Communication and Cancer? Part II: Conversation Analysis

Wayne A. Beach, PhD

Jennifer K. Anderson, MA

ABSTRACT. In Part I, the authors pointed out that despite the increasing focus on communication in psychosocial oncology, a comprehensive review of the literature revealed that the primary emphasis has been individuals' self-reported experiences rather than naturally occurring interactions between cancer patients, family members, and health professionals. Thus, an empirical foundation for understanding communication activities is in its infancy. In Part II, the authors provide all overview of "conversation analysis" as an alternative method for studying patterns of interaction during medical encounters and family interactions. Transcribed excerpts from ongoing research, focusing on how family members talk through cancer on the telephone, exemplify how "news delivery sequences" and "managing optimism" are crucial resources for understanding and dealing with cancer journeys. The authors conclude by discussing the need for discernment between self-report and interactional data, 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-HA WORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www. HaworthPress.corn> © 2003 by The Haworth Press, Inc. All rights reserved.]*

Dr. Beach is a Professor, School of Communication, San Diego State University, San Diego, CA 92182-4561 (E-mail: wbeach@mail.sdsu.edu). He also is an Adjunct Professor. Division of Surgery, and an Associate Member, Rebecca & John Moores Cancer Center, School of Medicine, University of California, San Diego. Ms. Anderson is Breast Cancer Patient Navigator, Chao Family Comprehensive Cancer Center, University of California at Irvine, Orange, CA.

The research was funded by Grant #ROG-98-172-01 from the American Cancer Society. The materials in Excerpts 1 through 5 are copyrighted by Dr. Beach.

Journal of Psychosocial Oncology. Vol. 21(4) 2003
http://www.haworthpress.com/web/JPO

Digital Object Identifier: 10.1300/J077v21n04 0l

KEYWORDS. Communication, psychosocial oncology, conversation analysis

Conversation analysis is a methodological alternative for closely examining the detailed and patterned organization of interactions in natural settings, including oncological involvements in both clinical and home environments. To exemplify the relevance of research on conversation analysis to cancer and families, we describe emerging findings from a research project funded by the American Cancer Society that focuses on conversations between family members facing a diagnosis of terminal cancer, treatment, and care (W. A. Beach, 2001a, 2001b, in press; W. A. Beach & Anderson, 2003; W. A. Beach & Lockwood, 2003; W. A. Beach & Mandelbaum, in press). Before doing so, however, we provide readers with an overview of basic assumptions concerning the methodology of conversation analysis and a summary of how research has tended to examine clinical encounters rather than family conversations.

METHODOLOGY

Two basic assumptions of research on conversation analysis-that data are naturally occurring and that interaction is designed sequentially-are elaborated in Box 1. Specific issues comprising the validity, reliability, and generalizability of conversation analytic findings are summarized in Box 2.

Studies of Communication in Clinical Encounters

Conversation analytic studies of medical interactions have focused almost exclusively on clinical and institutional encounters (see D. L. Beach, 1995; W. A. Beach & Dixson, 2001; Frankel, 1995; Heath, 1988; Jones, 1997; Maynard, 1992). Considerable attention has been given to talk *within* clinical encounters involving medical interviewers, therapists, patients, and family members (e.g., W. A. Beach & Dixson, 2001; W. A. Beach & LeBaron, 2002; Drew & Heritage, 1992; Gill & Maynard, in press; Heritage & Maynard, in press; Heritage & Stivers, 1999; Jones & W. A. Beach, in press; Kinnell & Maynard, 1996; Morris & Cheneil, 1995; Perakyla, 1993, 1995).

During medical interviews, recent, though comparatively few, studies have focused on how providers deliver and patients respond to both

 BOX 1. Basic Presuppositions of Conversation Analysis *Data Are Naturally Occurring Talk and Embodied Activities*

Conversation analysis involves the direct examination of recordings and transcriptions of naturally occurring verbal, nonverbal, and nonvocal communication activities-interactions that would be occurring whether or not a recording device was present **(W. A.** Beach, 1990a). Thus, data are not idealized or hypothetical constructions of communication; they are records of actual interactional involvements (see Atkinson & Heritage, 1984, pp. 2-5; Heritage, 1984, pp. 234-238).

Although systematic collection and analysis of interactional data are often complemented with intensive fieldwork, enacted to understand better how interaction is used in situ as a resource for participants as they collaborate in organizing natural environments, researchers' field observations, notes, or interviews are not treated as primary but as secondary data about interaction. The reason for giving priority to recorded and transcribed interactional data is straightforward: The detailed contingencies that make up interactional events, and, more generally, the circumstances addressed through speakers' actions, cannot be intuited, anticipated in advance, nor reconstructed fully after the occurrence of any given interaction or series of involvements. Such embedded temporal and spatial features are impossible to capture by means of self-reported information. Thus, researchers do not prompt either the commencement or content of the talk, nor do they need to be present during the interaction. Observations about interactional phenomena are anchored in contingently organized features of diverse ordinary conversations and institutional encounters involving bureaucratic representatives (e.g., in medical, legal, and corporate settings).

Interaction Is Organized Sequentially

During communication, participants continually reveal their orientations to and understandings of moment-by-moment interactional involvements. In the precise ways speakers construct and respond to turns-at-talk and related embodied actions (e.g., gaze, gesture, touch, and the use of objects), they demonstrate first for one another (and subsequently for analysts' inspections) their real-time and practical understandings of evolving conduct-in-interaction. Thus, exactly what gets achieved in communication is a result of how speakers construct and make available to one another their understandings of the local environment of which they are an integral part (see W. A. Beach, 1990a, 1990b; 1991, 1995; Jefferson, 1981; Sigman, 1995; Wootton, 1988).

