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PAPER

Experiences of "openness" between mothers and daughters during breast cancer: implications for coping and healthy outcomes

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Abstract

Objective Mother-daughter communication is central to how women adjust to breast cancer. They may be aided by models of healthy communication that illustrate both women's perspectives. Families establish normative communication patterns that inform how they cope. We used family communication patterns theory to examine correlations between openness/avoidance and health. We extended this by capturing mother-daughter open/avoidant narratives to illustrate how these behaviors function in helpful (health-promoting) and unhelpful ways.

Methods Phase 1 of this mixed-method study involved 41 patients and 37 mothers/daughters (N = 78) completing surveys on mother-daughter openness, avoidant coping, and quality of life. Phase 2 involved interviews with 40 patients and 38 mothers/daughters (N = 78) to ascertain what diagnosed women share (or do not share) with their mother/daughter and their reasons.

Results Diagnosed women reporting more open mother-daughter bonds had better relational health (r = .730, P < .001). Those who engaged in more avoidant coping reported poorer physical health (r = −.431, P = .01). Mothers and daughters talked about treatment side effects and procedures, disease risk and prevention, and medical decisions. They avoided discussions about distressing emotions and topics as well as uncertainty about the future. Motivations to disclose/avoid centered on protecting themselves and/or their mother/daughter. Qualitative findings illustrate the tension between openness and avoidance. Developmental differences and relational role perspectives illustrate women's diverse needs.

Conclusions A history of openness is linked with relational health, but coping is not as simple as "be open." Both openness/avoidance are helpful and unhelpful depending on age, topic, and responses.

KEYWORDS

avoidance, breast cancer, coping, family communication, oncology, openness

1 | BACKGROUND

When coping with cancer, resilience and healthy outcomes are partly a function of families' ability to communicate in supportive, health-promoting (adaptive) ways.[1] This communication competence may not come naturally, and what may work in a health-promoting manner for 1 relationship (or even 1 partner) may not function in the same way for another individual or in a different bond. Evidence-based interventions are needed that are more tailored to specific family relational contexts.

For women diagnosed with breast cancer, their mother-daughter bond can be a critical part of their coping experience. Yet their interactions may not always be health promoting or helpful to their cancer adjustment.[2–6] Mothers with breast cancer are uncertain about how much to disclose to their daughters (and when or how),[2,4] which may in turn limit daughters' ability to support their mothers. Helping

mothers and daughters communicate well is particularly vital, for they tend to mirror one another's adjustment.[5] Diagnosed women's and their daughters' psychological distress is highly correlated.[6] For example, when diagnosed women have symptoms of PTSD, their daughters are more likely to as well.[7] Diagnosed mother's psychological distress is also related to daughters' psychological functioning, immune status, and hormone secretion.[6] Moreover, daughters of diagnosed women are affected psychologically and physically in ways that could increase their breast cancer risk. They exhibit higher levels of stress hormones and more emotional distress (anxiety, depression, somatization, and perceived level of stress) in comparison with daughters whose mothers do not have a breast cancer history.[8] And when their mothers have a more advanced stage of the disease, daughters have higher stress hormone secretion.[6] These daughters spent more time with their mothers and had more caregiving burden.[6] How mothers and daughters communicatively cope with breast cancer and risk across the cancer trajectory and into survivorship undoubtedly plays a role in how they are both faring psychologically and physically.

The centrality of mother-daughter communication to healthy or adaptive coping suggests that models of health-promoting mother-daughter interaction[4,9] would be valuable during illness experiences. Much of the cancer coping research looks at communication in general or in the moment (are they talking about it or not). It is also important to reflect on communication norms that characterize a relational history. Mothers' and daughters' normative way of communicating will play a role in how they communicate through cancer. To do so, the present study uses a family communication theoretical lens to explore how established mother-daughter communication patterns of openness affect women's health. We also explore the effect of avoidant coping on their health outcomes. At the same time, it is important to understand openness/avoidance more comprehensibly and capture the communication process more ecologically (as opposed to only examining whether talk predicts certain health outcomes). Thus, we also explore mothers' and daughters' experiences of openness and avoidance as they attempt to cope with breast cancer together. Our overarching aim of the study was to produce knowledge suitable for intervention making and reinforce the need for relationship-tailored interventions, bringing the family's voice to the forefront in ways that can enhance mother-daughter communication during breast cancer.

