Communication and Cancer?
Part I:
The Noticeable Absence of Interactional Research

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ABSTRACT. Although increasing attention is paid to communication in psychosocial oncology, a comprehensive review of the literature reveals that emphasis has been given to individuals' self-reported experiences. Because naturally occurring interactions between cancer patients, family members, and health professionals have not received systematic attention, the authors propose that an empirical foundation for understanding communication activities is in its infancy. In this two-part article, Part I expands on how communication has been identified as central to family relationships, yet has been accessed through individuals' reports. Specific examples drawn from both qualitative and quantitative research methods illustrate the predominance and limitations of self-reports for studying communication and psychosocial oncology. Part II provides an overview of "conversation analysis" as an alternative method

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for studying interactional patterns in medical encounters and family interactions. The discussion focuses on the usefulness of conversation analysis for oncology professionals and the possibilities for collaborative research. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress. com> Website: <http://www.HaworthPress.com> © 2003 by Tlie Haworth Press, Inc. All rights reserved]*

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Historically, and with increasing regularity, communication has emerged as a primary concern for psychosocial researchers focusing on cancer diagnosis, treatment, coping, and care-and for good reason:

- Family members who communicate psychosocial support promote enduring family relationships, function as more effective caregivers, and experience less stress (Leiber et al., 1976; Litman, 1974; Rowland, 1990a, 1990b).
- Open, honest, and frequent communication is essential for ensuring that the wishes of

patients and family members are heard and attended to when facilitating decision making regarding care options (Bloom, 1996;Hilton, 1994;Kelleretal., 1996;Northouse& Northouse, 1987).

- Communication is associated directly with quality of care and life in terminal cancer (Engle, Fox-Hill, & Graney, 1998; Gotcher, 1993; Hess & Soldo, 1985; Heusinkveld, 1972; Shields, 1984).
- Throughout uncertain and often troubling cancer journeys, a vast amount of time and effort is invested by patients, family members, and health professionals as they attempt to manage understandings, relationships, and healing outcomes (e.g., Benjamin, 1987; Bloom, 1996; Dunkel-Schetter & Wortman, 1982; Hilton, 1994; Keller et al., 1996; Kristjanson & Ashcroft, 1994; Northouse & Northouse, 1987; Zerwekh, 1984).

The primacy of communication has been evident for at least 20 years, when cancer became associated with various "interpersonal dynamics" contributing to dysfunctional barriers to communication in social relationships (Dunkel-Schetter & Wortman, 1982)-including the family, which "constitutes perhaps the most important social context within

which illness occurs" (Litman, 1974, p. 495). Because "the family must somehow endure" (Rait & Lederberg, 1985, p. 586) throughout changes and problems associated with cancer, communication is perhaps understood best as fundamental for the family unit's quality of life and survival. Diverse research has targeted basic needs for (1) clinicians and caregivers to help facilitate and improve communication between patients and family members (Glimeus et al., 1995; Lewis et al., 1997; Skorupka & Bonnet, 1982), (2) provision of advice to practitioners on how to communicate better with patients and their families (see Bennett & Alison, 1995; Bertolone & Scott, 1990; Cournos, 1990; Foley, 1993; Lomax, 1997; Pace, 1993; Parle, Maguire, & Heaven, 1997; Rittenberg, 1996; Sullivan, 1990; Weissman, 1997; Westman, Lewandowski, & Procter, 1993), and (3) use of support groups as a forum for sharing experiences (McGuire & Kantor, 1987; Mulcahey & Young, 1995). Taken together, these targeted areas testify to the broad importance of enhancing communication between people whose lives have been affected somehow by cancer.