A speaker's current turn at talk projects the relevance of a next turn because "talk amounts to actions" and "action projects relevance" (Schegloff, 1991, p. 46). Not just any response will normally suffice because prior speakers project the relevance of some (not just any) range of appropriate and next actions. The range of possible activities accomplished by the

second speaker display variations of "responsiveness" because talk is sensitive to "recipient design"actions revealing how speakers hear and orient to specific social actions comprising prior speakers' utterances. By describing and explaining the precise ways participants organize and thereby shape their interactions, evidence is therefore provided about the inherent consequentiality of communication. And because "context" is not treated as external to or removed from communication (see W. A. Beach, 1990b; Goodwin & Duranti, 1992; Mandelbaum, 1991) but is achieved through interaction, social actions are both context shaping as speakers tailor them to prior and immediate circumstances and context renewing as speakers contribute to evolving and subsequent actions.

BOX 2. Verification of Conversation Analytic Findings

Validity

Recordings and carefully produced transcriptions allow for examinations of actual communication-as noted, not idealized, hypothetically derived, or self-reported/reconstructed choices and actions "driven" by participants' motives, needs, or other observer-imposed phenomena (see Atkinson & Heritage, 1984, pp. 2-5; Heritage, 1984, pp. 234-238). No details of interaction are dismissed prematurely as disorderly, accidental, or irrelevant (Heritage, 1984), which allows for what is referred to as "unmotivated" analysis: As best possible, working to avoid predetermining what is meaningful in interactional data and to minimize bringing social problems "to" analysis but instead allowing such problems (and their possible resolutions) to *emerge* from systematic inspections of speakers' practices for organizing actual communication events and activities. Thus, in the ways that empirical findings are grounded within and exemplified through close inspections of interactional materials rather than through preselected categories or abstract assumptions about communication practices, one can understand conversation analysis as a science for discovering and verifying the social organization of everyday life.

Reliability

However random naturally occurring conversations and institutional interactions initially might appear to be, considerable evidence exists to support a central tenet of social interaction studies: There is "order at all points" (Sacks, 1992), much of which awaits examination by analysts, and all of which was produced in the first instance as meaningful and thus *in* meaningful ways by participants. Recordings and transcriptions of these real-time communication involvements allow for *repeated* re-hearings, re-viewings, and re-inspections of "actual and determinate" (Schegloff, 1986) social events and activities.

Although neither recordings nor transcriptions are conversations in and of themselves (W. A. Beach, 1990a; Zimmerman, 1988), they nevertheless preserve and embody the integrity and distinctiveness of many conversational activities. Moreover, as selected fragments of transcriptions are made available for readers' critical inspections, attention is drawn to specific details of actions rather than to glossed versions of what might or could have happened (i.e., idealized, intuited, or recollected data; see Atkinson & Heritage, 1984; Heritage, 1984).

It also is a central tenet of conversation analysis to make data available for public inspection: for example, to provide readers with the opportunity to agree or disagree with claims being advanced. Transcriptions are published with findings, and (when possible) recordings of the phenomena being investigated are disseminated for listening through dissemination of audio- and videorecordings. Most recently, various web sites can be accessed for listening to and inspecting digitized interactional materials.

Generalizability

Conversation analytic inquiry begins with a single case study to form a grounded basis for developing generalizable descriptions of communication phenomena (Schegloff, 1987; Hopper, 1989; see also, Pomerantz, 1990; **W. A.** Beach & Dixson, 2001). Once the foundation is laid with a single case, analysts use a procedure of "constant comparison" to examine how instances of communication reflect generalized actions and patterns across diverse settings and cultures (see Atkinson & Drew, 1979; Haakana, 2001; Mandelbaum,

1993; Maynard, 1990). The frequency of the communication event is not what is considered important; instead, the occurrence of the action is significant because it can indicate the same or similar patterns of communication occurring elsewhere (e.g., see **W. A.** Beach, 2001 b; Maynard, in press; Schegloff, 1968). Thus, conversation analysis closely examines both single cases and larger collections of recurring phenomena (Schegloff, 1991, 1996).

good and bad news about cancer (Lutfey & Maynard, 1998; Maynard & Frankel, in press). Limited attention also has been paid to how cancer patients provide explanations (Gill & Maynard, in press) and solicit diagnostic information (Jones & W. A. Beach, in press) from physicians who, in various ways, tend to resist patients' voluntary contributions. For example, Lutfey and Maynard (1998) analyzed how the same physician delivered bad news (allusively and indirectly) to three different patients in an oncology setting. Of relevance to our discussion in Part I about the predominance of self-reports, Lutfey and Maynard framed their inquiry by observing how prior research on illness, death, and dying "emphasizes abstract, internal experiences of individuals who confront mortal or chronic illness ... typifications and generalizations" (p. 1) that fall short of exposing communication problems emerging from allusive and indirect approaches to delivering bad news. The implications of their discussion emphasized a recurrent theme: How treating individuals as units of analysis essentially overlooks how illness processes become socially organized and embedded within communicative contexts.

Research on medical encounters, only briefly alluded to here, provides considerable insight into the construction and preservation of professional-lay relationships, most notably the asymmetries that distinctly characterize them. Such inquiries are unequivocally of central importance to comprehending the management of illness as a communicative achievement. However, comparatively little is known about how patients and families use and rely on communication in attempting to make sense of and deal with pervasive medical predicaments *outside* of the clinic in their home environments. This state of affairs can be summarized in near-paradoxical terms: The vast majority of time spent by ordinary people is outside of medical contexts and professional-lay relationships. Yet research has produced only minimal knowledge about how family members rely on interaction, informally and routinely, as a vehicle for making sense of illnesses by and for themselves. Thus, there is an urgent need to broaden the scope of research on communication about health beyond illnesscare settings and into home environments, including telephone conversations (see W. A. Beach, 1996; Heritage & Sorjonen, 1994; Rootman & Hershfield, 1994).

As Ira Byock (1997), president of the American Academy of Hospice and Palliative Medicine, observed (p. 35): "Dying cannot be reduced to a collection of diagnoses. For the individual and the family, the enormity and depth of this final transition dwarfs the myriad medical problems."