2 | FAMILY COMMUNICATION PATTERNS THEORY: LINKING OPENNESS AND HEALTHY COPING

Open and avoidant communication patterns are often juxtaposed in scholarship, with open communication typically referring to disclosing feelings, experiences, or information and avoidant communication conceptualized as evading talk or keeping things to oneself. Norms of open communication are typically associated with healthier outcomes both in the context of cancer coping and other health crises, such as reduced depression and stress.[10–12] Avoidance is more often associated with unhealthy outcomes, including poorer relationship functioning, distress, and compromised physical health.[11,13–17]

Although much of the literature focuses on how families talk about (or do not talk about) cancer in the moment, their normative way of communicating is also of concern. According to family communication patterns theory (FCPT), families develop norms (patterns) of communication across their relational history that includes an established pattern or degree of openness.[18] This normative pattern of communication informs members' expectations of one another's behavior across their relational life span. Essentially, these family communication patterns direct members' behavioral responses in everyday moments as well as stressful experiences. Per FCPT, a particularly important communicative norm reflects a family's "conversation orientation"—the degree to which a family fosters openness. Families considered high on this dimension participate in unrestrained interaction about a wide array of topics.

This established pattern of communication will influence how families respond to stressful experiences. However, the recognition of a family's norms and expectations as to how to communicate has received little attention in understanding how cancer patients cope. Notably, FCPT does not propose a single ideal form of communication but recognizes that "different families function well by employing different types of behavior" (p. 61).[18] This important theoretical assumption is contrary to other (and sometimes more dominant) ways of thinking about health and family communication—perspectives that emphasize simplistic conceptualizations and interpretations of openness.

FCPT has the potential to provide insight into how openness is more multidimensional and might function in both healthy and unhealthy ways with respect to coping. This is particularly important given research on family interaction, health, and intimacy indicates that openness, avoidance, and privacy are all potentially beneficial[19,20] and not all families benefit from openness.[21] Although some families who talk frequently report less difficulty coping,[22] others indicate only small effects or suggest openness or avoidance effects the partner and not the patient.[23,24] In sum, neither openness nor avoidance is inherently a good or bad coping mechanism, and how families are accustomed to communicating may play a role. Thus, we ask,

RQ1. After a breast cancer diagnosis, what health implications for diagnosed women and their mother/daughter are associated with openness and avoidance?

3 | THE QUALITY (AND HEALTH-PROMOTING POTENTIAL) OF MOTHER-DAUGHTER OPENNESS/AVOIDANCE

In addition to linking open and avoidant coping with health outcomes, as Goldsmith and Miller[25] note, if we are to provide guidance to families coping with cancer on talking about cancer, "we need to know what they should talk about and how." In their research, they identified that renowned cancer resources commonly advocate for open communication. The American Cancer Society advocates for patients to directly express feelings and needs. Similarly, Susan G. Komen for the Cure encourages openness to prevent relational turbulence or to not

inhibit closeness. However, advice on how to talk about experiences is missing. Research on actual "communication activities" or the process of being open (or not) and how families perceive it affects their ability to cope is less available.[26] Goldsmith and Miller found that cancer talk covers a broad spectrum of issues for couples, and these topics may vary in other familial bonds. Some topics are more challenging than others and perspectives may vary. They found that dominant measurements of openness in research do not fully appreciate how "openness, frequency, difficulty, topical focus, and disagreement are conceptually distinct facets of how couples talk." A qualitative, narrative approach to capturing openness and avoidance is an optimal step in capturing knowledge that can build off scholarship that shows connections between health outcomes and communication (our first focus) by also providing knowledge that can be used to guide mothers and daughters on how to facilitate these conversations.