We propose that although a general trend in research promotes the crucial importance of communication in cancer care, and thus a movement away from cancer as "an isolated experience of the patient" (Baider, Cooper, & De-Nour, 1986, p. xvii), a predominant focus is on individuals' experiences accessed through self-report and anecdotal data in psychooncological investigations. By using survey research methods, questionnaires, interviews, and direct observation (reconstructed through note taking and diaries), rich insights are offered about individuals' perceptions of and reported experiences about relationships and coping mechanisms. Yet, in clinical and home environments alike, such data should not be treated as synonymous with "real time" examinations of actual communication events. Observations anchored in videorecordings of face-to-face interactions, audiorecordings of tele-phone calls, or both, in unison with careful transcriptions, facilitate close analysis of communication activities comprising cancer journeys. What people *say* about communication often stands in marked contrast to how interactions reported on actually get *done,* in part because self-reports offer only general depictions of detailed and contingently organized interactional involvements (Atkinson & Heritage, 1984).

Our extensive review of the literature, summarized here, reveals a noticeable absence of research on the social organization of naturally occurring interactions involving cancer. Surprisingly little knowledge has been generated about how cancer patients, family members, and health professionals actually talk through diverse predicaments associ-

ated with illness, including distinctive patterns through which troubles involving communication arise and are resolved (or not). For example, no studies were reviewed that carefully examined

how families *inter-actionally* accomplish such work as open and frequent communication, supporting (but see Pistrang, Barker, & Rutter, 1997), or coping. Therefore, we concluded that an empirical foundation for understanding ordinary social communication, and thus communicative activities of cancer journeys, is in its infancy.

A basic inconsistency is noted: As communication processes are increasingly theorized as central to psychooncological research, empirical verification of interactional patterns remains limited. Grounded knowledge about how participants rely on communication to organize cancer-related care and treatment is thus underspecified (see W. A. Beach, 2001, 2002, 2003a, 2003b, in press; W. A. Beach & Good, J. S., 2004; Lutfey & Maynard, 1998; Maynard & Frankel, in press).

Our discussion is organized into two parts. In Part I, we expand on how communication has been identified as central to family relationships, yet has been accessed through individuals' reports. Specific examples drawn from both qualitative and quantitative research methods are provided to illustrate the predominance and limitations of self-reports for studying communication and psychosocial oncology. Then, we draw implications for future psychooncological research in three related ways by providing an overview of how communication has been investigated directly in related medical encounters and family interactions.

In Part II, we address how "Conversation Analysis" is a viable methodological alternative for studying recordings and transcriptions of naturally occurring interactions and provide selected and transcribed excerpts focusing on how family members talk through cancer on the telephone. Areas addressed include the delivery and receipt of "good and bad cancer news" and how speakers manage "hope and optimism" when talking about and through cancer. The article concludes with a discussion regarding the potential for converging communication research on ordinary interactions with psychosocial oncology.

PREDOMINANCE AND LIMITATIONS OF SELF-REPORTS

Communication among cancer patients, family members, and health professionals is enormously important for patients' and caregivers' lives. A comprehensive review of the *Journal of Psychosocial Oncol-*

ogy revealed that attention has been given to an array of topics crucial to communication: coping and adjustment before and after a parent's death (Mireault & Compas, 1996); social support from family, friends, and health professionals (Ma, 1996; Wortman & Dunkel-Schetter, 1979); quality of life (Fuller & Swensen, 1992; Yancik, Edwards, & Yates, 1989); overcoming of the challenges posed by long-term illness (Benjamin, 1987); facilitation of hopefulness (Bunston et al., 1995); and the need for qualitative methods (Waxler-Morrison, Doll, & Hislop, 1995). Across these articles and a broader review of psychooncological studies discussed below, the vast majority of investigations are rooted in reported, perceived, or experienced information when generating observations about communication events.