Selected studies of interactions among family members addressing health issues do exist. Attention has been given to problems associated with the pursuit and avoidance of bulimia (W. A. Beach, 1996), death announcements among friends and acquaintances (Holt, 1993), and dilemmas involved in giving and receiving unsolicited advice between British home health care nurses and first-time mothers (Heritage & Lindstrom, 1998; Heritage & Sefi, 1992; Heritage & Sorjonen, 1994).

For example, W. A. Beach's study (1996) involving family conversations about bulimia revealed that two predominant bodies of literatureon bulimia and on grandparent caregiving-situated family communication as the single best predictor of eating disorders and caregiving problems. However, "across nearly 300 reviewed sources ... not a single study was found that directly examined interactions between either family members expressing concerns about bulimia or grandparent-grandchildren conversations on any set of health-care topics" (p. 19). Regarding cancer, one crucially important implication raised in the conclusion of Beach's study of bulimia was that fundamental research needs to be done on how family members talk through the diagnosis and progression of terminal cancer.

HOW FAMILIES TALK THROUGH DIAGNOSIS AND TREATMENT

Because telephone calls are so prominent in everyday life, considerable attention has been given to their interactional organization (Schegloff, 1968, 1986; Hopper, 1992). However, access to naturally occurring recorded telephone calls involving families talking through cancer has only recently become a focus of investigation. To exemplify the applicability of conversation analysis as a methodological and theoretical alternative for researching communication and cancer, we provide a summary of emerging findings involving how family members, faced with a longitudinal and terminal diagnosis of a mother, wife, or sister, communicate about and essentially come to grips with the nature and consequences of cancer. Analysis reveals how family members dealing with cancer work through personal, professional, relational, and temporal quandaries interactionally. We focus specific attention on the interactional practices that family members use as they attempt to make sense of and somehow deal with the consequences of cancer.

Selected excerpts of data in the form of transcriptions from family members talking on the telephone are provided below for readers' inspection. (See Box 3 for the conventions of transcription.)

Data: The "Malignancy Telephone Calls"

The data for this study consisted of 54 local and long-distance telephone calls that were recorded and transcribed over a 13-month period. The length of the calls ranged from 10 seconds to 45 minutes (M = 10 minutes, 15 seconds). The number of turns totaled more than 18,000, and 25 people participated in the calls: a son, a mother, a father, a daughter, an aunt, a grandmother, a former wife, various friends, and service representatives).'

Beginning with the son's first call to his father, and throughout, the calls reveal the social and emotional impacts of terminal cancer not only on family members but also on selected friends, acquaintances, and service representatives as they deal with the uncertain, but often inevitable, trajectories of the cancer. All phone calls were recorded by the son at his home and, with the guarantee of anonymity, were subsequently submitted to the San Diego Conversation Library. The family granted permission to conduct research on these materials contingent upon delaying initiation of research on the calls for five years. When the present article was written, more than 10 years had transpired since the mother's death.

Two basic research questions have guided this ongoing study: What recurring and unavoidable communication problems arise? and What interactional patterns and resources are enacted when talking through the progression of cancer? To date, we have identified an array of inherent patterns and problems of communication when family members attempt to describe and understand being "caught up within" the diagnosis and treatment of cancer. Among a diverse array of communication phenomena, five prominent activities and their frequency are summarized as follows: 110 news delivery sequences, 187 expressions of uncertainty, 117 expressions of hope and optimism, 57 examples of "doctor" talk, and 38 expressions of assimilation and commiseration. Thus far, as noted previously, a series of publications addressing these patterns have been completed (W. A. Beach, 2001 a, 2001 b, 2002a, 2002b, 2002c, in press; W. A. Beach & Anderson, 2003; W. A. Beach & Good, 2004; W. A. Beach & Lockwood, 2003; W. A. Beach & Mandelbaum, in press).

Two brief overviews of the type of empirical analyses being conducted are summarized below. First, we examine how news delivery sequences are primary resources as family members simultaneously work

to offer "lay diagnoses" of what physicians and other medical staff have informed them about good and bad news regarding the mother's diagnosis and treatment and to disseminate updated information to loved ones, friends, and others. Second, we demonstrate how family members rely on hope and optimism as resources for dealing with bad and uncertain news about cancer.

News Delivery Sequences

Maynard (1997) showed how good or bad news delivery sequences are organized interactionally. Such sequences generally consist of four key actions:

TIE: Topic Initial Elicitor (e.g., HoWs things?)
ME Itemized News Inquiry (e.g., Is something up?)
I
1-~ Announcement 2 -4 Response 3-~ Elaboration 4->
Assessment

In Excerpt 1, J and L display shared, yet limited, knowledge about a third person apparently diagnosed with cancer (Maynard, 1997, p. 5):

I**J:INI -.**How **G Martin]**2L:1[a-a-a-] Well **she's (.)'l 0ut'v'll** hospit'l31 -+, *no [:w, I* 4J:2**[Is] [she]**5 L3[a]nd uh- you know it is: it is I thin:k ;i cancer6J:4 -tch (w)c:-:-o:-:1I

In response to J's specific inquiry about Gay Martin, L announces some good news (She's out of the hospital), and J responds in a mildly surprised manner ("Now"). Next, L elaborates (but in a nondefinitive manner) with some bad news ("I think cancer"), followed by J assessing the news with some sadness ("Well"). Notice that the speakers display limited familiarity with and concern about Gay Martin's condition: They mark the news as worthy to inquire, report, and only briefly comment on. Both speakers thus construct the news as events happening to someone else-events that are minimally consequential for their daily lives. By so doing, neither speaker claims ownership of the news as a person embroiled in the circumstances of the illness being reported. Thus, it is crucial to determine how relationships among speakers, as acquaintances or as *main consequential figures,* work together to shape the delivery and reception of news.

