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Crying Women: An Investigation of the Lived Experience of Women With and Without Cancer

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To the Graduate Council:

I am submitting herewith a dissertation written by Jean W. Hunt entitled "Crying Women: An Investigation of the Lived Experience of Women With and Without Cancer." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Psychology.

Howard R. Pollio, Major Professor

We have read this dissertation and recommend its acceptance:

Ron Hopson, Kathleen Lawler, Sandra P. Thomas

Accepted for the Council:

Carolyn R. Hodges

Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

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Kathleen A. Lawler

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Associate Vice Chancellor
and Dean of the Graduate School

CRYING WOMEN:

AN INVESTIGATION OF THE LIVED EXPERIENCE

OF WOMEN WITH AND WITHOUT CANCER

A Dissertation

Presented for the

Doctor of Philosophy

Degree

The University of Tennessee, Knoxville

Jean W. Hunt

August, 1992

To

MOTHER

who cries for each of us.

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ABSTRACT

This study attempts a more holistic perspective on cancer and the emotions than previous research which has tended to focus on either biological, psychological or social aspects individually. Crying was chosen as an aspect of human existence which simultaneously implicates biological, psychological and social aspects of being human. Over a 30-day period, frequency and intensity of crying behavior was tracked in a group of 27 women with cancer and 22 women without. Women in this study ranged from 20 to 69 years of age. Among women with cancer, fifteen were participants in therapist facilitated psychosocial support groups and eleven were not. All participants completed a series of questionnaires that provided information regarding personal characteristics related to emotionally expressive style (Personal Attributes Questionnaire: Spence & Helmreich, 1978; Toronto Alexithymia Scale: Taylor, Bagby, Ryan, & Parker, 1990) as well as body image (Balogun, 1986). A written description of one crying episode as it occurred during a 30-day period was provided by each woman. Sixteen of the women, five women without and eleven with cancer, also provided in-depth verbal interviews in response to the question: "Can you describe for me your experience of crying?"

Quantitative and qualitative methods of data analysis were employed in this study. A one way analysis of variance (ANOVA) was performed across the three groups for data derived from test scores and crying frequency and intensity. Analysis revealed no significant differences in the means and standard deviations of any of eight variables. Pearson product moment correlations also were used to examine relationships between specific variables. The intensity of crying episodes was found to increase with frequency among all women regardless of health status. The more positive a woman's body image, the better able she is to identify and distinguish between feelings and bodily sensations of emotional arousal. Among women with cancer, both intensity and

frequency of crying decreased with age. When these women expressed dissatisfaction with their body image, they also tended to express feelings in a concrete cognitive style. None of the variables employed in this study either singly nor in interaction predict frequency and/or intensity of crying episodes for all women. Among women with cancer who do not participate in psychosocial support groups, approximately 69% of all differences in crying intensity were predictable on the basis of an interaction between the ability to differentiate bodily sensations and feelings, to talk about feelings, and degree of emotionality and capacity for empathy and warmth.

Three major themes emerged from a hermeneutic analysis of descriptions of crying experiences: Being Separate From which accounted for 46% of all descriptions, Barrier (15%), and Being In Unity With (39%). Experiences of Being Separate From included experiences of both Tension and/or Loss. These experiences were equally as figural for women with cancer as without. Experiences of Barrier related to experiences of Control and/or Immersion. Descriptions of Being In Unity With included experiences of Letting Go and/or Connecting. Women with cancer focused more on experiences of Control and Letting Go while the Immersion and Connecting themes were more figural in descriptions provided by women without cancer.

Among women with and without cancer, crying provides a method for dealing with existential crises although the meaning of the experience is quite different for each group. Descriptions of crying provided by women with cancer make figural that which moves the world away or separates the woman from tensions and losses that threaten to overwhelm. Women without cancer describe being more aware of that which connects them to deeply felt emotions and/or draws the world closer. Both groups of women cry with similar frequency and intensity and do not vary significantly in terms of behavior, personal characteristics and/or body-image. Their crying, however, means different things to them; they live the same world in fundamentally different ways.

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CHAPTER 1

INTRODUCTION

When do human beings cry? Most of us tend to cry in the midst of sadness or pain; when we are happy, angry, or frustrated; we might even "laugh so hard we cry" when confronted with the paradox of life's absurdity. Sometimes, however, we experience situations in which we feel a need to cry yet cannot and a good deal of anecdotal evidence suggests that cancer patients express a need to cry but often report difficulty doing so. Among comments I have heard in working with cancer patients are some of the following: "I wanted to cry so badly my throat hurt." "I just couldn't get it out." "I would feel so much better if I could just cry." "I was too angry to cry, my husband did that," or "I just never feel the need to cry."

When human beings cry, what does it mean to them? One of the most pervasive cultural assumptions about all emotional expression is that it is antithetical to reason or rationality (Lutz, 1986). Although reasons why emotions occur may be posited, it is rare that any emotion is seen as reasonable, most often we tend to view emotion as a disruption of, or barrier to, some more rational understanding of events. From a Darwinian perspective, crying is an emotional expression that is closer to the biological in contrast to thinking which is viewed as purely mental. This view is reflected in the theories of Izard (1977) and Tomkins (1963;1980). Freud (1930/1961) viewed thought as a reflection of cultural values shaped by the society. In this theory emotion is assumed to originate from instinctive urges.

More recent theories have combined emotion with cognition, e.g., emotion is a biological event regulated by cognitive processes (Beck, 1967; Lazarus, 1977). Zajonc (1980) has argued, however, that cognitive appraisal is not necessarily involved in every

expression of affect since pure sensory input alone is capable of bringing about a full emotional response, involving visceral and motor activity with subjective feelings often following. Tomkins' (1979) view presents emotion as an experience more "natural," "real," and "true" than thought in his discussion of "pseudo-emotions" -- those which are suppressed or constrained by cultural/social dictates. Thus, emotions are seen to possess a paradoxical relationship to human existence, being both closer to animal instincts than rational thought and, at the same time, more real, more human and less mechanical.

Although human beings throughout the world experience a variety of emotions and most are able to recognize emotional expressions across cultures (Ekman, 1980), different emotions are considered "acceptable" or "unacceptable" in different cultures. Social context and the expectations of others also have been shown to influence crying thresholds; or that point at which one is overwhelmed by a need to cry (McGreevy & Van Heukelem, 1976). While the expression of anger is more acceptable among men than women in Western culture (Hochschild, 1983), crying has traditionally been unacceptable as an avenue of emotional expression for men. In certain circumstances, however, crying is expected of women and parents typically expect girls to cry (Labott & Martin, 1990). Sex differences in crying frequency and intensity begin to show up in early adolescence (Kramer & Hastrup, 1988) and women continue to report more frequent crying than men throughout the life span.

One excellent example of the effect of cultural expectations on emotional expression is presented by Lutz (1986) with regard to the criticism Jackie Kennedy received for not crying at her husband's funeral. Conversely, Edmund Muskie was strongly criticized for crying publicly in the midst of his presidential campaign. As Lutz noted, "American beliefs about the appropriateness of particular emotions to particular situations enter into assessments of public figures. Tears are expected at funerals but

not in political contexts. A man who did not cry at a funeral, or a woman who cried because her husband was insulted in a political campaign would be unremarkable because such behavior is culturally proper" (Lutz, 1986). Interestingly enough, when General Schwarzkopf shed tears publicly while thanking American troops for their performance in the recent Gulf crisis, he was not criticized by the media. In fact, his actions were viewed as sensible given the situation. This view might serve as reinforcement for Hochschild's (1983) point that men's emotions are interpreted differently than those of women, being viewed as less characterological and more situational; hence, sensible. Or, more positively, we might assert some transformation in the cultural attitude in which "tough" men can also be sensitive and caring toward others but only once their "toughness" is beyond question.

People with chronic disease and/or terminal illness of any kind but particularly cancer, experience difficulty expressing emotions, especially those considered to be "negative" such as anger or crying (Eysenck, 1988). A review of the rather extensive literature on cancer and emotional expression, however, reveals a curious lack of data regarding cancer and crying. Interestingly enough, however, crying has been mentioned in the context of medical interventions as something medical professionals "tend to avoid" with attempts to stop the crying immediately at all costs (McGreevy & Van Heukelem, 1976). A single case of behavior modification implemented in an effort to curtail crying in a 64-year old cancer patient (Redd, 1982) stands alone as the total extent of current medical literature related to crying in cancer patients.