Cancer, Communication, and Family Relationships

Diverse psychosocial reviews of cancer and families (Blanchard, Ruckdeschel, & Albrecht, 1996; Crosson, 1998; S. Heath, 1996a, 1996b) confirm the long-standing and unequivocal importance attributed to communication and relationships (see Blitzer et al., 1990; Butow et al., 1996; Chesler & Barbarin, 1987; Conrad, 1987; Eden, Black, & Emery, 1993; Finlay, Stott, & Kinnersley, 1995; Foley, 1993; Friedenbergs et al., 1982; Friedman & DiMatteo, 1982; Glaser & Strauss, 1965; Kubler-Ross, 1969, 1974; Keitel, Cramer, & Zevon, 1990; Lichter, 1987; Mac-Donald, 1996; Montazeri et al., 1996; Mulcahey & Young, 1995; Northouse & Northouse, 1987; Pace, 1993; Paternoster, 1990; Ptacek & Eberhardt, 1996; Rittenberg, 1996; Scherz,

Edwards, & Kallail, 1995; Stuber, 1995; Sudnow, 1967; Watson, 1994; Wortman & Dunkel-Schetter, 1979). Understanding comprehensive psychosocial support for cancer and the improvement of quality of life requires careful attention to communication (Razavi & Delvaux, 1995). Even when communication is not mentioned specifically, social support, relationships, and social networks are hailed as essential and beneficial to patients coping with cancer (see Bloom, Kang, & Romano, 1991; Creagan, 1993; Davis, 1963; Kutner, 1987; Lyons & Meade, 1995). Across these and related studies of communication, numerous and important findings have been observed and verified repeatedly.

Open and frequent communication between patients and their families when working through the anguish and uncertainty of cancer (Bloom, 1996; Hilton, 1994; Keller et al., 1996; Northouse & Northouse, 1987) and when communicating about illness within the family has been associated with "positive rehabilitation outcomes" (Mesters et al.,

1997). Although families may be expected to feel comfortable when discussing cancer, enacting "normal" conversations and interactions with the patient (Benjamin, 1987), much of the literature suggests that cancer leads to difficult and inconsistent patterns of communication (Dunkel-Schetter & Wortman, 1982).

It is curious, but not surprising, that open and frequent communication about cancer has been described as rare among family members (Gotcher, 1995; Heinrich, Schag, & Ganz, 1984). Because cancer is often viewed as an intruder in the family (Farrow, Cash, & Simmons, 1990), families are confronted with numerous dilemmas throughout their cancer experiences (Fitzgerald, 1994; Fitzsimmons, 1994; Seaburn et al., 1996). Indeed, discussion of unpleasant issues may disrupt and violate traditional patterns of communication (Gotcher, 1995)-what Maynard (1996) described as a "rupture" of everyday experience.

Problems in communication routinely arise as families learn to cope with their evolving cancer situations (Hinds, 1992; Lichter, 1987). For example, over time, family members may experience difficulty determining what their "job" is within the family system, simply because cancer arises from unknown origins and has an uncertain future (Comaroff & Maguire, 1986; Karp, 1992; Stewart & Sullivan, 1982).

Perhaps one of the most difficult and ongoing tasks, especially in cases involving a diagnosis of terminal cancer, is the routine management of interpersonal relationships (Caiman, 1987). A major stressor for patients is "altered interpersonal relationships" (Rowland, 1990a), and the majority of patients report moderate to severe problems in family relationships (Dunkel-Schetter & Wortman, 1982; Gotay, 1984; Heinrich, Schag, & Ganz, 1984; Rowland, 1990b).

Some authors have argued repeatedly that interpersonal problems affect the quality of life of both patients and family caregivers (Leiber et al., 1976; Rowland, 1990a, 1990b). Interpersonal crises are normal as patients and loved ones cope with the disruptive nature of the disease (D. L. Beach, 1993). Family caregivers play a vital role in a terminal patient's social life, functioning as mediators between the patient and the outside world. In Addington-Hall and McCarthy's study (1995) of more than 2,000 patients with terminal cancer, more than 80% of the primary caregivers were family members. Three additional and significant findings support continued focus on patient-family communication: (1) Terminal patients communicate predominantly with family caregivers (rather than with others) about their physical and emotional condition (Hinton, 1998), (2) Patient-family communication predicts patients' level of adjustment to cancer (Gotcher, 1993), and (3) The family "tends to be in-

volved in the decision-making and therapeutic processes at every stage of a family member's illness" (Litman, 1974, p. 501).

