’s going to happen afterwards,” so it was really nice to know the steps.

Carolyn went on to describe how not only did her mother’s matter-of-fact approach help her grasp the diagnosis, but hearing it along with her sister brought some comfort. She reported that outside of the family, she did not discuss her mother’s diagnosis or treatment with anyone.

Amy (21, college senior, in a relationship) explained that her mother had chosen not to share her breast cancer diagnosis with anyone outside the immediate family. Thus, Amy did not
feel it was appropriate for her to talk about her mother’s treatment or overall experience with others at that time. When asked who helped her to cope, she answered:

Often my mom… Because I was the only person that she had to talk to. And since she was the one in the situation, and she was the one dealing with it, I felt like I could talk to her about everything.

Similar to Carolyn, Amy chose not to discuss her mother’s treatment or experience with anyone, including extended relatives.

**Strong Mothers.**

Daughters described looking up to their mothers and viewing them as very strong individuals who did not always accept help readily. Liz (21, college senior, in a relationship) remarked, “I really look up to her as a role model… to do well, to succeed and be independent, she’s definitely instilled that into my personality.” Liz reported also desiring her mother’s opinion when making “major decisions” and communicating with her on a regular basis.

**Attentive Fathers**

The second theme, attentive fathers, was quite prevalent throughout the interviews. Following their mothers’ diagnoses, participants’ fathers became increasingly attentive to their wives’ needs. Although fathers had difficulty vocalizing their emotions, participants still noted and valued their concern and increased efforts to assist with the household responsibilities. Aside from one case, participants all reported that their parents grew closer – they observed more physical and verbal displays of affection and also found that their parents spent more time together.

I feel like they, after her diagnosis, I feel like they became closer – they were never were affectionate like out in public or anything, but even now, I still see them holding hands, or now they just take random trips together, or like I think they’ve really gotten – kind of like they got more out of life, because they both work full time, um, and so just a couple weekends ago they went and left for Vegas [laughs] … um, they went with our best friends of the family, Mr. and Mrs. Smith – they always go on vacation with us every year, so those four are the best friends, and, um, they went out to Vegas, and now they’re
planning a trip to Paris, and I think they are getting more of a “This is our life, and we need to, you know, explore and do things” (Liz, 21, college senior, in a relationship).

Liz also said that she enjoyed watching her parents act with more affection toward each other, and that her parents had “connected” more fully since her mother was diagnosed.

Their fathers’ reactions gave participants an idea of what to expect or look for in current or future relationships or marriages. Partners also said that following their mothers’ diagnoses, the “ideal partner” would have traits that reflected what they had observed in their parents’ marriages (if their fathers had been supportive). Olivia (23, registered dietician, recently married), discussed her simultaneous experience of being engaged and observing her mother’s breast cancer experience:

I had always looked at their marriage as a good example of what people have gone through hard times and come out of it stronger… and, um, I think that just reaffirmed, you know, my belief in their marriage, and hoping that my marriage would be like that, too.

Olivia had been engaged for only a few months when her mother was diagnosed with breast cancer, and her mother was still going through treatment when Olivia married.

Regarding the parents’ relationship, Mary (20, college junior, in a relationship) offered advice for young women whose mothers are undergoing breast cancer:

If their father is still around, and there’s a good relationship there, I would say that’s a really good example of the kind of things to look for in your own relationships because I know that my dad’s a great guy and my parents are obviously still together and, um, which isn’t all that common these days, and my parents have always had a wonderful relationship, but I think that seeing them in that particular relationship gave me more to look at and more to think about, um, and then on the other hand, it’s a good example if your parents don’t do well for that, it’s a good example of maybe what you may want to think about in the long run, um, as being a negative quality in a relationship.
The above quote succinctly expressed the daughter’s recognition that positive or negative, the quality of her parents’ relationship helped shape her schema for a solid relationship of her own.

**Participants’ Partners’ Reactions**

After asking participants about their familial relationships, the researcher questioned them about their own intimate relationships. Their answers elicited the third theme, participants’ partners’ reactions, which was then divided into the nature of their reactions. Participants described a wide variety of positive behaviors from their partners. One group of behaviors was *supportive*, in that partners were very proactive in approaching participants about how they were feeling and in asking about their mothers. Another group of partners’ behaviors was *concerned*. While they were not as active in participating in the familial experience, they were still invested in participants’ fears and discussions.