Crying is a physiological process, an emotional response, and an action taken in the surrounding world. It may be described as an aspect of human existence which simultaneously implicates biological, psychological and social aspects of being human. Emotional crying has been described at the biological level as a bodily "catharsis" serving the physical functions of expelling toxic substances and enhancing immune

response (Frey and Langseth, 1985). A possible mechanism for the catharsis of toxic wastes (Frey, DeSota-Johnson, & Hoffman,(1981), weeping is believed to rid the body of the chemical byproducts of stress; for this view the relief we feel after weeping is due to the cleansing action of tears. Extensive studies dealing with bereavement, however, indicate suppression of the immune response during mourning (Bartrop, Luckhurst, Lazarus, Kiloh, & Penny, 1977), and findings from empirical studies of immunological effects of weeping also disagree with the position taken by Frey and his colleagues.

Various other studies over the past five years have examined physiological, emotional and self-report ratings of mood and body-tension while subjects watched either sad or happy movies (Marston, Hart, Hileman, & Faunce, 1984; Silverstein, Hastrup, & Kraemer, 1986; Choti, Martson, Holston, & Hart, 1987; Kraemer and Hastrup, 1988; and Labott and Martin, 1988). When subjects wept in response to a sad film and careful measures were taken of self-reported affect and physiological arousal, weeping did not appear to lead to any appreciable decrease in physiological tension or stress in and of itself (Kraemer & Hastrup, 1988). When salivary IgA levels were sampled during and after observations of sad or happy films, analysis indicated suppression of the immune response when crying was of low intensity and short duration (Labott, Ahleman, Wolever, & Martin, 1990). Cornelius (1981) asked healthy subjects to describe episodes of weeping and to rate how positive or negative their experience was before, during and after they wept. Analyses indicated subject ratings of crying were much more positive during weeping than before and much more positive after weeping than during the episode. Studies measuring physiological correlates of weeping, however, have failed to support self-report claims.

There does seem to be a general tendency for crying as an effective coping mechanism to decrease across the life span and for crying to increase with physical disability (Labott & Martin, 1990). Crying remains a complex, complicated phenomenon,

however, and its role in health has proven difficult to assess. The effect of crying may differ from one situation to another. Based on traditional views of emotional expression -- events that occur at the interface between instinct and rational thought -- reports of tension reduction following weeping might be expected to reflect some change in autonomic nervous state (Cornelius, deSteno, & Labott, 1992). As noted, however, inconsistencies exist between self-reports of reduced tension and physiological measures and little actual physiological change is noted even when persons report feeling "better." Perhaps such inconsistencies indicate some relationship between crying and tension reduction that may be only loosely associated with the physiological event. A reduction in tension in the body might be expected to result from a change in the situation if in fact cognitive appraisal acts as regulator of all emotions. Since this doesn't always happen (Zajonc, 1980), other possibilities need to be considered.

One such consideration might be that tension reduction is not as directly and immediately affected by cognitive appraisal as tension production appears to be; for example immediately prior to crying episodes in the Kramer & Hastrup (1988) study, physiological indices reflected arousal whereas following the crying, physiological measures did not immediately reduce to baseline even though subjects reported feeling reduced tension. Another possibility is that reported experiences of reduced tension may reflect a change in the individual's relation to the surrounding life-world rather than to some internal bodily state. If such were the case, a change would not be immediately reflected at the physiological level since the perception of reduced tension, like the perception of the event precipitating the arousal, would come through the world rather than the intellect. One would have to "live" the surrounding world less "tensely" just as the tense moment was lived or experienced as "real." Knowing the tension in the movie has resolved itself does not mean it has been directly experienced. Support for this possibility may also be gained from Kraemer & Hastrup's (1988) finding of little or no

arousal in movie watchers when they were asked to suppress crying episodes. Unfortunately, Kraemer & Hastrup failed to report whether or not subjects asked to deliberately suppress their crying experienced arousal during tense scenes.

It has been suggested by Helman (1985) that chronically ill patients shift responsibility for pathogenic personality, body parts, or socially unacceptable ("bad") emotions to other people or to the surrounding environment. During illness it is often difficult to acknowledge the relationship of the disease to **me**. There is, as philosophers Merleau-Ponty (1962) and Richard Zaner (1981) noted, a fundamental ambiguity in my sense of lived intimacy between my "body" and my "self." The body can be experienced as an aspect of the unity of self or as a distanced and distancing component. An important aspect of illness is the fear of disempowerment and/or a loss of competence. Fear of losing competence, power, and gratifying personal relationship may lead to social withdrawal, or conversely, to a new sense of commitment to the integration of the self (Zegans, 1987).

Recent reports of the effect of social interaction and psychosocial interventions with cancer patients reveal a significant increase in survival for patients participating in support groups (Spiegel, Bloom, Kraemer, & Gottheil, 1989). It has also been noted that "there is nothing a cancer patient likes more than meeting an ex-cancer patient" (Benjamin, 1987). Meeting an ex-cancer patient is an affirmation that recovery is possible. In striving for recovery from cancer, these patients seek to come to terms with biological, psychological, and psychosocial aspects of their disease. The effect of participation in psychosocial support groups on emotional expression in cancer patients however, has yet to be fully examined.

Singer (1983) has suggested that holding back emotional reactions, including tears, occurs during a process of rationalization in which people with cancer hide from their emotions. Singer believes emotion suppressors often cut off feelings from direct

awareness by using the excuse that family members would be upset. Recent literature addressing the effect of cancer patients participating in psychosocial support groups has emphasized the role of group participation in allowing patients to "lower defensiveness and become aware of feelings in a direct way" (Friedman, Baer, & Nelson, 1988; Singer, 1983; Speigel, Bloom, Kraemer, & Gottheil, 1983; Speigel, 1991). Unfortunately, this research has been concerned with the effect of crying on so called psychological defense mechanisms rather than on the meaning of the experience for the cancer patient in relation to his or her surrounding world. In addition, the perceived meaning and value of the cancer patient's beliefs about the effect of emotional expression on significant others, whether actual or created has not been addressed.

Cunningham (1985) has described cancer as a reaction of the whole organism which, as such, has meaning. Culturally we tend to equate "understanding" cancer with empirical definitions of physiological precursors to the formation of neoplasms. A causal analysis of physiological factors involved in cancer has been underway for many years, and progress is being made in understanding the biological mechanisms involved. It also seems useful, however, to explore the meaning of the disease and its emotional and psychological manifestations in cancer patients in order to combine these findings with current physiological data in our progress toward understanding the disease.

Over the past several years, attempts have been made from the holistic perspective to study and formulate hypothesis about relationships among biological, psychological, and social phenomena as they pertain to persons suffering ill-health (Lipowski, 1968). The present study proposes a view of emotion that combines two seemingly antithetical theories. This approach originated in James (1961) view of emotion as "bodily feelings" and combines that notion with the more modern view of emotional expression as a "world dependent" phenomenon linked to external affairs (Harre, 1986). Crying among cancer patients is addressed as an experience that stands

at the interface between person and world, rather than between body and mind, and supports the view of body/mind and person/world as inextricably intertwined. The nature of this intertwining is such that when person and world or body and mind are circumstantially juxtaposed, crying erupts as a signal that the natural flow of lived existence is disrupted and a reconfiguration of these relationships is required. Crying may continue to be described as a nexus defining an experience that makes manifest the connection between biological, psychological, and social phenomena as uniquely embodied and expressed in human being. This study of crying is designed to examine the meaningful relatedness of crying as a form of emotional expression to the cancer patient's surrounding life-world. It is hoped the nature of such relationships will be clarified within the present program of research.

CHAPTER 2

A PHENOMENOLOGICAL PERSPECTIVE ON PSYCHOLOGICAL RESEARCH ON THE EXPRESSION OF EMOTION IN CANCER PATIENTS

INTRODUCTION TO THE LITERATURE

What is the emotional mode of being-in-the-world of the cancer patient? Over the past 30 years, relationships between cancer and the emotions have been considered from a number of different perspectives. In summarizing these findings, it seems appropriate to look at methodological issues in the study of cancer and emotion as well as at some operational issues as they emerge from a review of the literature. We also need to consider various aspects of personality as they relate to the development and progression of cancer as well as the effects of stress on mood and emotional expression in cancer patients. Since the focus of this work will be on relationships between cancer and emotions in human beings, animal studies -- though invaluable to our understanding of possible effects of cancer risk and tumorigenesis -- will not be considered except when such studies directly affect current research involving the study of emotions in human beings.