BOX 3. Transcription Symbols

The transcription notation system used for data segments is an adaptation of Gail Jefferson's work by Atkinson and Heritage (1984) and **W. A.** Beach (1989). The symbols can be described as follows:

Colon(s): Extended or stretched sound, syllable, or word. Underlining: Vocalic emphasis. Micropause: Brief pause of less than 0.2 seconds.
Timed Pause: Intervals occur within and between speaker's utterance.

Double parentheses: Scenic details.

Single parentheses: Transcriptionist's doubt. Period: Falling vocal pitch.

Question marks: Rising vocal pitch.

Arrows: Pitch resets; marked rising and falling shifts in intonation. Degree signs: A passage of talk noticeably softer than surrounding talk. Equal signs: Latching of contiguous utterances, with no interval or overlap. Brackets: Speech overlap.

Double brackets: Simultaneous speech orientations to prior turn. Exclamation points: Animated speech tone. Hyphens:

Halting, abrupt cut off of sound or word.
Less than/greater than signs: Portions of an utterance delivered at a pace noticeably faster (> <) or slower (< >) than surrounding talk.

CAPS: Extreme loudness compared with surrounding talk.
H's: Audible outbreaths, possibly laughter. The more h's, the longer the aspiration. Aspirations with periods indicate audible inbreaths.

H's within parentheses mark within-speech aspirations, possible laughter.

OKAY
hhh .hhh

ye(hh)s

pt Lip smack: Often preceding an inbreath.

hah, heh, hoh Lauqh syllable: Relative closed or open position of laughter $

Smile voice: Laughing/chuckling talk between markers.

In contrast to the nonconsequential example in Excerpt 1, W. A. Beach (in press) examines how a father and son delicately share ownership of a serious health condition at the outset of a family cancer journey. The opening moments of the first of 54 calls reveals how Dad informs Son, for the first time, that Mom's tumor has been diagnosed as malignant. This bad news is not announced immediately, however, as Dad and Son work together to delay and project the negative valence of forthcoming news, withhold personal and emotional reactions, and essentially enact a "biomedical" demeanor replete with technical language. Maynard (1997, in press) argued that consequential figures use *stoic* orientations routinely when managing and coping with dreaded news events, resources allowing for bad news to be presented and clarified before commiseration.

Consider Excerpt 2, in which Dad (D) treats Son's (S) "What's up?" as a direct solicitation to announce news about Mom:

I S: What's Q.

20 (0.6)

211a -+ I): pt(hh) They game ba:ek with thj hh needle -$_b$iopsy 22 results, or at least

in p ..

23 S: °Mm hm:

241h -. I):.hh The tum:or:: that is the:: uh adrenal gla:nd

25 tumor $_{tots}$ p itive.=lt is: malignant.

262-. S: okay?

27 1): =.hhh a::hh(m)=

282 -. S: =That's the one above her money?

After a pause (Line 20), Dad further delays the actual and eventual bad news ("malignant") (Lines 21, 22) by enacting a distinct biomedical demeanor. First, with "They came back. ..," he displays an orientation to what is often an impersonal medical process-waiting for laboratory results from anonymous staff and having no influence whatsoever on the outcome of testing procedures. These are troubling predicaments for patients and family members, not only because of the inherent uncertainties of results, but also because laboratory news is often delayed. Second, "needle biopsy results" invokes technical terminology report
ing what physicians have informed him but is not fully understood (which a fuller analysis of this phone call reveals). Third, "at least in part" (Line 22) marks the news as partial, inherently ambiguous, and consequently in need of future updating and refinement.

It is noteworthy that Son's next and quietly produced "Mm hm" (Line 23) invites a more complete description from Dad, yet Son noticeably withholds from speaking further in anticipation of forthcoming bad news. Dad then extends his delivery of news (Line 24) by specifying the tumor as not only a particular kind (adrenal gland) but perhaps as one of several being tested as well. And with his emphasized "tests positive" (Line 25), he first uses a medical and scientific description for what he states next in a more straightforward manner:

"It is malignant" (Line 25).

Of particular interest is how Dad, as a lay deliverer of bad news, relies on medical vernacular he no doubt heard some version of from physicians and perhaps from other medical staff. He also enacts what is understood stereotypically as an objective, somewhat removed, and technical demeanor of a medical professional. We do not mean to imply that Dad does not care or that physicians are insensitive; we mean that people often need to devise strategies for simply coping with and attempting to get through a delivery replete with technical (and one hopes correct) information. By not becoming overly emotional, Dad invites Son to receive the news stoically as well. With Son's "Okay? That's the one above her kidney?" (Lines 26, 28), Son accepts Dad's invitation to refrain from displaying emotion, a continued willingness to attend to technical details at the outset of hearing that Mom has been diagnosed with cancer.

At least initially, many who have heard this recorded moment consider it to be an odd response to just having heard about Mom's malignancy. Yet, in these recorded materials, and across social interaction in general (Maynard, 1997, in press), it is exceedingly normal to itemize details regarding bad news first before assessing and commiserating further about the impacts of the news. W. A. Beach (in press) has referred to these occurrences as "assimilating" and "owning" bad news, which is evident only minutes later as Dad and Son not only recognize but also audibly vent their feelings (e.g., a nightmare of not knowing).

Of course, the fact that neither Dad nor Son uses cancer as a descriptive term for Mom's diagnosis is significant. The avoidance of this term here (and throughout the communication) raises complex issues surrounding a key question: What relationships exist between naming an

illness and associated fears, denials, and postponements of coming to grips with potentially serious consequences of medical problems?

In a related article, W. A. Beach (2001 b) revealed that when family members act as if Mom would soon be dying, they display being caught up within uncertain illness trajectories. As they arrange and change travel plans (see W. A. Beach & Lockwood, 2003), they reveal themselves as implicated within emerging ambiguities occasioned by Mom's tenuous health status. When her health stabilizes, there is less need for urgent travel. Conversely, as news emerges that Mom's health is failing, crucial and immediate decisions are made to travel hone to be with her and the family. A delicate relationship thus exists between the stability/ instability of Mom's condition and how long-distance family members (especially Son) make decisions to travel home (or not).