**Supportive Partners.**

Partners – whether they were in a relationship with the participants at the time of diagnosis or thereafter – were always upbeat, and most participants felt that they could confide in their partners about their mothers’ conditions and their own feelings. Many partners were already close to the mothers and talked with them about their diagnoses. Partners also encouraged participants to talk about how they were feeling.

Liz (21, college senior, in a relationship) was shocked to discover how much she and her boyfriend had in common when she told him about her mother’s diagnosis:

I think his reaction was – I think he tried to take everything in consideration… um, he sees my mom as a very, like, independent person, speaks for her own mind, so he didn’t want to, like, he didn’t want to like, put down the situation, because I knew he wouldn’t, but he kind of just took it in after I told him, and he was like, “Okay, your mom can get through this, she’s a really strong person and she has your dad… you know, it’s not in the hard stages to get through it,” and then… he kind of said, “I don’t know if you ever knew this, we didn’t really talk about it,” but he was like, “My mom had breast cancer,” and I was just floored, I was like, “What?” So, um, and eventually I – we ended up visiting his
family another weekend, and, you know, I told her, and she was very supportive, and so was John. It was almost like he knew my mom was going to get through it. Like, he knew that she was strong enough and that the radiation would work it out and he was very supportive, and just very, “It’s going to work out, don’t worry about it,” so I think it definitely helpful to just have him as my rock, so….

Liz appreciated John’s awareness of the trials of breast cancer in the family. Later in the interview, she recalled her boyfriend suggesting that she buy breast cancer awareness items to encourage her mother during and following treatment.

This same partner also offered advice concerning Liz’s outlook and information seeking:

Um, and so he just scratched it all away from my mind. He was just like, “No, that’s not going to happen. Try to think positive through this. This could be like a learning experience for your whole family.” So I talked about it a lot with him.... I think he was actually the one who pulled up information on some research website… yeah, it was John… he did it and was like, “If your mom has had breast cancer, you know you need to start your mammograms at like age 25,” I think the website said, and he started – we started to look through things and I think he said, you know, “If you’re smart about it and you’re careful and you do stay up on your self-checks and you start getting those mammograms early,” um, he kind of took it on as, “You’re going to find it” or “You’re going to beat it if you do have it,” um, and so I did talk to him about it.

Although Liz admitted that occasionally John’s involvement in her mother’s breast cancer experience was overwhelming, she valued his supportive attitude and behaviors.

Concerned Partners.

All of the partners wanted to help, even if they did not always know what to say. With this group, participants often had to explain to their partners what they needed. Jane (18, college freshman, single) said about her previous boyfriends, “Um… no, not really, but when I got really upset, like the lads don’t know what to do… [laughs] They don’t know what to do because you’re crying… like, missing your mum and that.” This same group of partners often took a more passive approach. For example, (Olivia, 23, R.D., married) explained,
He just waits for me to say it, and that’s just how his character is. But yeah, he was just supportive, just told me I needed to talk about it whenever I wanted to, and, um... but he was definitely concerned.

Olivia never reported being bothered by her fiancé’s passive approach. She recognized his character as such, and simply appreciated his concern and desire to listen to her when she needed to talk.

Whether participants discussed their mothers’ experiences with their current partners often depended on how long they had been in a relationship and whether they had been in that relationship at the time of the diagnosis. Mary (20, college junior, in a relationship) recalled:

At first it wasn’t really [easy to go to him], because we had just started dating, um, so it was kind of awkward and you know, I didn’t want it to seem like I was dating him because I needed that support so, um, so I tried not to bring it up too much or anything, um, but then later on, with the frustrations of not being filled in on what was going on and things like that, um I definitely turned to him a lot more.

In her next relationship, Mary was able to discuss her mother’s diagnosis and treatment experience more readily.