Historical Overview:

Modern medicine tends to treat each disease as if it were an entity unto itself, "a complete whole without relationship to other aspects of the body" (Stanwyck & Anson 1986). Each person may, however, be viewed as a complex integration of many aspects e.g. physical, chemical, psychological, sociological, genetic, etc. Accordingly, studies of people during both health and illness would do well to take human complexity into account. There is even a possibility that illnesses may relate to each other, and that

clusters of illnesses may be associated with particular patterns of personality. For example, Friedman & Booth-Kewley (1987) utilized a meta-analysis to help organize and understand a total of 101 studies concerning emotional aspects of personality e.g. anger, hostility, aggression, depression, anxiety, and extraversion in relation to the development of disease. Results of this analysis revealed some degree of consistency across diseases. The most striking single relationship seemed to be an apparent correlation between depression and disease. It seems overall that psychological disturbances produce systemic effects on immune system function and metabolic processes rather than affecting specific organs directly. The existence of a "disease prone" personality, as hypothesized by Friedman & Booth-Kewley, has since been extended to link personality factors with the development and progression of cancer (Eysenck, 1985, 1987, 1988).

Although the American Cancer Society seems to disagree that personality and emotional factors play a significant role in cancer incidence, (Holleb, 1986) references to connections between personality, cancer, and emotion have been prevalent in the literature as far back as the second century, when the physician Galen noted that "melancholic" women were more prone to breast cancer than their more "sanguine" counterparts (Kowal, 1955). During the 18th century the following report was noted: "Upon the death of her daughter, one woman underwent great affliction, perceived her breast to swell which soon became painful; at last the woman broke out in a most inveterate cancer which consumed a great part in a short time" (LeShan, 1980). And, in 1870 Paget wrote, "The cases are so frequent in which deep anxiety, deferred hope and disappointment are quickly followed by the growth or increase in cancer that we can hardly doubt that mental depression is a weighty addition to other influences that favor development of the cancerous constitution" (Locke & Colligan, 1986).

Methodological Design And Operational factors:

Research on cancer and the emotions has been pursued in three different types of studies: (1) retrospective studies which look back at previous life experiences from the point of view of the patient after a diagnosis of cancer is made; (2) prospective studies track the person across a span of years usually before cancer is diagnosed; and (3) post-diagnostic studies which only begin following diagnosis. In an effort to maintain some coherence in understanding research on cancer over the past 30+ years, studies included in this review will be presented sequentially in terms of the three types of studies discussed above; namely retrospective, prospective, and post-diagnostic.

LITERATURE REVIEW

Retrospective Studies:

Retrospective studies historically have consisted of interviews conducted with individuals following a diagnosis of cancer in which they are asked about their relationships with other people, their personality and/or affective style (Bahnson, 1969; Blumberg, West, & Ellis, 1954; Kissen, 1966; LeShan, 1959). Such interviews have tended to focus on life events as they occurred prior to the diagnosis; sometimes on events that occurred in childhood. In one such study, Blumberg, West, & Ellis engaged cancer patients in clinical interviews and administered standard psychological tests to measure anxiety, depression, and the ability to release pent-up emotions and tensions. Personality attributes and interpersonal characteristics also were compared to rate of disease progression (Locke & Colligan, 1986). Voth (1976) used an autokinetic experiment and the Embedded Figures Test in a retrospective study of women with cancer: In this study, a statistically significant relationship was reported between cancer and autokinesis. The author concluded that cancer is preceded by or associated with a

sense of helplessness or hopelessness coupled with some degree of resignation from life. A statistically significant relationship also was found between scores on the Embedded Figures Test and cancer. Other studies have employed a retrospective technique to examine the effect of stressful life events on emotional expression in cancer patients (Bageley, 1979; Lerher, 1980; Conti, Bondi, & Pancheri, 1981). A descriptive summary of findings derived from retrospective studies on cancer and the emotions is given in Table 1.

TABLE 1

RESULTS OF RETROSPECTIVE STUDIES CONCERNING

CANCER AND EMOTIONS

STUDY	SUBJECTS	METHODS DESIGN	OPERATIONAL FACTORS	RELEVANT FINDINGS
Blumberg, West & Ellis (1954)	Adult Cancer Patients N = 65	Interviews, psychological tests	Anxiety; ability to release pent-up emotions; depression.	People who develop cancer tend to be polite, apologetic, and acquiescent.
LeShan (1959)	Adult Cancer Patients N = 250	Interviews	Depression; interpersonal relationships	Tense & hostile relationships with parents; irreplaceable loss of some significant job, person, or relationship within one year of cancer diagnosis.
Kissen (1966)	Lung Cancer patients N = 77	Interviews	Personality	Difficulty expressing feelings; bottling up emotions; a bleak, emotionless past and inner life.
Bahnson (1969)	Adult cancer patients	Interviews	Personality	Cancer patients are "emotion suppressors" who are cold, aloof, out of touch with their own wants and needs; emotionally rigid.
Voth (1976)	Women with cancer N = 26	Autokinesis, Embedded Figures Test	Personality Variables	Women with cancer exhibit less autokinesis than controls. Cancer is preceded by or associated with a sense of helplessness or hopelessness and some degree of resignation from life.
Bageley (1979)	Breast cancer patients N = 45	Self-reports, interviews	Stress, expression of emotions	Concealment of emotions and bottling up anger are significantly correlated with stress.
Lerher (1980)	Gastric cancer patients N = 54	Self-report questionnaire	Life change up to 2-years pre diagnosis	Emotional stress may be a predisposing factor in gastric cancer.
Conti, Bondi, Pancheri (1981)	Adult Cancer patients n = 144	Self-reports	Life change up to 10-years pre diagnosis	Cancer patients are less in touch with emotional lives and therefore less prone to report stressors.

The common criticism of retrospective studies that attempt to address the relationships between mood, emotional expression, and cancer is that such studies are conducted after diagnosis and usually consist of self-report interviews with little if any empirical evidence given to support the claims (with exceptions noted herein -- Blumberg, West, & Ellis, 1954; and Voth, 1976). As a result of these criticisms, retrospective reports of events preceding the diagnosis of cancer have given way in recent years to results obtained from prospective longitudinal studies, summarized below.

Prospective Studies:

The first large prospective study to address relationships between personality and interpersonal relationships on the development of cancer began at Johns Hopkins University in 1946 as a study of precursors of various chronic diseases among medical students (Thomas, 1988). After preliminary results of this study were published in 1973 (Thomas & Greenstreet), the prospective method soon became a major trend in studies of this genre. Prospective studies following the Johns Hopkins paradigm have continued to dominate published research literature on cancer and emotions almost exclusively since that time. These studies address three general areas: interpersonal relationships, physiological factors, and/or mood and emotional expression.

Relationship Factors: Although only a few prospective studies have addressed the effect of interpersonal relationships on cancer, those available provided a wealth of valuable information. A summary of prospective studies addressing interpersonal relationships and cancer is presented in Table 2.

TABLE 2

RESULTS OF PROSPECTIVE STUDIES OF CANCER AND EMOTION

EXAMINING RELATIONSHIP FACTORS

STUDY	SUBJECTS	METHODS DESIGN	OPERATIONAL FACTORS	RELEVANT FINDINGS
Thomas & Duszynski (1974)	Medical Students N = 1337	Questionnaire Psychological & physical tests	Closeness to parents	Decreased closeness to parents among people who develop cancer.
Thomas, Duszynski& Shaffer (1979)	Medical students N = 1337	Questionnaire	Family attitudes	More negative family attitudes in youth reported in people who developed cancer.
Kaplan & Reynolds (1988)	Residents of Alameda Co. Calif. N = 6928	Self-report questionnaire	Social interaction, social isolation, feelings of being alone	Social isolation is significantly correlated with cancer incidence among women.
Thomas (1988)	Medical Students N = 1337	Questionnaire self-reports	Relationships	Decreased closeness to parents and increased emotional detachment from parents with negative attitudes about the family correlated with cancer incidence.