Being open versus being closed (or avoidant) are complicated communication patterns, especially within the midst of coping with health crises like cancer. Relational dynamics of openness/closedness vary with each family bond and, therefore, affect the nature of cancer coping. In general, the mother-daughter bond is characterized by a tension between openness and avoidance across the entirety of their relationship. This intergenerational struggle begins as early as a daughter's adolescence and extends across their relational trajectory. They want to be there for each other and involved in each other's lives but also struggle with how to do so in ways that respect each other's privacy, independence, and individual needs. This dialectical tension between openness and closedness is influenced by variant generational needs or preferences, relational role differences, and societal expectations of what it means to be a mother or a daughter.[27].

Likewise, in the context of coping with breast cancer, mothers and daughters describe wanting to be there for one another after a diagnosis but also struggle with how to do so in a way that is health promoting or enhances their ability to cope.[3–6] In particular, mothers and daughters express uncertainty with how to cope together in ways that are not burdensome. Although being open is certainly connected to better health outcomes, simply instructing mothers/daughters to "talk openly" about cancer-related experiences and feelings does not appreciate diverse family norms or contextual factors that complicate interactions. Capturing the setting in which communication is enacted allows an ecological approach to understanding behavior and illness[28,29] and recognizes that "effective communication must be adapted to a *situation* to overcome constraints and obstacles" (p. 23).[30] Moreover, this approach to scholarship allows for the extraction of rich narrative accounts from the family's voice—stories that are ideal for intervention making focused on behavioral modeling or teaching healthy communicative behaviors.

Three contextual factors (topic, motivation, and age) may shed light on how mother-daughter openness/avoidance is perceived as both helpful or unhelpful when adjusting to breast cancer.[30] Mothers and daughters have various motives for sharing or not, which may affect whether the behavior is adaptive or not (and differ for each relational partner). Further, in light of developmental influences on goals and appraisals of behavior, the health-enhancing potential of a given behavior may be linked to mothers' and daughters' placement in the life span. Thus, to expand on RQ1, we sought to not only link openness/avoidance with health outcomes but also have mothers/daughters describe, from their perspectives, the quality of these interactions. We sought to understand, from mother's and daughters' viewpoints, how openness and avoidance affects their coping experiences in both helpful and unhelpful ways. In light of previous research, we paid close attention to factors that likely affect the health promotion potential of openness/avoidance such as the topic, reason for disclosing, and women's developmental place in the life cycle. We also sought the perspective of both diagnosed women (patients) and their mother or daughter. We ask,

RQ2. What breast cancer-related topics do diagnosed women share with mothers/daughters?

RQ3. What breast cancer-related topics do diagnosed women avoid talking about with mothers/daughters?

RQ4. What motivates their open and avoidant behavior?

4 | METHODS

The study reported is part of a larger mixed-method study. Phase 1 was a survey design based on self report data to investigate RQ1. Phase 2 extended these results with interview data to answer RQs 2–4.

4.1 | Participants

Women diagnosed with breast cancer receiving treatment within 36 months and their mother/daughter participated. IRB approvals were obtained from a university and hospital in the United States. Recruitment flyers were distributed via a university database, waiting rooms, support groups, and practitioners. Participants received $25. Most women completing Phase 1 participated in Phase 2. Demographics are provided for each data set.

For Phase 1, 78 women participated (41 diagnosed; 37 mothers/daughters). Patients were in young, middle, or later adulthood. Only 39 diagnosed women provided demographic information: 9 young adults (mean age = 34.63, SD = 3.34, range 30–39), 18 middle-aged adults (mean age = 48.16, SD = 3.11, range 42–52), and 12 later-life adults (mean age = 61.92, SD = 4.48, range 57–69). Nearly 30% were in treatment, 37.5% had treatment within 12 months, and 35% had treatment within 12–36 months. Also, 41% were diagnosed in stages 0 or I, 27.5% in stage II, 25% in stage III, and 5% in stage IV. Four were experiencing a recurrence. Thirty-seven of their mothers/daughters participated (N = 37, 12 mothers and 25 daughters; mean age = 38.8, SD = 20.35).