Advice to Other Daughters

The fourth theme, advice to other daughters, consisted of two major sub-themes. Participants gave advice on two chief topics: the need for and how to support one’s mother during this turbulent time, and the need for expressing one’s needs to one’s partner.

Supporting Mom.

When asked, “What relationship advice would you give to other daughters whose mothers have been diagnosed with breast cancer,” nine of the 10 participants discussed the mother-daughter relationship, rather than an intimate relationship. This advice was mainly to be strong for their mothers.

I think it’s really important to, um, spend as much time with your mom as you can through the process, because it might be hard for you, but it’s harder for her, and she
would probably really enjoy spending time with you and appreciate the support – any support you can give her through the process. (Carolyn, 19, college sophomore, single)

Support might range from calling frequently to taking mothers to doctors appointments, and depended on where the daughter was living at the time. Carolyn was in high school and living at home at the time of her mother’s diagnosis, and so her support consisted of talking with her mother and minimizing fighting with her older sister. Liz (21, college senior, in a relationship) offered the following:

Um, I would tell them to stay strong for their moms. Especially in my case, um, I feel like I was actually the shoulder to lean on for my mom.

The role-reversal, as explained by Stiffler, Hosei, and Haase (2008), can be stressful for the daughters, but absolutely required by the mothers going through breast cancer diagnoses and treatment. Steph (23, graduate student, single) had reported a significant blow to her family’s stability following her mother’s breast cancer diagnosis. For a while after her mother’s diagnosis, Steph’s parents’ marriage had been in jeopardy, and she had had to step in to fill her mother’s role as caregiver and overseeing household responsibilities.

I’ve really appreciated that role reversal that we had. I really think that has done a lot for our relationship, and we’re just a lot more mutual now, and we talk to each other a lot more, and she’s definitely still the mom and I’m definitely still the daughter, but… it’s not like here, it’s more like here [gestures with her hands, narrowing the space between them]. So, we still like – we still depend on each other now, rather than me depending on her as a child, and that was really big. And then the idea that things are going to go back to normal… never have that conception. [laughs] That is totally a misconception. And you know, no one was really there to tell us, you know, “Things aren’t going to go back to normal.” … it’s just not something that’s going to happen, and before everything is smooth and seems like it was just a moment in time, it takes four or five – it’s only four or five years recently that it’s just kind of a moment in time. And accepting that things don’t go back to normal is really hard to deal with, because Mom is Supermom. She is the one that did everything, and we stepped in as a kind of temporary, “Let’s get through
this, not like we’re taking over, and not like you’re never going to be back, but Mom, we were just temporary [laughs]. Can you go back to the way you were?”

Steph commented that eventually things became smoother, but they never went back to the exact family dynamic that had existed prior to her mother’s diagnosis.

**Educating the Partner.**

When prompted what intimate relationship advice they might offer, participants discussed the need to be open and honest with partners, and to recognize that partners do not always know what to say or how to respond to their concerns, and so it is important to express themselves directly.

Angela (29, stay at home mother, married) advised women to “... have a more open line of communication no matter what. That way, they have support at home, you know, to help them deal with the emotional issues that come along with finding out something like that about your mom.” Support at home focused more on emotional issues, versus the doctor’s support that focused more on treatment information and help with decision-making.

Amy (21, college senior, in a relationship), had been in several relationships since her mother had been diagnosed with breast cancer four and a half years ago, and had some experience discussing her mother with them:

With partners I would say be understanding that they don’t understand what you’re going through… So they don’t always have the expectations or don’t always know… if you don’t want to do something and they want to know why you don’t want to do it… so even if you don’t feel like you need to explain it, you need to express it, and if you feel like you should explain it, go ahead.

Amy had explained earlier in her descriptions of intimate relationship experiences following her mother’s diagnosis that sometimes her boyfriends did not understand why she went home often to spend time with her parents, and that sometimes her boyfriends even became angry.