Thomas (1988) and her colleagues at Johns Hopkins Medical School gave successive classes of medical students between 1946 and 1964 --a total of 1337 subjects -- questionnaires to assess habits of nervous tension and family relationships . Physical and psychological tests were given to participants and elaborate family histories collected. A total of 48 participants developed cancer over the next 30-years. The first reported association between interpersonal relationships and the development of cancer was derived from this prospective study. In 1974, Thomas & Duszynski evaluated closeness to parents as a predictor of malignant tumor and, in 1979, Thomas, Duszynski, & Shaffer defined family attitudes in youth as potential predictors of cancer. An overall analysis of these findings (Thomas, 1988) revealed subjects who later developed cancer scored noticeably lower on psychological tests evaluating family relationships. They also had the lowest scores on closeness to parents (particularly

father-son relationships), demonstrativity, and matriarchal dominance; in addition, they were less well balanced in their approach to interpersonal relationships. Participants who later developed cancer described themselves as emotionally detached from parents and mentioned that their parents had been disagreeable to one another. More negative attitudes about the family prevailed among cancer patients than among any other group in the study. The overall psychological profile of cancer patients was comparable to students who later became mentally ill, particularly those who committed suicide.

Kaplan & Reynolds (1988) analyzed responses to questionnaires given to a group of 6,928 residents of Alameda County, California in 1965. A component of social interaction was included in this study and revealed that women who were socially isolated, e.g., reported little contact with friends and relatives, had a significantly elevated risk of cancer death. Both social isolation and feelings of being alone resulted in a higher risk of cancer incidence and mortality among women in this study.

Factors of Mood and Emotional Expression: Numerous aspects of mood and emotional expressive style have been the focus of prospective studies since Thomas & Greenstreet (1973) issued the first report linking cancer and depression. As is evident from Table 3, which summarizes results of these studies, standard psychological or semi-structured interview techniques are used often. Self-report questionnaire and psychological tests-- most commonly the MMPI -- have also been utilized to assess depression, repression and/or suppression of emotions, particularly anger in relation to various other personality factors.

Four studies in this category employed the MMPI as a measure of depression. Bieliauskas, Shekelle, Garron, Maliza, Ostfeld, Paul & Raynor (1979) followed 2020 male factory workers in Cleveland, between the ages of 40-50. The workers completed the MMPI in 1957-58. At that time, 18.8% of them scored "depressed" on the D scale. During a 17-year followup, these subjects had twice the expected number of deaths

TABLE 3

RESULTS OF PROSPECTIVE STUDIES OF CANCER AND EMOTIONS

EXAMINING FACTORS OF MOOD AND EXPRESSION

STUDY	SUBJECTS	METHOD DESIGN	OPERATIONAL FACTORS	RELEVANT FINDINGS
Thomas & Greenstreet (1973)	Medical Students N = 1337	Questionnaire Psychological and physical tests	Depression	Decreased depression among people who developed cancer
Margery, Todd & Blizard (1977)	Wmen undergoing breast biopsy N = 90	Interviews	Fears about surgery	Women who were later diagnosed with cancer had lower level awareness of anxiety prior to biopsy.
Bieliauskas, Shekelle, Garron, Maliza, Ostfeld, & Raynor (1979)	Men aged 40-55 N = 2082	MMPI-D scale	Depression; cause of specific mortality	Psychological depression is related prospectively to increased risk of cancer death.
Dattore, Shontz & Coyne (1980)	Cancer pts. N = 75; Non-cancer pts. N = 125	Premorbid MMPI	Repression-Suppression, Depression	Repression-suppression increased in patients who developed cancer; depression decreased in patients who developed cancer
Morris, Greer, Pettingale & Watson (1981)	Cancer patients N = 71	Interviews, personality tests	Expression of emotions	Decreased neuroticism, increased state and trait anger for all except younger patients; increased anger suppression for all cancer patients, especially younger women.
Shekelle, Raynor, Ostfeld, Garron, Bieliauskas, Lui, Maliza, & Paul (1981)	Male factory workers N = 2020	MMPI	Depression (17-year followup)	Increased scores on MMPI-D scale correlated with increased of cancer death but D-score elevations were not in the pathological range.
Wirsching, Stierlin, Hoffmann, Weber, & Wirsching (1982)	Women undergoing breast biopsy N = 56	Interviews	Psychological syndrome	Correctly predicted 94% of all cancer diagnoses; 68% of benign cases (81% overall).
Grossarth-Maticek, Kanazar, Vetter, & Schmidt (1983)	Yugoslav village inhabitants N = 1353	Interviews, self-report questionnaire	Personality factors	High hopelessness and high anti-emotionality are highly correlated with cancer incidence.
Wirsching, Hoffmann, Stierlin, Weber, Wirsching (1985)	Women undergoing breast biopsy N = 63	Semi-structured standardized interviews	Psychological syndrome	Biopsy results were correctly predicted in 75% of all cases.
Reynolds & Kaplan (1986)	Residents of Alameda Co. Calif. N = 6928	Self-report questionnaire	Well-being; happiness	Sense of well-being and happiness were predictive of reduced incidence of cancer and decreased mortality in women who developed cancer
Persky, Kempthorne-Rawson & Shekelle (1987)	Male factory workers N = 2020	MMPI	Depression, repression	Higher correlations between increased depression and cancer mortality and risk; no correlation between repression and risk or mortality.
Kaplan & Reynolds (1988)	Residents of Alameda County Calif. N = 6928	Self-report questionnaire	Depression	Depression not significantly related to cancer incidence or death.

from cancer than other members of the sample (Shekelle, Raynor, Ostfeld, Garron, Bieliauskas, Lui, Maliza, & Paul, 1981). Differences were not attributable to age, use of tobacco, family history, occupation or alcohol consumption. Although higher MMPI scores on the D-scale did indicate increased risk of death from cancer, depression among these patients was not necessarily within the pathological range.

A 20-year followup of the Western Electric study again confirmed an association between depression as measured by the MMPI which seemed to be more strongly associated with cancer mortality than with incidence (Persky, Kempthorne-Rawson & Shekelle, 1987). Stepwise discriminant function analysis of MMPI scores collected from previous admission records of 75 cancer patients and 125 noncancer patients at a VA hospital revealed cancer patients were significantly separated from the noncancer group on both the repression-sensitization scale (greater repression) and the depression (less self-report of depression) scale (Dattore, Shontz, & Coyne, 1980).

There was no statistically significant relationship between depression and cancer incidence or death in a 17-year followup of the Alameda County Study (Kaplan & Reynolds, 1988). Thomas (1988) and her colleagues also noted lower levels of depression on self-reports of medical students who later developed cancer although the MMPI was not used as the measure of depression. Other contradictions to the findings of Dattore, Shontz, and Coyne (1980) have been provided by Persky, Kempthorne-Rawson & Shekelle (1987) who found no correlation between repression measured on the Welsh R-scale of the MMPI and either cancer incidence or mortality.

Morris, Greer, Pettingale, & Watson (1981) evaluated 71 patients (30-69 years old) prior to breast biopsy. A significant difference was demonstrated in expression of anger between women with benign breast disease and breast cancer. Findings suggested breast cancer patients were more stressed by impending biopsy and that younger breast cancer patients were more likely than other patients to use denial in the

face of stress. Again, it was noted that cancer patients demonstrated significantly more suppression of anger than noncancer patients, especially in younger women. In an excellent study along similar lines, Pettingale, Watson & Greer (1984) used behavioral data to test the validity of reported hesitancy of cancer patients to show socially undesirable feelings. Findings indicated that breast cancer patients tended to express significantly less intense emotional expression during stressful situations, although there were no significant differences between breast cancer patients and controls with regard to changes in facial expressions. A significant positive correlation was noted between the involvement of the breast cancer patients in the stressful event and her attempts to hide her emotions; an association that was not found in the control group. Findings reported by Grossarth-Maticek, Kanazar, Vetter, & Schmidt (1983) also revealed a tendency to suppress emotions, especially anger, ostensibly to maintain control over "irrational" or "hysterical" impulses. A lack of autonomy also characterized "cancer prone" individuals in this sample of inhabitants from a Yugoslavian village.