For example, in three instances occurring across three phone calls over a two-day period, Son (S) delivered and updated news to his (recently) separated wife (G) about the stability of his mother's condition. As an upshot of previous informings, news updates about how Mom was doing are reconstructed from reports of other family members and health professionals. In Excerpt 3, one of these instances is drawn from the "malignancy" phone calls:

1 S:1 ...hhhh hhhh Well there's a po::ssibility I might

2 not be I wing now.

3 G:2 -. 'Why?'

4 **S:3 -.** pt Oh- hh.hh [Because-) [well?

6 S:3 - I L lQt Ding g , :: g but at least s:ta:bilized=an:d

7 of course I can only be gone; k ng,=So .hhh if it

8 looks like she's gonna (.) log in for another (0.2)

9 couple of wee:ks? then I'll wanna wait a couple of 10 weeks hut,=

1 1 G:4 . =Oh my $g(h)o[::d.$

In Line 1, prefaced with an extended sigh indicating his frustration, fatigue, or both, Son announces the possibility that his travel home may

be delayed or cancelled. In response to G's "Why?" in Line 3, and after her guess regarding whether or not his mother may "pull through," Son elaborates (Line 4) by clarifying for G that although his mother is not "pulling through," she is "stabilized." This relatively good news creates ambiguities for him, however, because how long Mom "hangs in there" will shape the duration of his waiting and thus subsequent travel plan! He must now discern, for example, how long he can be absent from work, when it might be best to visit with Mom, and how to assess her constantly changing health status during this phase of the cancer journey. In so doing, he reveals himself as a family member whose personal and professional decisions remain in flux, a quandary influenced by the inevitably uncertain trajectory of his mother's illness.

When G assesses Son's news with "Oh my god" (Line 11), she ac- complishes two related actions: Her own surprise about the seriousness of his mother's condition, but even more prominently, an appreciation for Son's dilemma. In this way, G momentarily displays identifying and "being with" him in this ambiguous time. Yet, it is the laughter in her *in*-vocation of "god" that exhibits more than a delicate orientation to his predicament-indeed, an orientation both lightening and distancing her- self from a trouble that ultimately affects his circumstances much more than her own (see W. A. Beach, 2001 b).

Clearly, this excerpt from the malignancy calls reveals how news about cancer gets produced collaboratively by deliverers and recipients of updated information. These interactions also provide unique opportunities to examine how closeness, distance, and social relationships are enacted as speakers demonstrate being affected variably by the new; To understand family cancer journeys thus requires examinations of such matters as dealing interactionally with the ongoing volatility of the diagnosis, how ambiguities get built as practical achievements, and the delicate balance between being with another while also marking distance as a figure less directly involved in and affected by the news.

Managing Optimism in Talk About Cancer

A related and recurrent set of communication activities involves how family members construct hopeful and optimistic responses to potentially despairing cancer circumstances (W. A. Beach, 2002b). Excerpt 4 represents excerpts from the first seven instances occurring in the ma-

G:2 -.

[°( )^{0} / pull t[hrough)?o

lignancy phone calls. These data, drawn from more than 100 instances, occurred within phone calls 1 and 2.

Dad: So hhh n:o:: I would hope by Monday or Tue:sday 1

Dad: hhh j3uu (0.2) she did have two nice things ha:ppen today. 1

Mom: *No* there's nothin to say. >You just-< .hh I'll- III wait to talk to Dr. Leedon today.= He's the cancer man, and = I

Mom: My only, - I mean- (.) my only, t ice. i

Son: Well where's our magic wand Mom. I

Mom: hh Is find a reason to keep fighting and () to keep being hopeful. 1

Son: See, [then] there's a small battle=

Mom: [()]

Son: ='That we've won.

Only three of these excerpts reveal hope or hopeful as being invoked directly. In these instances, hope/hopeful is invoked in contrasting ways: Dad's reference to medical procedures, a personal reflection on Mom's ill-fated circumstance, and her display of perseverance and tenacity. Yet, the other instances are related to hopeful and optimistic orientations in a broader way. For example, Dad lightens previous and serious discussion while Mom waits and relies on news from the "cancer man," Son invokes and Mom responds seriously to magic, and Son later attempts to edify and cheer up his mother in response to a story she initiates.

As a whole, these moments reveal "managing optimism" to be an ongoing and practical matter for family members. Consider, for example, the shift from bad to good news apparent in Excerpt 5 between Dad and Son:

*2*Dad:A:: yeah.hhh () j}V she seemed to be doing () >as I said<pt

hh at this point it was mostly (0.5) gQ,~ffmna€ion and resignation.3Son:[Mmhmm:.]4Dad:[Cause she] said,.bhh I just hurt too b ;W to be anything else5(0.2) >ya know.< It j to be som- (0.7) rs 3metbing drastic.6Son:Mmhm.7Dad:And she was really having some problems with pa:in today. She8had hh one and a half (0.2) odans< in her and it wasn't9hardly slowin' it down.10Son: --

_'Mmm wow.[0]11Dad:.hhh jj (0.2) she did have two nice thin& ha:ppen today. She12was on her way down and .hhh and was t kinda, d9pressed or13conn:ned I guess with having >to go down< for these needle14biopsies and Njll? showed up.

In this excerpt, Dad summarizes to Son what is essentially a bad news description of how Mom is doing. Notice that Dad's reconstruction escalates in its telling. His initial reference to confirmation and resignation (Line 2) is followed by a report of what Mom had said (she "hurts too bad"), which he concludes was "something drastic" (Line 5). By responding to both descriptions with "Mmhm," Son acknowledges but does not comment further on the serious nature of Dad's update. It is only after Dad's reporting of Mom's "problems with pain today," which even "percodans" were ineffective in slowing down (Lines 7-9), that Son's quietly uttered "Mmm wow" achieves two key actions: He assesses the news as troubling rather than simply acknowledging and soliciting Dad's continued description of prior events, and he neither comments further on nor invites Dad to elaborate additional bad news.