Thirty-five dyads (N = 78, 40 patients and 38 mothers/daughters) participated in Phase 2. Three had an additional daughter participate. Five diagnosed women participated alone. Eight patients were young adults (all daughters: mean age = 34.62, SD = 3.34, range 30–39), 20 middle-aged adults (13 mothers: mean age = 49.42, SD = 2.50, range 44–52; 7 daughters: mean age = 46.00, SD = 3.00, range 42–51), and 12 later-life adults (all mothers: mean age = 61.92, SD = 4.48, range 57–69). Patients' mothers/daughters included 25 emerging or

young adults (all daughters: mean age = 24.74, SD = 6.94, range 18–37), 5 middle-aged adults (4 mothers, 1 daughter: mean age = 54.00, SD = 2.35, range 51–56), and 8 later-life adults (all mothers: mean age = 69.86, SD = 7.59, range 58–83).

The majority were Caucasian (98.7%), 85.3% lived on the East Coast, and half had annual incomes less than $70,000. Half were married, 20% single, and 30% separated, divorced, or widowed. Half worked full time, 21.3% part time, 16% did not work, and 17.3% were students. Most had a college-level education or college credit.

4.2 | Phase 1 measures/analysis

To investigate links among communication and health, participants completed scales measuring mother-daughter openness, avoidant coping, and quality of life.

4.2.1 | Mother-daughter openness

The conversation orientation subscale (15 items) of the Revised Family Communication Pattern (RFCP) measure[31] assessed openness between mothers and daughters. Women indicated agreement (1 strongly disagree to 5 strongly agree) with statements such as, "I can tell my mother almost anything." Items were averaged; higher scores indicated more openness (mean = 3.86, SD = 0.74). Internal reliability was high (α = .90).

4.2.2 | Avoidant coping

Avoidant coping (in general) during cancer was assessed using the Impact of Event Scale (IES), which measures avoidance[32] via items such as "I tried not to talk about it." Participants indicated agreement on a 5-point scale: 0 (not at all) to 4 (extremely). Higher scores indicated greater engagement in avoidance. Reliability was acceptable (α = .71, mean = 1.39, SD = 1.01).

4.2.3 | Distress

The IES was also used to evaluate distress, in the form of intrusive thoughts.[33] Items measuring distress included "I thought about it when I didn't mean to." Higher scores indicated greater distress. Reliability was acceptable (α = .73, mean = 1.45, SD = 0.98).

4.2.4 | Relational satisfaction

The 11-item Marital Opinion Questionnaire (MOQ) was modified to measure relational satisfaction among mothers/daughters.[34] This scale has been successfully adjusted and used in other family relationships, including parent–child bonds.[35] Ten items use 7-point semantic differentials (eg, from miserable to enjoyable). One additional item measures overall relational satisfaction. The mean score was 5.97 (SD = 0.91). The measure demonstrated good reliability (α = .93).

4.2.5 | Physical well-being

The subscale for physical health from the Functional Assessment of Cancer Therapy–Breast (FACT-B) assessed the effect of cancer on physical well-being. Only diagnosed women completed this measure. They indicated agreement on a 4-point scale for items such as "I have pain" (0, not at all, to 4, very much). Items were reverse coded; higher scores indicated better physical well-being or lower degree of effect. Overall, participants reported good physical health (mean = 3.34, SD = 0.61). The scale was reliable (α = .81).

4.3 | Phase 2 measures/analysis

All 78 women were interviewed using a retrospective, life span technique in a laboratory or via phone. Interviews lasted approximately 90 min (range 30–180 min). Women described what was shared (or not) about cancer, why, and the effect of these decisions. Transcribed interviews resulted in 2434 single-spaced pages. Data were analyzed using well-known constant-comparative method procedures, criteria for thematic salience, and verification techniques.

5 | PHASE 1 RESULTS

Pearson's *r* correlations were computed using SPSS 23.0 to assess relationships between mother-daughter openness (RFCP) and avoidant coping (IES—avoidance) and 3 self-reported health outcomes: (1) relational health (MOQ), (2) psychological well-being (IES—intrusion), and (3) and physical health (FACT-B). Diagnosed women with high levels of mother-daughter openness reported better relational health (r = .730, P < .001) (see Table 1). Diagnosed women who engaged in more avoidant coping also reported poorer physical health (r = −.431, P < .01). Analyses revealed no significant associations for the mother/daughter of diagnosed women (see Table 2).