In a related review of 200 research articles focusing on the family's journey through cancer, Kristjanson and Ashcroft (1994) identified four themes emerging from the literature:

- The family's developmental stage-problems and concerns faced by families, taking into account the ages and relationships of the patient and family members.

- The trajectory of the illness-the family's experience over time as the illness progresses, characterized by the following stages: preventive, diagnostic, acute care, remission, rehabilitation, and possible recurrence and terminal disease.
- The family's responses to cancer-the family's needs, demands, role changes, communication, and health.
- The behaviors of health care providers-helpful/caring behaviors involving their communication with families.

Throughout Kristjanson and Ashcroft's exhaustive review, complex roles of communication, both within the family and with health professionals, are characterized repeatedly as a central factor in the family process (e.g., in providing social support). However, as we previewed at the outset of this review, access to patterns of communication and mechanisms of coping are gained through interviews, questionnaires or surveys, and theoretical speculation: In other words, individuals' self-reported experiences have been emphasized to generate insights about communication and relationships.

This emphasis on self-report data can be contrasted with Gubrium and Holstein's observation (1990) that constructing and maintaining a family is inherently a social, interactional process. Families derive their distinctive character, not from a setting or a societal label, but through the interactional achievement of a wide spectrum of family involvements as traditions, ideologies, and problems are shared and confronted over time. Through close examination of family members' communication activities, grounded understandings of what families "do" and "are" can be generated.

For example, communication activities consisting of caregiving, emotional support, healing, and grieving (see D. L. Beach, 1995) remain to be examined interactionally. Similarly, work on cancer and emotion refers to such problems as "communication barriers," but how such communication is achieved remains unspecified (Barraclough,

1994). Surbone and Zwitter(1997) exemplified these empirical and theoretical tendencies further in an edited volume titled *Communication With the Cancer Patient,* providing alternative descriptions and overviews of the pervasiveness and impact of communication; however, they made only limited data on communication available for readers' inspections.

Analyses of recorded and transcribed interactions, though rare in psychosocial research, offer an alternative to relying exclusively on self-reported information about the complex roles of communication throughout cancer journeys. In these cases, readers are provided with excerpts drawn from communication events in real time.

One alternative is to emphasize content-analytic observations about individuals' comments during key moments. For example, in Hunt's study (1991) of audiorecorded informal conversations between nurses and terminally ill patients, one nurse eased the concerns of a patient's relative by saying, "You are not holding us up. My time is your time love, ok? ... and don't ever worry about whether you should...." when the relative indicated that the nurse had spent a great deal of time tending to the family.

Notice, however, that examining the social action of "easing" a relative is accomplished through quoting an isolated utterance emphasizing the nurse's individual actions. What is not made clear is how the speakers worked *together* to enact this episode: How was the nurse's utterance designed as *responsive* to some previous turns-at-talk, and what actions did the nurse understand the relative was displaying? How was the nurse's "easing" itself consequential for ensuing talk: that is, as the relative heard and responded (or not) to the nurse's apparent offering of assurance? Without closely examining the *interactional* environment within which such easing is claimed to have occurred, the focus remains on the contributions of individuals (in this instance, only the nurse) rather than on emergent patterns of communication co-enacted by both speakers. Furthermore, little progress can be made toward describing and explaining basic patterns of communication: How do nurses and relatives collaborate in managing what appears to be, but cannot be communicatively substantiated as, a potentially delicate moment

of cancer caregiving?

As we noted earlier, few studies have attempted to examine interactions through which patients and families express needs and accomplish work, such as supporting or coping (Surbone & Zwitter, 1997). However, a study by Pistrang, Barker, and Rutter (1997) revealed that tape-assisted recalls of the interactions between patients with breast

cancer and their partners yielded insights into how supportive attempts are delivered effectively and why those attempts sometimes fail. These researchers found that patients perceived the most unhelpful messages as lacking empathy and changing the focus of a conversation concerning the illness. Although these investigators used tape recordings as the foundation for investigating support in cancer care, the data they provided were reconstructed versions of prescribed conversations, not naturally occurring interactions between patients and their partners.