Participants felt strongly that one should feel comfortable discussing her mother’s experience with a partner, and that the partner’s response mattered greatly:
[I] think that you should be able to talk with your partner about what’s going on and if you don’t think you can talk to them, then you might want to reevaluate the relationship, I guess you would say. I think it definitely should be able to make your relationship closer because you guys are bonding on a different level through a different situation that you’ve probably never been in before, I guess. (Melissa, 22, server, in a relationship)

Melissa recalled that her boyfriend had been very upset when he learned of her mother’s diagnosis, and that they frequently discussed both her mother’s treatment and Melissa’s own thoughts following her mother’s diagnosis.

Um, probably be open about it. Um, because I know I told John right off the bat – he was the first person I told – um, be open about it and kind of see their perspective, and if they’re the kind of person that’s not going to be supportive, is not going to help you or is going to be a negative influence, it almost – it almost might not help you in the long run. Like, you – you want a supportive base, and you want someone that’s going to be there for you, um, and so I would definitely take that into consideration if you were dating someone and they just kind of brushed it off their shoulders – I wouldn’t – John and I wouldn’t still be together if he did that, I feel like. I think you need a support system, and, um, if they – if they are supportive, don’t take that for granted, um, there’s a person that cares for you and wants to be there for you, so take that into your consideration if you still want to date him or her or not. (Liz, 21, college senior, in a relationship)

Participants recurrently advised other women in similar circumstances to consider how their partners were reacting to the daughters’ mothers’ diagnoses, and whether their partners were supporting them or not. They suggested that the partner’s sensitivity and supportiveness (or lack thereof) might suggest their worth as partners.

**Discussion**

The purpose of this study was to explore the relationship between the mother’s breast cancer experience and her adult daughter’s intimate relationship decisions. Several themes came from the interviews: initial strong mother-daughter relationships, attentive fathers, a spectrum of participants’ partners’ responses, and advice to other daughters. It was clear that familial and intimate relationships strong prior to the diagnosis helped ensure that those relationships would
remain strong, or even improve, following the diagnosis. I did not expect to learn how important
participants’ fathers’ reactions were, especially with regard to how the participants viewed their
own intimate relationships. Where I expected to hear that the mother’s own experience was a
large determinant, I actually learned the father’s reaction and the parents’ closeness following the
diagnosis was a greater factor.

Given the literature on how families react to a family member’s illness, it was
unsurprising that adult daughters reported varying levels of stress caused by their mothers’
diagnoses, as well as expressing different components that might have affected their outlook on
their intimate relationships since their mothers’ diagnoses. The results indicated that adult
daughters are in fact affected by their mothers’ breast cancer experiences, particularly if the
daughters were living at or near home and were thus more capable of observing how their
mothers and their mothers’ partners reacted to the diagnosis and treatment.

Daughters felt that their relationships to their mothers grew stronger following the
diagnoses. Results indicated that close mother-daughter relationships prior to the diagnosis
ensured that dyads remained strong following diagnosis and during the mother’s treatment for
breast cancer. Spira and Kenemore (2000) reported that daughters often provide the most help to
their mothers. Rossi (1980) referred to the transition periods in a mother-daughter relationship as
the “winding up daughter and winding down mother” (p. 142). Thus, while the mother-daughter
relationship was already in the midst of transforming, the mother’s illness could have encroached
on this process or it may have sped up the process.

The theme Attentive Fathers was quite prevalent throughout the interviews. Following
their mothers’ diagnoses, participants’ fathers became increasingly attentive to their wives’
needs. Although fathers had difficulty vocalizing their emotions, participants still noted and
valued their concern, emotional support, and increased attempts to assist with household
responsibilities that the wife had held previously. Nearly every participant reported that their
parents grew closer – participants observed more physical and verbal displays of affection and
also found that their parents spent more time together. It may be that my participants all
happened to have strong families prior to their mothers’ diagnoses, so that naturally their
experiences post-diagnosis would be of higher quality than other families’ experiences. This
could even be due to self-selection bias.
Stronger familial relationships in general withstand the stress and turbulence of a breast cancer diagnosis (Rolland, 1987). It may be too much for some families to handle if they do not already have a solid foundation. Still, more information should be made available to families going through breast cancer diagnoses and treatment. As Steph commented, family dynamics may not easily slip back to “normal” once the breast cancer patient has completed her treatment. It takes time for families to get back on their feet, and if patients and their relatives are made aware of that from the beginning, it may assist them in discussing changes to their lives and relationships and how to combat the uncertainty of new family functions and responsibilities.