6 | PHASE 2 RESULTS

Emergent themes (for each inquiry) help illustrate how openness/avoidance enhance or inhibit mother-daughter coping. Women's descriptions demonstrate various degrees of openness/avoidance as well as how these behaviors may function differently depending on the relational partner's role (mother versus daughter; patient versus healthy partner) as well as their developmental place in the life cycle (or generational cohort).

6.1 | RQ 2: openly shared experiences

6.1.1 | Treatment side effects and procedures

Diagnosed women commonly shared with their mothers and daughters treatment side effects and information about procedures associated with scans or treatments. Women focused most on physical experiences versus emotional ones. This was particularly true of diagnosed mothers who "downplayed" experiences to avoid scaring daughters. Such disclosures often functioned adaptively allowing women to stay informed about how their mother/daughter was doing. Disclosures about physical changes were sometimes challenging. One daughter explained:

> I saw every aspect of her side effects and it was not too fun. She had drainage pipes on the side and the fact that were constantly pulling and it's like—no, it's not right. Something shouldn't be coming out of your body from inside like that—[It] has to hurt. So it's seeing that and realizing how much pain she actually

TABLE 1 Correlations between variables for participants diagnosed with breast cancer

	1	2	3	4
1. Mother-daughter openness (RFCP—conversation orientation)				
2. Avoidant coping (IES—avoidance)	.025			
3. Relational health (MOQ)	.730***	.079		
4. Psychological well-being (IES—intrusion)	−.047	.499**	−.154	
5. Physical health (FACT-B)	.095	−.431*	.161	−.626***

All tests are 2-tailed.

*$P < .05$.

**$P < .01$.

***$P < .001$.

TABLE 2 Correlations between variables for mothers/daughters of participants diagnosed with breast cancer

	1	2	3
1. Mother-daughter openness (RFCP—conversation orientation)			
2. Avoidant coping (IES—avoidance)	.087		
3. Relational health (MOQ)	.346†	−.323††	
4. Psychological well-being (IES—intrusion)	.230	.284	.098

All tests are 2-tailed; $n = 32$ s.

†$P = .052$.

††$P = .072$.

> is in made me realize, all right, I guess I got to be a little bit more receptive to this than I am.

Diagnosed women (particularly older generations) rarely shared emotional aspects of treatment. One daughter said her mother only shared physical effects of chemotherapy, although her father confided that her mother was experiencing depression. Although rare, diagnosed women who disclosed emotions were in young adulthood and typically shared feelings about hair loss, weight gain, and fears regarding infertility.

6.1.2 | Disease risk and prevention

Having cancer seemed to propel daughters and mothers to openly talk about family medical history and risk, often for the first time and for the most part with general ease. For diagnosed young-adult daughters, the pros/cons of genetic testing were also discussed. Diagnosed women who were mothers were especially concerned about daughters' risk. Although mothers were not inhibited to engage in conversations about treatment side effects/procedures, they reported tempering the delivery of such information as not to "preach" but instead to "drop hints." Although most women engaged this topical domain fairly easily, daughters in their teens or early 20s often withdrew and avoided talk about their own risk, a point we address further in the Discussion section. Yet daughters in their late 20s–40s expressed interest (sometimes *urgent* interest) in prevention, which facilitated openness and served, they recognized, to ease their mothers' minds. As one daughter said, "I think it made her feel better knowing that we were going to [get a mammogram]."Although many daughters were open to discussing prevention, they also felt guilty for being concerned with themselves. One daughter explained,

> [My mom] told me I better always go get mammograms and she didn't go. She skipped a year and the lump could probably have been caught earlier. So she said she'd never do that again and that I should go. But she's also said that most people's breast cancer isn't hereditary. … It made me feel a little bit better but then it made me feel bad that I was worried about myself getting it when she actually had it.