In Line 11, notice that Dad's immediate response to Son's noninvitational assessment is to withhold further reports of bad news. By shifting to "But she did have two nice things happen today," an obvious move from "bad to good news" is apparent. At that moment, Dad displays an understanding that the Son had heard enough about Mom's grievous circumstances. Although he eventually announces that "Will showed up" (Line 14) (an old friend of Mom's who unexpectedly

showed up for a visit), notice also that his reporting is preceded by a final description of bad news: Mom was "kinda, depressed or concerned" about having to experience needle biopsies (Lines 12-14).

From Excerpt 5, one can observe that Dad and Son collaborate in bringing closure to bad news, which provides an opportunity for Dad to move to good news by initiating a story about a visit from one of Mom's old friends. This instance provides insight into what Holt (1993), in her analysis of telephone calls in which death announcements are offered by speakers who are not particularly close to the deceased, described as "bright side sequences": There is a recurrent tendency to balance bad with good news in everyday life. In cases of

naturally occurring interactions examined thus far, this balance between bad and good news emerges throughout delicately managed moments of interactional involvement.

Excerpt 5 also can raise a series of central and complex questions: How are bad and good news interwoven? At what point does the delivery of bad news become excessive? How do recipients of bad news display interest and concern, yet also move to close down additional elaborations of bad news? Does good news always emerge as a remedial action for bad news? On what occasions does good news give rise to subsequent reports of bad news? In what ways does talk about cancer-related troubles reveal troubling talk as participants work together to deliver and receive updates about another person's cancer diagnosis and treatment? The answers to these questions, and considerably more questions, can be generated only from close inspections of how speakers interactionally organize their orientations to moments when cancer becomes the focus of attention.

CONCLUSION

Numerous possibilities emerge when diverse cancer researchers and professionals collaborate:

- What has often been considered to be "basic" and "applied" research can be reframed as inherently false distinctions. Thick descriptions of communication activities can lead to the identification of "best and worst" practices for talking about and through the circumstances of cancer. Therefore, describing and explaining communication practices in real time is fundamental to interventions
  focusing on the prescription of enhanced techniques for managing delicate moments and relationships that make up cancer care.
- Settings often studied separately-home, work, and clinical environments-can be examined simultaneously and more seamlessly as different but interrelated parts of a normal (i.e., trans-situational) cycle of cancer care.
- The goodness-of-fit (or lack thereof) between what people say about social relationships and how (or if) they actually engage in such activities when communicating with others (see W. A. Beach & Lindstrom, 1992; Maynard, 1988) can become a unified focus of investigation. Assessing what reports about cancer experiences adequately capture, and how such reports underspecify, real-time circumstances faced by families and health care professionals should be a matter of mutual concern for practitioners, social scientists, and family members undergoing the trials and tribulations of cancer.
- Just as practical benefits can be gained from understanding how individuals feel and think about cancer, so too are valuable insights generated when actual (recorded and transcribed) dilemmas of communication are examined closely. Attention needs to be given to building curricula that fully integrate both similarities and contrasts in reports and enactments of interactions about cancer. Such materials can promote refined resources for training, including the development of skills among oncology professionals and patients as well as family members.

Ultimately, the pragmatic value of conversation analytic assumptions and methods, only sketched here, will emerge as oncology professionals and researchers increasingly work together to examine recordings, transcriptions, and alternative forms of data (e.g., self-reports, surveys of patient satisfaction): How are specific communication practices crucially important for diagnosis, healing outcomes, and quality of life? What interactions would oncology professionals be interested in recording, transcribing, and analyzing? What possibilities exist for improving care? And how might educational programs and interventions be grounded in findings about the organization of ordinary communication encounters?

Answers to these questions would only begin to reveal the primal importance of communication for cancer care. There is unlimited potential in recognizing that whenever peoples' lives are touched by cancer, communication is omnipresent and thus omnirelevant.

NOTE

1. Family members included the son, father, mother, daughter, aunt, and grandmother. The calls also included an assortment of other conversations between the son and his ex-wife, the ex-wife's brother, representatives from various airlines (when the son sought flight information and reservations), an academic counseling office receptionist, a receptionist at an animal boarding kennel (when the son made and canceled reservations for his dog), a woman the son had begun dating, an old friend of the mother's from St. Louis, a graduate student who covered the son's classes during travel, and a variety of other calls involving routine daily occurrences (e.g., paying bills, leaving messages on answering machines).

REFERENCES

American Cancer Society (ACS). (2001). *Cancer facts &figures 2001.* Retrieved October 29, 2001, from http:www.cancer.org.

Atkinson, J. M., & Drew, P. (1979). *Order in court: The organisation of verbal interaction in judicial settings.* London: Macmillan.

Atkinson, J. M., & Heritage, J. (Eds.). (1984). *Structures of social action: Studies in conversation analysis.* London: Cambridge University Press.

Beach, D. L. (1995). Caregiver discourse: Perceptions of illness related dialogue. *Hospice Journal, 10,* 13-25.

Beach, W. A. (Ed.). (1989). Sequential organization of conversational activities [Special issue]. *Western Journal of Speech Communication, 53,* 85-246.

Beach, W. A. (1990a). Language as and in technology: Facilitating topic organization in a Videotex focus group meeting. In M. J. Medhurst, A. Gonzalez, & T. R. Peterson (Eds.), *Communication and the culture of technology (pp.* 197-220). Pullman: Washington State University Press.

Beach, W. A. (1990h). Orienting to the phenomenon. In J. Anderson (Ed.). *Communication yearbook 13* (pp. 216-244). Beverly Hills, CA: Sage Publications. Reprinted in F. L. Casmir (Ed.) (1994). *Building communication theories: A socio-cultural approach (pp.* 133-163). Hillsdale, NJ: Lawrence Erlbaum.