In smaller prospective studies using similar methods,Wirsching, Stierlin, Hoffmann, Weber, & Wirsching (1982) interviewed 56 women admitted consecutively for breast biopsy. On the basis of the interviews, interviewers and blind raters predicted correct diagnosis in 94% of cancer patients and 68% of benign cases, respectively, or 81% overall. Predictions were made on the basis of a psychological syndrome consisting of: (1) being inaccessible or overwhelmed when interviewed, (2) emotional suppression with sudden outbursts, (3) rationalization, (4) little or no anxiety before the operation, (5) demonstration of optimism, (6) superautonomous self-sufficiency, (7) altruistic behavior, (8) harmonizing and avoidance of conflicts. Wirsching, Hoffmann, Stierlin, Weber & Wirsching (1985) later examined 63 women the day before breast biopsy using a semi-structured standardized interview technique. Findings again revealed cancer patients to be inaccessible, altruistic, to suppress feelings, and to

demonstrate a tendency to rationalize and harmonize. Biopsy results were predicted in 75% of all cases in this study.

Any possible etiological significance of the study by Wirsching, Stierlin, Hoffmann, Weber & Wirsching (1982) can not be derived from their results since all breast cancer patients and one fourth to one-third of women with benign findings demonstrated the psychological syndrome described. The authors suggest that this pattern may represent a long-standing defensive pattern adopted by many women in the face of extreme emotional stress. Though results are similar in Wirsching, Hoffmann, Stierlin, Weber & Wirsching (1985) no consensus has been reached on the significance of these findings.

It is also difficult to determine whether persons who develop cancer demonstrate less or more depression than persons who do not. Results from the Western Electric study indicate (Shekelle, Raynor, Ostfeld, Garron, Bieliauskas, Lui, Maliza, & Paul, 1981) that psychiatric criteria for depression may not be entirely applicable to cancer research. Part of the problem seems to be that the preponderance of studies suggesting an increase in depression among persons who develop cancer have been derived from data obtained using the MMPI. A single exception is the study by Dattore, Shontz, and Coyne (1980) who evaluated premorbid MMPI scores obtained from patients admitted into a Veterans Hospital. Perhaps this discrepancy might be accounted for by the possibility that veterans may have been depressed as a result of factors unrelated to cancer which also precipitated previous hospital admissions.

Another possibility pertains to the MMPI itself and to the fact that most of the elevations were not in the pathological range (Bieliauskas, Shekelle, Garron, Maliza, Ostfeld, Paul & Raynor, 1979: Shekelle, Raynor, Ostfeld, Garron, Bieliauskas, Lui, Maliza, & Paul, 1981; Persky, Kempthorne-Rawson & Shekelle, 1987). As Bieliauskas (1984) noted previously, the chronic state of distress measured in studies with humans may

reflect a long-standing and inefficient coping style. The presence of this coping style, coupled with the presence of stressors, may increase the risk for cancer. This position is supported by Webb, McNamara, & Rodgers' (1981) description of the MMPI-D scale:

> In general, it is the best single, and a remarkably effective, index of psychic distress, immediate satisfaction, comfort, and security; it tells something of how individuals evaluate themselves and their role in the world and of their optimism-pessimism. (p 16)

On the basis of these results we might conclude that repression or suppression of emotion are not predictors of either cancer risk or death. Among women, social isolation and alienation are clearly risk factors (Kaplan & Reynolds, 1988; Thomas, 1988) although results for men are somewhat equivocal since a survey of Japanese men living in Hawaii (Joffres, Reed, & Nomura, 1985) established no increased risk of cancer associated with low levels of social connection in contrast to findings by Kaplan & Reynolds (1988) and Thomas (1988).

Physiological Factors: Although few prospective studies have focused on interactions between physiologic factors as they relate to emotions and cancer, some interesting findings have resulted from those available. A summary of results obtained from these studies is presented in Table 4.

Thomas (1988) and her colleagues at Johns Hopkins collected data from physical and psychological tests as well as gathering elaborate family histories from medical students. An overall analysis of findings (Thomas, 1988) revealed subjects who later developed cancer had the lowest resting heart rate and the lowest scores for depression, anxiety, and anger when compared to other students; they also reported the fewest responses on habits of nervous tension. The most intriguing result noted here seems to be the suggestion of a relationship between cholesterol levels, depression and

cancer incidence (Grossarth-Maticek, Kanazar, Vetter, & Schmidt, 1983). Persky, Kempthorne-Rawson & Shekelle's (1987) 20-year followup of the Western Electric study, reported an inverse correlation between serum cholesterol levels and depression (lower cholesterol to higher levels of depression) in both simple and multivariate analyses.

TABLE 4

RESULTS OF PROSPECTIVE STUDIES OF CANCER AND EMOTIONS

EXAMINING PHYSIOLOGICAL FACTORS

STUDY	SUBJECTS	METHOD DESIGN	OPERATIONAL FACTORS	RELEVANT FINDINGS
Grossarth-Maticek, Kanazar, Vetter & Schmidt (1983)	Yugoslav village inhabitants N = 1353	Serum	Cholesterol levels, lymphocytes	Low lymphocyte percentage and minimal cholesterol levels are highly correlated with cancer incidence.
Perskey, Kempthorne-Rawson, & Shekelle (1987)	Male factory workers N = 2020	Serum	Cholesterol levels	Inverse correlation between depression and serum cholesterol levels e.g lower cholesterol minimum = higher levels of depression (MMPI scores).
Thomas (1988)	Medical students N = 1337	Physical tests	Nervous tension	Lower resting heart rate, decreased anxiety and habits of nervous tension correlated with cancer incidence.

The selection process involved in this and other studies by Grossarth-Maticek have been questioned (Grossarth-Maticek, Kanazar, Vetter, & Schmidt (1983) and although their results have been strongly supported by Eysenck (1988) these findings are currently under scrutiny (Fox, Temoshok & Dreher, 1988). Results obtained from Persky, Kempthorne-Rawson, & Shekelle with regard to a correlation between cholesterol and depression, however, makes these findings even more provocative and perhaps worthy of further investigation. Clearly the physiological data obtained from prospective studies of persons who later develop cancer portrays them as having characteristics commonly assumed to be among the "healthiest," e.g lower levels of

cholesterol, lower resting heart rate, etc. The single positive note in all the research reviewed on the effect of mood and emotional expression on cancer was derived from an assessment of women with hormone dependent tumors in the Alameda County study (Reynolds & Kaplan, 1986). This assessment revealed well-being and happiness to reduce incidence of cancer and decrease mortality among such women. It also has been pointed out by de laPena (1983) that elation and euphoria have never been reported to be associated with the development of cancer.

Since LeShan (1983) first introduced the concept of despair into attempts to understand the etiology of cancer and people who get cancer, we have come to view the despairing cancer patient as being in despair of self, confronted with a seemingly impossible choice between nonexistence and existence in ill health, eternally doomed by isolation and rejection. In a unique and detailed hypothesis regarding the development and meaning of cancer, de LaPena points out that depletion and inactivation of norepinephrine in the CNS often produces depression. Increases in norepinephrine are associated with behavioral excitement and have an anti-depressant effect with enhancement of physiological activation. People with certain types of depression may simply be in a state of low physiologic arousal, with concomitant low cholesterol levels, lower resting heart rates, etc. Among these people, de laPena (1983) suggests, are persons who develop cancer. It is de LaPena's hypothesis that a mismatch between incoming information from the environment and information being processed within the CNS and/or non-CNS somatic structures results in a state we commonly refer to as "disease." The brain, as a result of either inadequate or excessive stimulation by stressors from the outside world, creates a diversion -- a compensatory sequela of a fundamental problem, or an "existential angst" -- that may result from a loss of meaning in one's relationship to the world.

Post-Diagnostic Studies:

Post-diagnostic studies are conducted on the assumption that cancer may itself be a source of personal and behavioral change. A number of these studies are prospective in nature, tracking the patient from the time of diagnosis for several months or even years in an effort to understand the effect of the disease on personality and emotions. The majority of post diagnostic studies of the relationships between cancer and emotions have addressed the relationship between cancer and depression. Other topics considered in this research have included anxiety, control of anger, motivation, existential fears, and degree of life change due to stressful events. A summary of results from post-diagnostic studies which have examined factors related to mood and emotional expression are presented in Table 5.