Mothers also experienced emotional guilt that their daughters had to be concerned about cancer.

6.1.3 | Medical decisions

Only diagnosed daughters described sharing medical decisions. Decisions included whether to have a mastectomy, reconstruction, and treatment options. These were not necessarily interactive disclosures. Typically, daughters provided information *after* they had made the decision. As 1 daughter stated,

> It's more reflecting on test results. Because any decision like with my mastectomies or anything that I have done has pretty much been my decision and my husband's—us talking together and stuff. I think anything I've shared with her has been just to tell "This is what I've done. This is what I'm going to do."

Mothers often recognized these were personal decisions for their daughter and did not offer an opinion. When a mother *did* offer her opinion or became emotional, it sometimes led to a daughter becoming less open. As 1 daughter explained, "She said, 'You should not have that. You should not have radiation.' … That's why I didn't discuss with her because she couldn't just objectively talk. She just got emotional right away."

6.2 | RQ 3: not shared (or avoided) experiences

6.2.1 | Distressing emotions and topics

Diagnosed daughters and mothers described avoiding distressing topics, particularly negative emotions (eg, sadness, fear). As 1 woman said, "I tried not to get really upset. … I have to turn my emotions on and off."Concerns about body image and sexuality

were particularly distressing topics that women avoided discussing. Women described struggling with changes in their breasts after mastectomy and/or reconstruction. Sometimes these concerns also affected sexual health. One young-adult diagnosed woman shared:

> I don't talk too much about the whole idea of the mastectomy and losing body parts … Now I am getting my energy back, just getting my sex drive back. I know I have all the issues that a woman will say like fooling around with a boy and how is this going to work? But I don't really talk to [her] about that because I don't want to talk about my sex life.

Although rarely if ever discussed, mothers/daughters of diagnosed women were often aware of emotional stress. As 1 daughter stated, "I think she was experiencing stuff like that, but she never really talked about it with me." Some women said they could see or sense their mother or daughter's depression although others learned about it from third parties. If daughters were still living at home, mothers noted the difficulty in controlling and concealing their emotions around their daughters.

6.2.2 | Dealing with an uncertain future

Diagnosed mothers and daughters rarely discussed concerns about mortality, recurrence, and not seeing children grow up. Confronting death was especially hidden. As 1 diagnosed mother indicated, "I don't want to share it with them [her children]. You know that's one thing I don't think [my daughter] and I have really said is about death." A daughter of a diagnosed mother recalled, "Pretty much immediately, either my mother or father or both of them said, 'Nobody's talking about dying.' I'm sure [this was] one of the first things my mom said after she told me about being diagnosed."

For daughters diagnosed in young adulthood, avoidance of death talk even excluded discussing another woman's passing (eg, when a friend died). Although some diagnosed mothers felt they should discuss the possibility of death, the topic was raised only once. Daughters of diagnosed women also avoided broaching this topic, believing it was the mothers' prerogative and preferring to avoid making their mothers uncomfortable or prompting them to think about cancer. Still, not all diagnosed women described avoiding the topic. This may be tied to having an early-stage diagnosis, as women referred to the high associated survival rate. Some mothers felt it unnecessary to talk about death because they did not believe they were dying. And others reported that they were just not "there" or ready at all to discuss or address death in any form.

6.3 | RQ 4: motivations for sharing or avoiding

6.3.1 | Protecting myself or my mother/daughter

Every diagnosed woman reported that disclosure decisions were dominated by the desire to protect themselves and their mother/daughter. Women not only prioritized their own well-being but recognized that their coping benefited from maintaining or enhancing their mother or daughter's well-being. This overarching motivation involved four subgoals.