This also speaks to the need for marriages that have a secure base of communication and support. Marriages that are already weak under everyday and/or long-term stress will have more difficulty surviving the blow of a breast cancer diagnosis. Moreover, children of all ages do see their parents’ marriages and recognize when one parent is unsupportive. It is important to know what the daughter observed of her parents’ marital relationship growing up, because as indicated by Rolland (1987), how families have reacted to illness in the past will determine how they react to illness in the present. Furthermore, if someone has only seen her mother’s spouse or partner react negatively (becoming withdrawn, being physically or emotionally absent), this could be the schema she will then use when thinking about her own partner’s potential response to a diagnosis. Participants echoed this reasoning when talking about their parents’ marriages and how that had caused them to look at their own relationship. More research needs to be conducted concerning how children observe parents’ marriages change throughout one parent’s illness.

There were meaningful differences between supportive and concerned partners, according to the participants. The former often had experienced breast cancer or other chronic illnesses within their family. Perhaps that made them more aware of what their female partners needed from them; it might also have had to do with age and/or maturity, or with the participants’ maturity and/or ability to convey what they needed. More research needs to be conducted and made available to men in intimate relationships in which their partner is experiencing the illness and possible decline of a family member. Lye (1996) discussed the “kinkeeper phenomenon” that women (in particular, mothers and daughters versus other female relationships) in families are more likely to oversee communication matters. When one’s mother
is undergoing diagnosis and treatment, the daughter will need to be able to rely on her partner, who may not be certain how to respond to her fears, emotions, or withdrawal.

Systems theory, as explained by White and Klein (2008), is the “assumption of interconnectedness in a system,” and that it is only possible to understand something by “viewing the whole” (p. 156). For this research, “she” (i.e., the woman whose mother has been diagnosed with breast cancer) is not just a partner or spouse. She is also a daughter, a sister, a friend, and an individual, and these roles all influence her and each other. Moreover, she and her roles will affect the other people in her life or system, and they in turn will affect her. Amy talked about how she wanted to return home from college often to visit her mom, and how leaving campus so often had upset past partners. Amy’s simultaneous roles as daughter and girlfriend often collided unsuccessfully. Likewise, Liz’s role as girlfriend, and specifically, as the girlfriend of the relative of a breast cancer patient, affected her role as daughter because her boyfriend encouraged her to support her mom in a variety of ways.

**Limitations and Directions for Future Research**

There were several limitations to this study. First, as a thesis, my parameters were defined by a certain number of women within a time limit, which meant I only had time to interview ten women. Ideally, I will be able to go back to this study in the future and gain more participants, so as to get a better representation of young women’s experiences. Second, although this study was broadcast in a variety of venues, only Caucasian and heterosexual women responded to the study. Still, by having sought a more heterogeneous sample for my pilot study, differences in participants’ responses related to intimate partnerships may have been based more on the differences between different-sex and same-sex relationships in the United States, rather than on their mothers’ breast cancer experiences, which was the purpose of this study.

It would be interesting and fruitful to discover how women of other races and ethnic backgrounds responded to their mothers’ breast cancer experiences, as well as to learn how women in same-sex intimate relationships were able to talk with and rely on their female partners about their mothers’ diagnoses and treatment. Newer research suggests that African American women have a different breast cancer experience than Caucasian women (Sheppard, 2010), as do lesbians and women in same-sex relationships (Fish, 2009). Future research should
continue to look at these populations, not only with regard to breast cancer patients, but to their family members and partners as well.

For family and medical professionals to relay useful information to patients and their families, it is imperative that we continue researching both the myriad ways that breast cancer affects families and what the partners and spouses of breast cancer patients’ relatives need with regard to emotional support. Daughters are especially affected by their mothers’ breast cancer because they are simultaneously integrating the information that their mothers are ill and that they too could become ill. As family and medical researchers, it is absolutely essential to devote ourselves to learning as much as possible about the phenomenon of breast cancer affecting the family. In this way, relationships within the family unit will not only survive the mother’s diagnosis, but they may even flourish. This study is a further step in that direction.
References


Appendix A: Consent Form

The Consequences of Mothers’ Breast Cancer Experiences for Their Adult Daughters’ Intimate Relationship Decisions
Written Consent Document

The interview involves research whose aim is to explore the experiences of daughters of women with breast cancer in the context of their intimate relationships.