Factors of Mood & Emotional Expression: Differences in method, population, tests and instrumental factors make it difficult to combine results of these studies into meaningful clusters. Several factors do seem to stand out, however. Eleven of the sixteen studies focused on the relationship between depression and cancer (Leiber, Plumb, Gerstenznag, & Holland, 1976; Plumb & Holland, 1977; Schonfeld, 1977; Plumb & Holland, 1981; Cassileth, Lusk, Hutter, Strouse, & Brown, 1984; Lansky, List, Herrmann, Ets-Hokin, DasGupta; Wilbanks, & Hendrickson, 1985; Robinson, Boshier, Dansk, Peterson , 1985; Derogatis, Morrow, Fetting, Penman, Piasetsky, Schmale, Henrichs, & Carnike 1983; Levy & Wise, 1987; and Payne, 1989). Four of these focused on the relationship between cancer and both depression and anxiety (Schonfeld, 1977; Plumb & Holland, 1981; Cassileth, Lusk, Hutter, Strouse, & Brown, 1984; and Payne, 1989). Holland, Korzun, Tross, Silberfarb, Perry, Comis, & Oster (1986) looked at total mood disturbance among patients with either gastric or pancreatic cancer while Bukberg, Penman & Holland, (1984), Robinson, Boshier, Dansk, & Peterson (1985), and Derogatis, Morrow, Fetting, Penman, Piasetsky, Schmale, Henrichs, and Carnike (1983),

TABLE 5

RESULTS OF POST-DIAGNOSTIC STUDIES OF CANCER AND EMOTIONS

EXAMINING FACTORS OF MOOD AND EXPRESSION

STUDY	SUBJECTS	METHOD DESIGN	OPERATIONAL FACTORS	RELEVANT FINDINGS
Leiber, Plumb, Gerstenznag & Holland (1976)	Cancer patients receiving chemotherapy	Beck Depression Inventory	Depression	No significant differences in levels of depression were detected between cancer patients compared to their spouses.
Plumb & Holland (1977)	Cancer patients N = 99; Next of Kin N = 66; Healthy pts who attempted suicide N = 99	Beck Depression Inventory(BDI)	Depression	No significant differences in levels of depression when cancer patients were compared to next of kin. Lower BDI scores for cancer patients overall than for physically healthy patients who attempted suicide.
Schoenfeld (1977)	Women with previous mastectomy N = 49	MMPI and a measure of anxiety	Depression, anxiety Prospective study (1 week post radiation and again 2 years later)	Women who survived without recurrence were less anxious initially and possibly also less depressed
Bageley (1979)	Breast cancer patients N = 45	Self report, interviews	Stress, expression of emotions	Chronic behavior pattern consisting of concealment of emotions and bottling up anger were noted.
Greer, Morris, & Pettingale (1979)	Breast cancer patients N = 69	Interviews, self-reports	Response to diagnosis	Survival without recurrence was significant correlated with early denial and "fighting spirit."
Plumb & Holland (1981)	Cancer pts N = 80; Healthy pts w/ attempted suicide N = 80	Beck Depression Inventory (BDI); self and observer reports	Depression and Anxiety	Cancer patients are less depressed and anxious than people who attempt suicide. Reality testing and social role performance are superior in cancer patients with less disturbance of affect or cognition.
Bukberg, Penman & Holland (1984)	Oncology patients N = 62	Hamilton Rating Scale	Depression	Degree of physical impairment is clearly associated with level of depression.
Cassileth, Lusk, Hutter, Strouse, & Brown (1984)	Adult cancer patients N = 54	Beck Depression Inventory (BDI); Spielberger State Anxiety Scale	Depression; anxiety	Depression and anxiety may be two labels for a single, broad underlying construct that involves vulnerability, agitation, and/or depression-anxiety.

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STUDY	SUBJECTS	METHOD DESIGN	OPERATIONAL FACTORS	RELEVANT FINDINGS
Lansky, List, Herrmann, Ets-Hokin, DasGupta, Wilbanks & Hendrickson (1985)	Ambulatory cancer patients seen for out-patient care N = 500		Depression	Only 5.3% of the total sample had major depression, a rate comparable to rates of major depression in the general population.
Robinson, Boshier, Dansk, Peterson (1985)	Adult cancer patients N = 57	Questionnaire	Psychological distress	A large portion of somatic symptoms among depressed cancer patients appear to be unrelated to the disease.
Derogatis, Morrow, Fetting, Penman, Piasetsky, Schmale, Henrichs, & Carnike (1983)	Terminal & non-terminal cancer patients	Self-reports	Depression, motivation, physical discomfort	Terminal patients are more depressed than non-terminal patients. Depression is unrelated to physical discomfort.
Holland, Korzun, Tross, Silberfarb, Perry, Comis, & Oster (1986)	Pancratic and gastric cancer patients	Profile of Mood States	Total mood disturbance	Patients with pancreatic cancer exhibited greater fatigue, tension-anxiety, confusion, and bewilderment on global dimensions.
Stanwyck & Anson (1986)	Meta-analysis of 68 studies of people with various diseases	MMPI	Personality	People with cancer tend to deal with psychological stressors by converting them into physical complaints, a process often accompanied by denial.
Kirkaldy & Koblinska (1987)	Breast cancer patients N = 76	Demographic questionnaire, MMPI	Personality	Existential fears and predominance of negative affect characterize cancer patients when they are compared to healthy controls.
Levy & Wise (1987)	Patients with advanced breast cancer N = 34	Self-report interviews	Survival over time, affect, depression.	Those surviving two or more years had significantly more positive affect at baseline, expressed significantly more joy, less depression than patients who died less than two years after baseline assessment.
Payne (1989)	Patients with advanced cancer N = 53	Self-report interviews	Effects of chemotherapy on anxiety and depression	Anxiety more prevelant than depression with distress most marked during the middle period of treatment. Younger patients (<50), experienced greater distress, with more depression and anxiety reported.
Van Der Ploeg, Kleign, Mook, Van Dooge, Pieters & Leer (1989)	Radiation therapy patients N = 51	Rationality/ Anti-emotionality Scale	Control of Anger	The ability to control anger is highly correlated with acting rational, reasonable, and trying to understand others in spite of negative feelings.

examined relationships between depression and level of physical impairment. Two studies focused on the relationship between emotional expressiveness and cancer (Bageley, 1979, and VanDerPloeg Klein, Mook, VanDooge, Pieters, & Leer (1989).

When levels of depression among cancer patients were compared to their next of kin (Plumb & Holland 1977) or to their spouses (Leiber, Plumb, Gerstenznag, & Holland (1976), no significant differences were noted. Findings of Lansky, List, Herrmann, Ets-Hokin, DasGupta, Wilbanks & Hendrickson (1985) suggest that depression among cancer patients is relatively comparable to that found in the general population. Zonderman, Costa, & McCrae (1989) used standard personality measures to compare levels of depression with mortality and found little support for the idea that depression increases cancer risk. Empirical evidence provided by Derogatis, Morrow, Fetting, Penman, Piasetsky, Schmale, Henrichs, & Carnicke, (1983) does support the view that a diagnosis of cancer triggers symptoms of depression. In this study, terminal cancer patients were more depressed than non-terminal cancer patients when compared to controls, although both cancer groups lacked optimism. Significantly less motivation for reward values and expectations of reward also were noted among both cancer groups compared to controls. Cancer patients expected significantly more punishers than did normal subjects. Both cancer and control groups reported equal amounts of discomfort which led Derogatis and colleagues to conclude that depression in cancer patients does not stem from physical discomfort.

These findings have been contradicted by those of Bukberg, Penman & Holland (1984) who found depression to be related to greater physical impairment among oncology patients when compared to healthy controls. Stanwyck & Anson (1986) performed analysis of aggregate clusters of samples taken from 68 American studies using the MMPI as a measure of personality among groups of people with various

illnesses. Results of their analysis indicate that people with cancer tend to deal with psychological stresses by converting them into physical complaints, a process often accompanied by denial. Conversely, Robinson, Boshier, Dansk & Peterson (1985) have suggested that somatic symptoms among cancer patients are not related to disease progression but rather to depressive illness unrelated to cancer.