Three Types of Self-Reports

The selected studies summarized briefly in this section demonstrate for readers what typically counts as self-reported "data" and thus exemplify how empirical and theoretical claims about communication and psychosocial oncology are typically advanced.

Anecdotal and narrative experiences. The first set of examples involves anecdotal and narrative data representing individuals' summarized versions of personal experiences with cancer events. In a case study of a man with small-cell lung cancer (Barraclough, 1994), "Jack" reported that his wife created an emotional scene upon learning of his condition, but eventually the couple was able to talk to each other much more easily. In a study of family communication patterns in coping with breast cancer, Hilton (1994) found that "talkers" (people who discussed the illness often) shared their concerns and fears and were open to listening to one another more often than "nontalkers" (people who rarely discussed the illness) although "talkers" had been talkers even before the diagnosis.

Readers do not have direct access to the activities reported in these studies-i.e., why talkers are able to talk to each other much more easily than are nontalkers, and how talkers and nontalkers share their concerns and fears about breast cancer-but instead must rely on reports about such phenomena as evidence for scenes and patterns of communication.

Although these data are generated from subjects' or researchers' subjective experiences, such qualitative studies of personal narratives provide extremely rich and deeply moving stories of cancer experiences for researchers, practitioners, and family members. For example, attention is given to a wide array of narrations central to patients' experiences and survival (Frank, 1991, 1995; Gabb, 1996; Goodell, 1992; Komp, 1992; Meyer & Rao, 1997; Ott, 1999; Surbone, 1996), family members helping each other to cope (Broccolo, 1997; Hensel, 1997), living with a cancer patient (Joseph, 1992; Spears, 1990), experiences of those who

suffer from the death of a loved one (Brookes, 1997; Byock, 1997;Ellis, 1993; Milton, 1996), nurses' experiences (locovozzi, 1991; Parisi, 1996; Renz, 1994; Spears, 1990), and diverse family survival guides for coping with cancer (Benjamin, 1987; Hermann et al., 1988; Kowalczyk, 1995; Quill, 1991).

Interviews. The second source of self-reported data involves interviews. Typically, actual quotes are used from interviewees' reported experiences about communication events and activities: For example, in a study by D. L. Beach (1993) involving 10 interviews with family caregivers, one woman indicated that to fulfill caregiver responsibilities, "You stop thinking about yourself. You spend your time thinking of the other person and what they need. You learn to fetch and carry a lot" (p. 39).

In a study of identity in cancer survivorship (Ott, 1999, p. 109), one participant reported that during chemotherapy, "Many family members called a lot, some too much. It was too hard to repeat the story over and over again." Eden, Black, and MacKinlay's study (1994) of communi-

cation with parents of children with cancer found that all 23 sets of parents interviewed reported deep shock and devastation upon learning of the illness, though 19 of the families "did not in retrospect wish that the information had been given in any different way" (p. 108). In a discussion with a clinical social worker, a cancer patient said, "I'm not very well educated and I don't understand some of the language used by my doctor when describing my cancer and treatment. I'm afraid to ask" (Farrow, Cash, & Simmons, 1990, p. 4).

These reports are responsive to interviewers' solicitations of information via diverse question formats. Findings also are shaped by interviewers' analyses of key moments within these reports, resulting in a reconstructed sense of social order based on the experiences of multiple informants. A focus on caregiving, for example, may emphasize what caregivers are thinking rather than how they rely on communication when enacting their caregiving tasks. Similarly, attention can be given to parents' retrospective wishes about receiving bad news regarding their child's cancer and not about the interactions involving these news reports. Or a patient's being "afraid to ask" about a physician's language rather than actual moments in medical interviews in which physicians use technical language and patients may (or may not) seek clarification.