Your participation in this interview is voluntary. If you refuse to participate in any or all portions of this interview there is no penalty to you. Also, you may discontinue your participation at any time before or during the interview. The interview consists of questions about your perception of family quality of life prior to and after your mother’s breast cancer diagnosis, what your mother’s treatment consisted of, how you coped throughout this time, and your perception of your relationships prior to, during, and following your mother’s breast cancer diagnosis and treatment.

Risks to you in participating in this interview are minimal. However, some participants may experience distress in discussing their experiences. Should you experience distress, feel free to ask to skip a question, take a break, discontinue your participation, or ask for referral information regarding ways to cope with this distress.

There are no direct benefits to participation. However, you may find it beneficial to discuss these issues. In addition, the study will provide information to the researchers that may later be used to help women with breast cancer and their female family members.

Your interview will be recorded and then following the interview your words will be transcribed. At the time of transcription your interview will be given a code number that will serve as the interview’s identification throughout the research process. Therefore, your name and contact information will be kept separate from your transcribed interview. Only the principal investigator will have access to information linking code numbers to participants’ names. All record of your participation will be kept safely in a locked cabinet accessed only by the principal investigator. Your confidentiality will be maintained in the reporting of the data and any reference to specific aspects of your responses will be referred to using a pseudonym. In return for your time and travel, you will receive a $10 Starbucks gift card.

By signing below, you agree that you are at least 18 years of age and are indicating that you consent to participate in this study.

Participant’s Signature ___________________________ Date ___________________________

Principal Investigator ___________________________ Date ___________________________

For questions regarding this research, please contact:

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If you have questions about your rights as a research participant, contact:

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Appendix B: Demographic Sheet

The Impact of Mothers’ Breast Cancer Experiences on Adult Daughters’ Intimate Relationship Decisions

ID number:                              Date:

About you:
What is your age?  _____________ years
How would you describe your sexuality? __________
What is your current relationship status? (circle one)
Never Married          Married/Living as married
Divorced/Separated     Widowed
How would you describe your racial/ethnic background? ____________________________
How many years of formal education do you have? _____________ years
(12 = high school; 16 = graduated from college, etc.)
What is your current occupation:

About your mother:
What is your mother’s age?  _____________ years
What is your mother’s current marital status? (circle one)
Never Married          Married/Living as married
Divorced/Separated     Widowed
How many years of formal education does your mother have? _____________ years
(12 = high school; 16 = graduated from college, etc.)
When was your mother was diagnosed with breast cancer?  _____________ years ago
Appendix C: Interview Guide

The Impact of Mothers’ Breast Cancer Experiences on Adult Daughters’ Intimate Relationship Decisions

Hi, ______. It means so much to me that you are willing to talk with me as part of a research study involving the daughters of women who have been diagnosed with breast cancer. I want to learn more about how daughters reacted to their mothers’ diagnoses and treatment, and how observing and participating in their mothers’ breast cancer experiences has impacted them later in life, with specific interest in whether their mothers’ illness has affected their intimate relationship decisions.

1. Your Experience

First of all, share with me your mother’s breast cancer experience [e.g., staging, treatment, age at diagnosis, current health status, troubles/triumphs].

- How had your mother’s health been up to the time of her breast cancer diagnosis?
- How is your mother’s health currently?
- Where were you in your own life at the time of your mother’s diagnosis? [e.g. college, grad school, moving, career change]

2. Family Quality of Life BEFORE Breast Cancer Diagnosis

For the following questions, family is defined as you, your parent(s), and your siblings. [You may also include fictive kin, if they are a close part of your life or if you were living with them during this period.]

Describe for me what your family quality of life was like before your mother’s diagnosis of breast cancer.

Describe for me your relationship with your mother prior to her diagnosis.