Thomas (1988) reported a similarity between the personal characteristics of medical students who develop cancer and those who later committed suicide. A few post-diagnostic studies also have compared levels of depression among cancer patients and healthy patients who attempted suicide. Plumb & Holland (1977) used the Beck Depression Inventory to make one such comparison and found that cancer patients scored significantly lower on scales of depression than healthy patients who attempted suicide. Findings suggest vegetative depressive symptoms in cancer patients may reflect advanced disease. Psychopathological profiles of cancer patients and psychiatric patients were analyzed at University Hospital in Zaragoza, Spain, and at Johns Hopkins Hospital in Baltimore (Fox, Borysenko, Temoshok, & Newberry, 1984). These results indicate that psychiatric disturbances among cancer patients stem from organic syndromes associated with the disease and, in that sense, differ from psychiatric depression. Payne (1989) studied 53 patients with advanced cancer for six-months to assess the effect of chemotherapy administration on levels of anxiety and depression. Anxiety was found, overall, to be more prevalent than depression. Psychological distress was most marked during the middle period of treatment with younger patients (< 50) experiencing greater psychological distress and a greater incidence of depression than anxiety.

Levy & Wise (1987) assessed survival over a period of time in patients with advanced breast cancer in a study initiated at the National Cancer Institute in 1979. Those surviving two years or more had significantly more positive affect at baseline,

expressed significantly more joy, and less depression than patients who died less than two years after baseline assessment. Schonfeld (1977) also found survivors of breast cancer to be less depressed and less anxious following initial mastectomy than women who died within two years of mastectomy.

With regard to the relationship between emotional expression and cancer, Bageley found significant correlations between stressful life events that occurred up to 15 years prior to breast cancer diagnosis and a chronic behavior pattern characterized by abnormal emotional expression; specifically the concealment of emotions and the bottling up of anger. Van derPloeg, Kleijn, Mook, vanDooge, Pieters, & Leer (1989) tested 51 consecutive patients entering the hospital for radiation therapy on a scale revised from previous prospective studies of residents in a Yugoslavian village (Grossarth-Maticek, Bastiaans, & Kanazir, 1985). High positive correlations between rationality, anti-emotionality and the control of anger were noted. These findings are compatible with those reported by Eysenck (1985) who stressed the absence of strong emotional reactions in cancer patients. The correlation obtained by Van derPloeg, Kleijn, Mook, vanDooge, Pieters, & Leer (1989) delineated two necessary factors: (1) acting rational and reasonable, and (2) trying to understand other people. Both factors were accomplished in spite of negative feelings. Goldstein & Antoni (1989) also reported that cancer patients scored above the norm on a scale called "being respectful" compared to people without malignancies.

Some interesting findings with regard to cancer patients' outlook on life have been provided by Kirkcaldy & Kobylinska (1987) who gave 76 female breast cancer patients a demographic questionnaire and the MMPI. Cancer patients characteristically demonstrated a lowering of mood, indigence of emotional life, feelings of uselessness and inability to accept optimistic options about the future -- features associated with existential fears and a predominance of negative affect -- when compared with healthy

controls. Plumb & Holland (1981) found cancer patients to exhibit superior levels of reality testing and social role performance with less disturbance of affect and cognition compared to a group of physically healthy patients who had attempted suicide.

The relationship between depression and cancer or depression, anxiety, and cancer has been the focus of the bulk of available research and, as Cassileth, Lusk, Hutter, Strouse& Brown (1984) suggested, may simply represent two labels for a single, broad underlying construct that might more adequately be described in terms of vulnerability and agitation or depression/anxiety. Despite a conglomeration of methods, instruments, and populations, a general overview of the literature seems to cast the typical cancer patient somewhere between a physically healthy patient who attempts suicide and the general population. Long term survivors of cancer typically exhibit less anxiety and depression than people with shorter survival times, even in advanced cases where chances of survival are tenuous at best.

Physiological Factors: The role of physiological factors as they relate to mood and emotional expression in cancer patients is an area less well studied than mood and emotional expression alone. As Borysenko earlier pointed out, however, cancer can affect a person's entire emotional state, even one's personality either by attacking the CNS or by skewing delicate internal balances of hormones (Locke & Colligan, 1986). Certain tumors are known to secrete hormones, some of which alter behavior or mood. The most commonly used method of studying relationships among physiological factors, mood and emotional expression among cancer patients has been on the basis of self-report interviews and questionnaires coupled with blood chemistries or serum analysis. Studies have commonly focused on both suppression and/or expression of anger (Pettingale, Greer, Tee, 1977; Greer & Morris, 1978; Greer, Morris Pettingale, 1979; Pettingale, Philalithis, Tee & Greer, 1981; Fox, Borysenko, Temoshok, & Newberry,

1984), hopelessness and/or hopelessness, and stoicism (Greer, Morris, & Pettingale, 1979; Grossarth-Maticek, Kanazir, Vetter & Schmidt, 1983), denial (Greer, Morris and Pettingale, 1979; and Pettingale, Philalithis, Tee & Greer, 1981), and "fighting spirit" (Greer, Morris & Pettingale, 1979; Pettingale, Philalithis, Tee & Greer, 1981). Psychosocial factors including availability of social support and the effect of fatigue have been reported by Levy, Herberman, Malusih, Schlien, & Lippman, 1985; and Levy & Wise, 1987). The relationship of stress to immune system function in cancer patients also has been examined recently as well (Levy, Herberman, Malusih, Schlien, & Lippman, 1985; Levy & Wise, 1987). A summary of post-diagnostic studies examining physiologic factors involved in cancer and emotional expression is given in Table 6 below.

Achterberg, Lawlis, Simonton, Matthews-Simonton (1977), studied the relationship between blood chemistries and psychological variables in 126 incurable cancer patients between the ages of 15 and 71. They found psychological variables and blood chemistries to be statistically correlated, and psychological factors to be predictive of subsequent disease status. They concluded that blood chemistries tend to reflect current or ongoing disease state. Experiences of non-directed struggle, lack of purpose in choosing to act and the degree of resignation with regard to the disease were related to the severity of the disease process.

In a series of studies involving 160 women admitted consecutively for breast biopsy (Pettingale, Greer, & Tee, 1977; Greer, & Morris, 1978; Greer, Morris, & Pettingale 1979; Pettingale, Philalithis, Tee, & Greer, 1981), 69 patients were subsequently diagnosed with breast cancer. Each patient was evaluated prior to provisional diagnosis, before surgery, and at 3, 12, and 24 months post operatively for expression of anger and serum immunoglobulins. Expression of anger was related to elevated serum IgA levels in women who suppressed anger as compared to women who expressed it.

TABLE 6

RESULTS OF POST-DIAGNOSTIC STUDIES OF CANCER AND EMOTIONS

EXAMINING PHYSIOLOGIC FACTORS

STUDY	SUBJECTS	METHOD DESIGN	OPERATIONAL FACTORS	RELEVANT FINDINGS
Achterberg, Lawlis, Simonton, Matthews-Simonton (1977)	Cancer patients N = 126	Self report, blood chemistry	Psychological variables, disease status	Blood chemistries and psychological variables are statistically correlated. Psychological factors predict subsequent disease status. Factors related to severity of disease are: resignation, non-directed struggle, purposeful action.
Pettingale, Greer & Tee (1977)	Breast cancer patients N = 69	Serum & Self-reports (Prospective)	Immuno-globulins	IgA levels increased among women with breast cancer who habitually suppress anger.
Greer & Morris (1978)	Breast cancer patients N = 69	Serum & self-reports (Prospective)	IgA and anger	IgA levels 2-years post surgery significantly correlated with increased anger 3-months post surgery.
Pettingale, Philalithis, Tee & Greer (1981)	Breast cancer patients N = 69	Serum & self-reports (Prospective)	IgM; IgG	Elevated IgM correlated with denial at 3-months following surgery; decreased IgG correlated with "fighting spirit."
Grossarth-Maticek, Kanazir, Vetter & Schmidt (1983)	Yugoslavian cancer patients N = 204	Serum, self-report questionnaire	Cholesterol metabolism; lymphocyte percentages	Chronic emotional stress due to hopelessness and anti-emotionality strongly correlate with lower lymphocyte percentage; weakly associated with minimum cholesterol levels among patients with cancer.
Fox, Borysenko, Temoshok, & Newberry (1984)	Melanoma patients	Serum & self-reports	Mitotic rate; lymphocyte counts	Increased expressiveness of anger correlated with lower mitotic rate and increased lymphocyte counts. Similar correlations have been accurate predictors of relapse in other tumors.
Levy, Herberman, Malusih, Schlien, & Lippman (1985)	Breast cancer patients	Serum & self-report interviews	Natural Killer cell activity	Patients who expressed a lack of desirable support coupled with fatigue tended to have lower NK-cell activity levels.
Levy & Wise (1987)	Melanoma patients N = 13	Serum	Natural Killer Cell activity	Negative correlations between NK activity, tension, fatigue, state depression, anxiety and total mood disturbance.