First, diagnosed women shared to keep their mother/daughter informed. Mothers especially liked being "included" in their daughter's care and many mentioned keeping calendars of their daughter's appointments. Similarly, daughters of diagnosed women felt it made things less scary. Second, women disclosed to attain social support. Women, particularly younger diagnosed daughters, described sharing because they needed someone to be there for them, reassure them, or validate decisions. Third, women were motivated not to disclose to maintain privacy. Many later-life women said they were "very private people." For example, diagnosed mothers avoided talking about wearing scarves instead of wigs because their daughters did not understand that the wig was a means of maintaining privacy. One mother explained, "A scarf around my head still tells people I have cancer. My wig does not. [My daughters] finally just stopped saying anything because they knew I was not going to change my mind." Privacy violation was a more significant issue for diagnosed daughters and could lead daughters to stop being open with their mothers. One daughter explained, "She was sharing my thoughts and feelings and everything with basically everyone she knew … I just wasn't happy with that … [Now] I just give her the [medical] facts. I will never talk about my feelings." Lastly, women were motivated to share (or refrain from sharing) to minimize distress and worry for themselves and their mother/daughter. For instance, a diagnosed daughter stated, "I think it helps me be stronger when I don't see someone else breaking down in front of me." Another woman talked about hiding her fear of recurrence, saying, "God no! No one knows about that. … There's no point in putting out stress to my mom. Knowing that I'm worried! No, no, no, no. Why worry her? No way!" Mothers with younger daughters were especially driven to not disclose. One mother shared, "I really didn't want to tell [my daughter] anything. I figured she had enough to adjust to going away to school … I wouldn't be selfish hurting her with all that until I needed to tell her. ."

Nonetheless, this type of "benevolent concealment" was sometimes problematic, with daughters finding ignorance not so blissful. One mother avoided telling her daughter about her hospitalization until after being discharged to avoid disrupting her daughter's studies. This elicited a furious response from the daughter who then withdrew communicatively. Similarly, another mother recalled not telling a daughter who was studying abroad about her diagnosis until she returned home. This daughter was also angry at being kept in the dark. In other situations, mothers wanted to disclose but saw that it created distress for their daughter. They exhibited avoidance (eg, changing the subject, ignoring their mother). One mother who tested positive for a BRCA gene mutation was especially worried about her daughters' future risk. She understood their avoidance but also illustrated the struggle to be open:

> They really don't want to talk about it. It's too much to deal with it right now. … Every now and then if I have an opportunity I'll say something but they probably don't like it … It is really hard when you're a mother, because you do want to talk to your children about it, but when they don't want to talk about it … It's a fine line of not being obsessed with it. You would like

them to come to you or something or just so they come to terms with it. … They wanted to ignore it for now.

7 | DISCUSSION

This study illustrates complex links between health and mother-daughter openness and avoidance as well as avoidant coping in general. Collectively, the findings help to further show that prescribing families to simply "be open" may not be reflective of their actual coping needs.[24] Rather, family relationships and cultures vary and both approaches (openness and avoidance) can function in adaptive and maladaptive ways during cancer-related adjustments.

The quantitative phase of our study lends support to the literature connecting openness with better health outcomes given diagnosed women with more mother-daughter openness and less avoidant coping reported better relational and physical health. Our findings extend this by showing that an established pattern of openness in one's mother-daughter bond is also linked to better relational health in the context of cancer. Much of the scholarship on being open is focused on engaging in social support.[24] Being able to talk openly facilitates support exchanges which may promote relational health. Furthermore, if one is engaged in more avoidant coping in general, this may inhibit physical health. These results may reflect that avoidant coping may be tied to lost opportunities for support. This supports research that shows social support is a predictor of patients' enhanced wellness.[36] However, our qualitative findings extend this further by adding context to the nature of open and avoidant interactions as they are experienced within the mother-daughter bond at various points in the life span. These women's narratives show that both openness and avoidance may, in their perspective, be helpful during the coping process. Furthermore, their stories show how openness can change across the cancer trajectory. Although mothers and daughters may begin with openness, they can become avoidant (when openness did not go well), which may limit support exchange. Navigating disclosures is challenging and interventions focused on helping mothers/daughters communicatively adjust would aid them in the coping process. We focus on those findings that might be best able to contribute to such resources.