Beach, W. A. (1991). Avoiding ownership for alleged wrongdoings. *Research on Language and Social Interaction, 24,* 1-36.

Beach, W. A. (1995). Preserving and constraining options: "Okays" and 'official' priorities in medical interviews. In G. H. Morris & R. J. Cheneil (Eds.), *The talk of the clinic: Explorations in the analysis of medical and therapeutic discourse (pp.* 259-289). Hillsdale, NJ: Lawrence Erlbaum.

Beach, W. A. (1996). *Conversations about illness: Family preoccupations with bulimia.* Mahwah, NJ: Lawrence Erlbaum.

Beach, W. A. (2001 a). Introduction: Diagnosing lay diagnosis. *Text, 21,* 13-18. Beach, W. A. (2001b). Stability and ambiguity: Managing uncertain moments when updating news about Mom's cancer. *Text, 21,* 221-250.

Beach, W. A. (2002a). Between dad and son: Initiating, delivering, and assimilating had cancer news. *Health Communication,* 14, 271-299.

Beach, W. A. (2002b). Managing optimism in talk about cancer. In P. Glenn, C. LeBaron, & J. Mandelbaum (Eds.), *Studies in language and social interaction: In honor of Robert Hopper (pp.* 175-194). Mahwah, NJ: Lawrence Erlbaum.

Beach, W. A. (2002c). Phone openings, "gendered" talk, and conversations about illness. In P. Glenn, C. LeBaron, & J. Mandelbaum (Eds.), *Studies in language and social interaction: In honor of Robert Hopper (pp.* 573-588). Hillsdale, NJ: Lawrence Erlbaum.

Beach,, W. A. (In press). Understanding how family members talk through cancer. In B. Whaley (Ed.), *Advancements in communication theory & research.* Mahwah, NJ: Lawrence Erlbaum.

Beach, W. A., & Anderson. J. (2003). Communication and cancer`? Part I: The noticeable absence of interactional research. *Journal of Psychosocial Oncology, 21(3),* 1-23.

Beach, W. A., & Dixson, C. N. (2001). Revealing moments: Formulating understandings of adverse childhood experiences in a health appraisal interview. *Social Science & Medicine,* 52, 25-44.

Beach, W. A., & Good, J. S. (2004). Uncertain family trajectories: Interactional consequences of cancer diagnosis, treatment, and prognosis. *Journal of Social and Personal Relationships, 21,* 9-35.

Beach, W. A., & LeBaron, C. (2002). Body disclosures: Attending to personal problems and reported sexual abuse during a medical encounter. *Journal of Communication,* 52, 617-639.

Beach, W. A., & Lindstrom, A. K. (1992). Conversational universals and comparative theory: Turning to Swedish and American acknowledgement tokens-in-interaction. *Communication Theory, 2,* 24-49.

Beach, W. A., & Lockwood, L. (2003). Making the case for airline compassion fares: The serial organization of problem narratives during a family crisis. *Research on Language and Social Interaction, 36,* 351-393.

Beach, W. A., & Mandelbaum, J. "My mom had a stroke": Understanding how patients raise and providers respond to psychosocial concerns. (In press). In L. H. Harter, P. M. Japp, & C. M. Beck (Eds.), *Constructing our health: The implications of narrative jor enacting illness and wellness.* Mahwah, NJ: Lawrence Erlbaum.

Biegel, D. E., Sales, E.. & Schulz, R. (1991). *Family caregiving in chronic illness: Alzheimer's disease, cancer, heart disease, mental illness, and stroke.* Newbury Park, CA: Sage Publications.

Bloom, J. R. (2000). The role of family support in cancer control. In L. Baider, C. L. Cooper, & A. Kaplan De-Nour (Eds.), *Cancer and the family* (2nd ed., pp. 55-71). Chichester, UK: John Wiley & Sons.

Byock, 1. (1997). *Dying well: The prospect for growth at the end of life.* New York: Riverhead Books.

Drew. P., & Heritage, J. (1992). Analyzing talk at work: An introduction. In P. Drew & J. Heritage (Eds.), *Talk at work: Interactions in institutional settings (pp.* 3-65). Cambridge, England: Cambridge University Press.

Easter, D. E., & Beach, W. A. (In press). Competent patient care is dependent upon attending to empathic opportunities presented during interview sessions. *Current Surgery.*

Frankel, R. (1995). Some answers about questions in clinical interviews. In G. H. Morris & R. Cheneil (Eds.). *The talk of the clinic: Explorations in the analysis of medical and therapeutic discourse* (pp. 233-258). Hillsdale, NJ: Lawrence Erlbaum.

Gill, V. T., & Maynard, D. (In press). Patients' explanations for health problems and physicians' responsiveness in the medical interview. In J. Heritage & D. Maynard (Eds.), *Practicing medicine: Structure and process in primary care consultations.* Cambridge, UK: Cambridge University Press.

Goodwin, C., & Duranti, A. (1992). *Rethinking context: Language as an interactive phenomenon.* Cambridge, UK: Cambridge University Press.

Haakana, M. (2001). Laughter as a patient's resource: Dealing with delicate aspects of medical interaction. *Text, 21,* 187-220.

Heath, C. (1988). Embarrassment and interactional organization. In P. Drew & A. Wootton (Eds.). *Erving Goffrnan: Exploring the interaction order* (pp. 136-160). Boston: Northeastern University Press.

Heritage, J. (1984). A change-of-state token and aspects of its sequential placement. In J. M. Atkinson & J. Heritage (Eds.), *Structures of social action: Studies in conversation analysis* (pp. 229-345). Cambridge, UK: Cambridge University Press.

Heritage. J., & Lindstrom, A. (1998). Motherhood, medicine, and morality: Scenes from a medical encounter. *Research on Language and Social Interaction, 31.* 397- 438.