An abundance of research relying on interview data exists in which researchers solicit and individuals respond to selected cancer-related topics. These studies provide insight into such issues as attitudes toward medical decision making (Blackball et al., 1995), the psychological as-

pects of caring for family members with cancer (Williamson & Schulz, 1995), suffering of family caregivers (Hinds, 1992), aspects of psychological coping (Wellisch, Hoffman, & Gritz, 1996), distress within families experiencing cancer (Schulz et al., 1996), remodeling of relationships after a diagnosis of serious illness (Lyons & Meade, 1995), changes in families and coping after a child's death of cancer (Martinson et al., 1994), and social work as a support system (Barnhart et al., 1994).

In one interview study, Robinson (1993) found that "normalization," or treating the patient as normal, is a strong reported theme and preference among patients and families coping with a chronic condition. The processes of normalization involve the construction of life stories, which inevitably are socially, and thus interactionally, enacted (see, also, Capps & Ochs, 1995), though they may be (and usually are) examined apart from the interactional environments in which they initially occurred.

In a unique application of participant observation, Perakyla (1991) provided rich insights into "hope work" in a hospital. Over time, as people were observed going about their business in hospital wards, copious field notes were generated and thorough descriptions of how people go about conveying hope were offered. In his reflexive conclusions, however, Perakyla emphasized that "hope work" is accomplished exclusively in and through conversation. He described such interactional involvements as accessed best by examining actual recordings, not by relying solely on his own observations, perceptions, and memories of the complexities of communication events.

In contrast, across numerous studies, interview and other field data are often mistaken for actual communication. What people "report" about reconstructed or imagined interactions is treated as synonymous with real-time communication events. For example, within the communication discipline, Gotcher and Edwards (1990) described their investigation as a study of "actual interaction," yet they acquired their data not through recordings of people interacting but through a survey and interviews revealing selected memories about interactions. Of course, implications about interactions can be drawn from analyzing interview data without examining the interactions themselves. For example, Gotcher (1993, p. 185) interviewed patients with breast or prostate cancer and concluded that

> "emotional support" was determined to be "highly valued" by families and most likely to decrease anxiety, guilt, hostility, and depression which are primary factors that compromise psycholog-

ical distress. ... If patient-family interactions can facilitate emotional support, and thereby decrease psychological problems, then patient-family interactions could enhance prognosis and ultimate survival.

Other research regarding interaction within families with a cancer patient also has relied on interview data, followed by coding, quantification, or both designed to understand content and themes better but not distinct interactional patterns (Bailey, 1985; Eden, Black, & MacKinlay, 1994; Gotcher, 1993; Northouse, 1994). A partial exception is a study by Weihs and Reiss (1996), who examined transcripts of a family conversing about the stresses they faced with cancer. However, because the recordings were made while a researcher was present, the resulting discourse was produced as an upshot of specific questions the interviewer asked. Content-analytic findings, such as "security of attachment" and "insecure relational processes," raise key implications for understanding family interactions but should not be mistaken for patterns co-enacted by family members outside of an interview format.

Surveys. A third source of predominantly used data involves surveys of participants (e.g., cancer patients and caregivers). Participants respond to varying measurement scales (e.g., paper and pencil), telephone interviews, or both shaped by predetermined questionnaire formats that trigger recall of previous scenes and patterns of communication. In Gotcher and Edwards's survey (1990) of cancer patients at a major cancer treatment center in the southern United States, 48 patients reported having imagined interactions with physicians, spouses, and family members. In another survey involving 102 patients receiving radiation therapy, Gotcher (1995) found that patients who adjusted effectively to their illness in seven areas (e.g., domestic environment, family relationships, social environment, and psychological distress) communicated more often and reported receiving more emotional support than did patients who did not adjust well to their illness. In a survey of communication between cancer patients and their spouses (Keller et al., 1996), approximately two-thirds of patients and their spouses reported talking about the illness "very often," and only 22% of the spouses and 11% of the patients reported difficulty in candidly discussing the illness.

Through surveys, then, these instances reveal how patients (and their spouses) reported having imagined interactions, communicating more often and receiving more emotional support, and talking about the illness in various ways. In each instance, access is (once again) not gained

to the events being reported on, but instead to triggered recollections about those activities.