- What was your relationship based on? [e.g. strictly parent-child, or perhaps one based on friendship as well]
- What were the strengths of your relationship?
- What were the weaknesses of your relationship?
3. Family/Relationship Quality of Life AFTER Breast Cancer Diagnosis

The next set of questions I am going to ask you have to do with the time after your mother’s breast cancer diagnosis. When thinking about and responding to these questions, family is defined as you, your parents, and your siblings. [You may also include fictive kin, if they are a close part of your life or if you were living with them during this period.]

Describe for me what your family quality of life was like after your mother’s diagnosis of breast cancer.

- Did you notice any changes to your family or changes to your relationships with family members after your mother’s diagnosis?

- What interaction did you observe between your mother and her partner (if she had one at the time)?

- How satisfied are you with your relationship with other family members?
  - Your parents?
  - Your siblings?

4. Your Coping

Since learning of your mother’s breast cancer diagnosis, who was/were your supporter(s)? How did that person or those people become your support?

Did you want or need to talk about your mother’s diagnosis or treatment with others? Why or why not?

After your mother’s diagnosis, did relationships change between you and friends or extended family members, etc? Please describe these.

5. Your Intimate Relationships

First of all, could you tell me how you would define the term “intimate relationship?” What does that mean to you?

Tell me a little about your relationship history.

- Had you been in any serious relationships prior to your mother’s breast cancer diagnosis?

- What was your relationship status at the time of your mother’s diagnosis?
- What have you noticed about your intimate relationships since your mother’s diagnosis?

Describe your “ideal partner.”

- What characteristics does he or she possess?
- Do you feel those characteristics have changed since your mother was diagnosed with breast cancer?

Since your mother’s diagnosis, have you begun a new relationship?

*If yes-*

- Are you comfortable discussing your mother’s breast cancer experience?
  - Why or why not?
- How have you discussed your mother’s breast cancer experience?
- What has/have your partner(s)’ reaction been?

*If no-*

- Do you worry about discussing her experience with a future partner?
  - Why or why not?

Having observed your mother’s breast cancer experience, do you have any concerns about your own health?

- If so, have you discussed these concerns with any of your partners?
  - What have been your partners’ responses?

Some research indicates that adult daughters of breast cancer patients report impaired sexual functioning or having less sex than adult daughters of women who did not have breast cancer.

- How do you react to that statement?

Has your mother’s diagnosis and treatment caused you to make changes to an intimate relationship? (i.e., started, ended, redefined, or taken a relationship to the next level?)

6. Conclusion
Having gone through this, what relationship advice would you give to other daughters whose mothers were diagnosed with breast cancer?

Is there anything else you would like to share with me?

Thank you for agreeing to assist me in this research study.
Appendix D: Flier

Participants Needed!

STARBUCKS GIFT CARD FOR YOUR TIME!

A graduate student researcher from the Department of Family Studies is looking for women between the ages of 18 and 30 whose biological mothers have been diagnosed with breast cancer in the last seven years.

Participants will take part in one-time face-to-face or telephone interviews conducted by the researcher, in which they will discuss topics regarding their mothers’ breast cancer experience, family relationships, intimate relationships, and health concerns.

These interviews will probably last between 45 and 60 minutes. Participants will receive a $10 gift card to Starbucks Company for their participation in this study.

This study has been approved by the Miami University Institutional Review Board (09-099)

The Consequences of Mothers’ Breast Cancer Experiences For Their Adult Daughters’ Intimate Relationship Decisions: A Phenomenological Approach

Are you a woman 18-30?

Was your mom diagnosed with breast cancer in the last seven years?

Please keep reading...

Amanda Ginter
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The Consequences of Mothers’ Breast Cancer Experiences

For Their Adult Daughters’ Intimate Relationships Decisions: A Phenomenological Approach

A graduate student researcher from the Department of Family Studies is looking for women between the ages of 18 and 30 whose biological mothers have been diagnosed with breast cancer in the last seven years.

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- If interested, please contact Amanda Ginter at ginterac@muohio.edu or at (513) 687-7258.

- This study has been approved by the Miami University Institutional Review Board (09-099).