Heritage, J., & Maynard, D. (Eds.) (In press). *Practicing medicine: Structure and pro cess in primary care consultations.* Cambridge, UK: Cambridge University Press.

Heritage, J., & Sefi, S. (1992). Dilemmas of advice: Aspects of the delivery and reception of advice in interactions between health visitors and first-time mothers. In P. Drew & J. Heritage (Eds.), *Talk at work: Interaction in institutional settings* (pp. 359-417). Cambridge, UK: Cambridge University Press.

Heritage, J., & Sorjonen, M. L. (1994). Constituting and maintaining activities across sequences: And-prefacing as a feature of question design. *Language in Society, 23,* 1-29.

Heritage, J., & Stivers, T. (1999). Online commentary in acute medical visits: A method of shaping patient expectations. *Social Science and Medicine, 49,1501-1517.* Holt, E. (1993). The structure of death announcements: Looking on the bright side of death. *Text, 13,* 189-212.

Hopper, R. (1989). Speech in telephone openings: Emergent interaction v. routines. *Western Journal of Speech Communication, 53,* 240 -252.

Hopper, R. (1992). *Telephone conversation.* Bloomington: Indiana University Press. Jefferson, G. (1981). *Caveat speaker: A preliminary exploration of shift implicative recipiency in the articulation of topic.* Final Report, Social Science Research Council, The Netherlands (mimeographed).

Jones, C. M. (1997). "That's a good sign": Encouraging assessments as a form of social support in medically related encounters. *Health Communication, 9,* 119-153.

Jones, C. M., & Beach, W. A. (In press). Patients' attempts and doctors' responses to premature solicitation of diagnostic information. In M. Maxwell (Ed.), *Diagnosis as a cultural practice.* New York: Mouton de Gruyter.

Kinnell, A. M. K., & Maynard, D. W. (1996). The delivery and receipt of safer sex advice in pretest counseling sessions for HIV and AIDS. *Journal of Contemporary Ethnography,* 24, 405-437.

Kumar, P. J., & Clark, M. L. (1990). *Clinical medicine.* London: Bailliere Tindall.

Lichtman, R. R., & Taylor, S. E. (1986). Close relationships and the female cancer patient. In B. L. Andersen (Ed.), *Women with cancer: Psychological perspectives* (pp. 233-256). New York: Springer-Verlag.

Lutfey, K., & Maynard, D. W. (1998). Bad news in oncology: How physician and patient talk about death and dying without using those words. *Social Psychology Quarterly,* 61, 321-341.

Mandelbaum, J. (1991). Conversational noncooperation: An exploration of disattended complaints. *Research on Language and Social Interaction,* 25, 97-138.

Mandelbaum, J. (1993). Assigning responsibility in conversational storytelling: The interactional construction of reality. *Text, 13,* 247-266.

Maynard, D. W. (1988). Language, interaction, and social problems. *Social Problems.* 35, 311-334.

Maynard, D. W. (1992). On co-implicating recipients in the delivery of diagnostic news. In P. Drew & J. Heritage (Eds.) *Talk at work: Interactions in institutional settings* (pp. 331-358). Cambridge, UK: Cambridge University Press.

Maynard, D. W. (1997). The news delivery sequence: Bad news and good news in con versational interaction. *Research on Language and Social Interaction, 30,* 93-130.

Maynard, D. W. (In press). *Bad news & good news in everyday life: Sociological and clinical implications.* Chicago: Chicago University Press.

Maynard, D. W., & Frankel, R. M. (In press). On the edge of rationality in primary care medicine: Bad news, good news, and uncertainty. In J. Heritage & D. W. Maynard (Eds.), *Practicing medicine: Structure and process in primary care encounters.* Cambridge, UK: Cambridge University Press.

Morris, G. H., & Cheneil, R. J. (Eds). (1995). *The talk of the clinic: Explorations in the analysis of medical and therapeutic discourse* (pp. 259-289). Hillsdale, NJ: Lawrence Erlbaum.

Perakyla, A. (1993). Invoking a hostile world: Discussing the patient's future in AIDS counseling. *Text, 13,* 302-338.

Perakyla, A. (1995). *AIDS counselling: Institutional interaction and clinical practice* Cambridge, UK: Cambridge University Press.

Pomerantz, A. (1990). Conversation analytic claims. *Communication Monographs, 57* 231-249.

Rootman, I., & Hershfield, L. (1994). Health communication research: Broadening the scope. *Health Communication, 6(1),* 69-72.

Sacks, H. (1992). *Lectures on conversation.* Blackwell, UK: Oxford University Press.

Schegloff. E. A. (1968). Sequencing in conversational openings. *American Anthropolo gist, 70,* 1075-1095.

Schegloff, E. A. (1986). The routine as achievement. *Human Studies, 9,* 111-152.

Schegloff, E. A. (1991). Reflections on talk and social structure. In D. Boden & D. H Zimnierman (Eds.), *Talk and social structure* (pp. 44 -70). Cambridge, UK: Polit, Press.

Schegloff, E. A. (1996). Confirming allusions: Toward an empirical account of action *American Journal of Sociology, 102,* 161-216.

Sigman, S. J. (Ed.). (1995). *The consequentiality of communication.* Hillsdale, NJ: Law rence Erlbaum.

Stevenson, B. S. *(1985).* Cancer in the family: Roles of the clergy. *The Christian Century, 102,419-421.*

Wootton, A. J. *(1988).* Remarks on the methodology of conversation analysis. In D. Roger & P. Bull (Eds.), *Conversation' An interdisciplinary perspective (pp. 238-258).* Clevedon, UK: Multilingual Matters.

Zimmerman, D. H. *(1988).* On conversation: The conversation analytic perspective. In J. A. Anderson (Ed.), *Communication yearbook I I (pp. 406-432).* Newbury Park, CA: Sage Publications.

Received: October 20, 2001

Revised: February 20, 2002

Accepted: July 28, 2002