A considerable body of quantitative, variable-analytic research has focused on cancer and families, relying predominantly on self-report data generated from measurement scaling instruments. These quantitative studies have examined the impact of illness-related demands on such variables as maternal depressive mood and opinions about marital quality (Lewis & Hammond, 1996), coping among parents of pediatric cancer patients (Shapiro & Shumaker, 1987), behavioral problems of siblings of children with cancer (Sloper & While, 1996), and family functioning as a resource variable (Fobair & Zabora, 1995). Attention also has been paid to assessments of adult cancer patients' orientations to support from family, friends, and health professionals (Rose, 1990), examination of coping variables within families (Friedrich et al., 1994; Hilton, 1994; Walsh-Burke, 1990), effects on rehabilitation of openness regarding illness within families (Mesters et al., 1997), "supportive communication as uncertainty management" (Ford, Babrow, & Stohl, 1996), family patterns of communication and a child's adjustment to cancer (Jospe, 1989), and adjustments among couples (Hoskins, 1995; Keller et al., 1996; Vess, Moreland, & Schwebel, 1985). Some researchers also have integrated methods, such as interview and questionnaire data, to solicit people's views from multiple perspectives (e.g., Jospe, 1989; Martinson et al., 1994; Miller, 1988; Scale, 1991; Walsh-Burke, 1990).

Taken together, these studies reconfirm that communication is considered to be among the fundamental needs of patients and families facing cancer (Shields et al., 1995). Similarly,

within the discipline of communication, scales and questionnaires have been used to conclude that matters of frequency, honesty, encouragement, and handling of troubling topics are central communicative issues (Gotcher, 1995) and that interaction with family members is central in "determining whether a patient had adjusted effectively" (Gotcher, 1992, p. 21). In these and related variable-analytic studies, communication is posited as centrally important for achieving such actions as moods, opinions, marital satisfaction, cohesiveness, expressiveness, and support. Overwhelmingly, communication is accessed through subjects' self-reported reactions and experiences, not by analyzing how family members coordinate their interactions in real time.

From the contrasting yet similar cancer experiences only sketched so far, communication is unequivocally the most important social resource when dealing with difficult predicaments related to cancer. However

suggestive and heuristic these self-reported findings might be, communication activities per se remain predominantly anecdotal, hypothetical, self-descriptive and expressive, or reconstructed. Reported interactions reveal important potential, including the ability to "facilitate emotional support" and thus "enhance prognosis and ultimate survival" (Gotcher, 1993, p. 185). Yet, family members' interactions, so fundamental to naturally occurring events, have not been explored systematically.

CONCLUSION

It is widely recognized that cancer is the most ubiquitous deadly disease in the world today (Kumar & Clark, 1990) and is the second leading cause of death in America (ACS, 2001). Three out of four families in the Western world are somehow affected (Biegel, Sales, & Schulz, 1991; Lichtman & Taylor, 1986), just as three quarters of American families are at some time affected by cancer (Bloom, 2000). From these statistics alone, the critical importance of communication throughout cancer diagnosis, treatment, and care is indisputable. In clinical settings and home or work environments alike, a wide array of interrelated communication involvements remain to be investigated: supporting, loving, being open and honest versus being withholding and deceptive, caregiving, describing alternative treatment options, explaining surgical (and other technical) procedures, managing uncertain and dreaded futures, assuaging others' fears, giving and receiving advice, talking about pain and comfort, articulating complex relationships between living and dying.

This review of the history of psychooncological research makes clear that researchers have tended to examine social activities by investigating individuals' perceived, interpreted, and reconstructed experiences. It is equally compelling that a unique opportunity now exists to integrate direct observations of recordings and transcriptions of naturally occurring events throughout cancer journeys. By bridging disciplinary expertise, priorities, and methodologies, it becomes possible to confront more fully how processes of communication influence the onset, progression, and remission of cancer.

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