For mothers and daughters, talking about physical, procedural, or logistical experiences seemed to come more easily as opposed to sharing emotions. Other scholarship has indicated that sharing fears or concerns is more challenging for patients and what might also be of concern is how patients feel about the issue.[24] Our findings suggest that for mothers and daughters, this struggle between openness/closedness may be tied to their desire to protect each other. Yet, at the same time, the mother/daughter's response to a disclosure about negative emotions (fears of recurrence, anger or sadness) can temper whether the diagnosed woman feels she can share this aspect of breast cancer adjustment in this family bond. Moreover, there is a tendency for mothers and daughters to mirror one another's avoidance. This may be further complicated by the fact that such disclosures may also be discouraged by a prevailing ideology that deems positivity central to survival.[27,37] Pennebaker's extensive research on the therapeutic benefits of disclosure demonstrates that patients need to release negative emotions.[38] It is important for mothers and daughters to be aware of this to encourage (and not silence) such disclosures when diagnosed women need to work through these challenging emotions. It might also be of value to consider how such disclosures may be better facilitated in other family bonds.

The qualitative findings also help reveal contextual factors specific to woman-to-woman bonds—factors prevalent in mother-daughter dynamics. Women in this study demonstrated what scholars have characterized as an enactment of "responsible womanhood"[39]: Women are socialized to exhibit gendered kin care behaviors, a key component of which is the mitigation of burdens on family. Women coping with breast cancer often shy away from communal coping opportunities for precisely this reason (indeed, diagnosed women in this study felt less able to disclose to mothers/daughters who appeared distressed). For breast cancer patients, this nondisclosure can result in emotional isolation. Moreover, despite being well-intentioned, it can be hurtful and contribute to anger, fear, and anxiety among mothers/daughters from whom information is concealed, which can also emotionally isolate the patient. These outcomes suggest that mothers and daughters need to negotiate a level of openness that is mutually acceptable.

Clinicians are in a position to help diagnosed women make sense of their emotions but also how to talk to their mother/daughter about them in ways that are mutually health promoting. Openness cultivates communal coping and intimacy, and it is clear that many mothers/daughters want to be included and know how their loved one is faring. Being involved facilitates the diagnosed woman's daughter/mother's own coping. In addition to these considerations, what seems particularly important for clinicians to voice is that releasing negative emotions is a natural part of dealing with cancer and can also be therapeutic. Taboo topics (sexuality, death, and depression) should be destigmatized, as discussing them can have therapeutic benefits (whether that is with a mother, a daughter, or a different relational partner). However, by just initiating conversations with patients about such topics, clinicians are helping to destigmatize such conversations. Yet not all disclosures between mothers/daughters function in a healthy manner. It is important mothers/daughters voice what they are comfortable hearing. Clinicians might also encourage patients to have open conversations with their mother/daughter about this to better ascertain each partner's comfort level with topics.

These women's narratives of openness/avoidance are also ripe for psycho-oncological intervention development. Such interventions can better highlight how to talk about complicated issues and also bring to mothers/daughters awareness about some critical issues of concern related to openness. These include control and autonomy as well as how these issues are tied to different needs depending on age/human development. Although diagnosed women should set the tone and pace for openness/avoidance in mother-daughter bonds, this might be especially important for younger diagnosed women still cultivating independence from parents. Our findings also demonstrate how generational cohorts view privacy differently, which affects their comfort with openness.

Ultimately, it is important families keep in mind that openness/avoidance can both be unhelpful and helpful. Mothers/daughters must be open about what they need but respectful of one another's (potentially divergent) needs.

7.1 | Limitations

Research indicates that mother-daughter behavior is influenced by culture.[40] Mothers and daughters have different expectations of behavior depending on their ethnicity. This sample was largely homogenous and findings need to be tested in various cultures. Although the sample size was small from a quantitative perspective and yet respectable for qualitative approaches, a larger sample size would allow for a detailed analysis at the relational level. A larger sample would further allow for a matched pair analysis and provide better comparisons among various dyads of mother-daughter pairs (ie, diagnosed mothers and their daughters, diagnosed women and their mothers, and diagnosed daughters and their mothers). We would also advocate for analyses with all mother-daughter types (blended or stepfamilies, adoptive families, and LGBT families) as similarities and differences will likely arise.

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