Although serum IgA levels remained elevated in these patients for two years, the elevations were only significantly greater in women who expressed anger during the three months post-surgery. A significant correlation has been reported between diagnosis of breast cancer and the behavioral pattern of abnormal release of anger (Greer & Morris, 1978). In most cases, this pattern consists of extreme emotional suppression. The psychological response of a breast cancer patient to diagnosis was assessed 3-months postoperatively and was found to be related to outcome 5-years after surgery (Greer, Morris, & Pettingale 1979). A majority of women with breast cancer could be distinguished by their extreme suppression of anger although a few were extreme expressors of anger. A tendency to suppress other feelings in addition to anger also was noted.

Fox, Borysenko, Temoshok, & Newberry (1984) compared serum samples taken from melanoma patients togehter with self-reports of emotional expression. The reported degree of emotional expressiveness, especially in relation to anger at the time of hospital admission, revealed significant negative correlations when compared to mitotic rate; in addition, strong positive correlations were obtained when emotional expression was compared with lymphocyte count. Greater expressiveness was correlated with lower mitotic rate and higher lymphocyte counts. Both high mitotic rates and low lymphocyte counts have been observed in other tumors to be predictors of early relapse.

Survival without recurrence also was significantly more common among patients who had initially reacted to cancer either by denial or by a "fighting spirit" than among patients who responded to their diagnosis with stoic acceptance or feelings of helplessness or hopelessness (Greer, Morris & Pettingale, 1979). Grossarth-Maticek, Kanazir, Vetter, & Schmidt (1983) reported long lasting (chronic) emotional stress due to hopelessness and emotional suppression (anti-emotionality) resulted in significant

changes in the metabolism of cholesterol. Stress-induced elevations of circulating cortisol and cholesterol epoxides result in concomitant reductions in levels of circulating blood cholesterol. These may have had a synergistic effect on the induction of cancer through activation of dormant genes or latent viral oncogenes and/or through suppression of immunologic surveillance. Supporting evidence for these conclusions was previously provided in human studies by Schaffner, Brill, & Singal (1980) and Petrakis, Gruenke, & Craig (1980) and in animal studies by Kelsey & Pienta (1979).

Pettingale, Philalithis, Tee, & Greer (1981) reported serum levels of IgM to be significantly higher postoperatively in breast cancer patients who showed "denial" in three month followup interviews than in those who showed "fighting spirit," or "stoic acceptance." Those who showed fighting spirit had significantly lower levels of IgG than those with stoic acceptance.

In studies addressing the effect of psychosocial support on mood and emotional expression in cancer patients, Levy, Herberman, Malusih, Schlien, & Lippman (1985) interviewed breast cancer patients who had blood samples drawn post operatively and before pathology results were returned. Patients rated as "well-adjusted to their illness," who received less than desirable support from their environment and who expressed symptoms of fatigue, tended to have lower natural killer cell activity levels. Levy & Wise (1987) also performed a small sample study of stress, coping and biological outcomes in patients with advanced melanoma compared to a group of normal volunteers. Strong positive correlations were found between natural killer cell activity and state anger, state and trait curiosity, and vigor on the State-trait Personality Inventory (Spielberger, Jacobs, Crane, Russell, Barker, Johnson, Knight, & Marks, 1979). Negative correlations were found between NK activity and tension, fatigue, state anxiety, depression and total mood disturbance. It is inadvisable to make generalizations from small samples (n=13), although the indication is that psychosocial factors are important even in advanced disease.

Again, it is difficult to make generalizations from numerous studies employing a diverse selection of methods and instruments across different populations. The relationship between immunoglobulin levels and emotional expression/suppression is intriguing, especially those that report elevated IgA levels in women who suppress anger post-operatively that remain elevated for up to two years. A more interesting finding, however, is that the differences are only significantly greater in women who expressed anger at 3-months post surgery (Pettingale, Greer & Tee, 1977; Greer & Morris, 1978). One wonders if IgA, which ostensibly serves to protect mucosal surfaces from invasion, receives some sort of inoculation during the three months post operative period in which these women reportedly expressed their anger. A continued elevation in the IgA up to two years may indicate that the three months post surgery period is a "critical phase" that effects outcome, especially among women who habitually suppress anger.

Another item of note among these studies concerns the finding of Grossarth-Maticek, Kanazir, Vetter & Schmidt (1983) regarding the relationship between circulating cholesterol and cancer incidence. Perskey, Kempthorne-Rawson & Shekelle (1987) found an inverse correlation between depression and serum cholesterol, e.g., lower cholesterol minimums were significantly correlated with higher levels of depression. Perhaps these findings suggest one possible mechanism for understanding how extreme suppression and/or expression of anger can be associated with the development of both heart disease (which is commonly associated with high cholesterol levels and bottled up anger with a majority demonstrating frequent outbursts) and cancer (which is herein associated with low cholesterol levels, bottled up anger with a majority demonstrating extreme suppression).

The Role of Stress in Cancer and Emotional Expression:

A dynamic view of stress has been provided by Fox, Temoshok, & Dreher,

(1988) in which stress is considered a psychological condition leading to physiological disequilibrium. The degree of disequilibrium resulting from the stressor is mediated by a host of factors including physical condition, personality, past experience, and social resources. It is not surprising, therefore, that the bulk of research seeking to link stress and cancer has been inconclusive. If stress has an direct effect on cancer, it has not been demonstrated and an interaction between stress and predisposing factors is more likely. How a person handles stress is probably more important to health outcome than the stressor itself.

A diagnosis of cancer places stress on every individual affected by the disease. Such stress relates both to the symptoms of the disease and to the meaning attached to them. The most common problems associated with a diagnosis of cancer involve the anxiety and depression related to adjusting to cancer (Holland, 1984). Depression and the inability to modulate expressions of anger have been implicated as specific predictors of poor prognosis. Clinical studies using animal models demonstrate effects of unrelieved anxiety and helplessness (Borysenko, 1982). Cell-mediated immunity affects the ability of a host to resist neoplasia and is affected by endocrinological sequelae of emotional states. Both corticosteroids and catecholamines are likely mediators of behavioral effects on immunological function. Hormonal factors may affect the growth of tumors directly or through non-immunological tissue-specific mechanisms.

With regard to the relationship between stress, the immune system and cancer, Rameriz, Craig, Watson, Fentiman, North & Rubens, (1989) examined the effect of stress resulting from adverse life events. They found a significant association between self-reports of stressful events and increased risk of breast cancer relapse. A different view of the effect of stress was presented by Nieburgs, Weiss, Navarrete, Strax, Teirstein, Grillione, & Siedleck (1979) who suggested on a physiological level that animals as well as people may be unable to respond beyond a certain point under stress when

reservoirs of norepinephrine (and possibly other biochemicals vital to normal body activities) have been drained in response to excessive challenge. The body requires neurotransmitters, e.g., norepinephrine, to enable muscles to function properly. When these important chemicals are diminished, the body is unable to react strongly to stressful situations. The will to respond is not lost, but rather, the physical capacity to respond. An accurate reflection of a physiological state is therefore being given when an individual describes feeling drained by a stressful experience (Locke & Colligan, 1986).

Although the study of relationships between the immune system and cancer is in its infancy, we are clearly learning a lot from these investigations. Unfortunately, the meaning of what we are learning is less clear. With regard to relationships between stress and immune system change, two schools of thought exist: One views the nervous system as the key linking stress to the immune response (Ader, 1981) and the other views the endocrine system as the chief mediator (Fox & Newberry, 1984). Stress may be precipitated by some internal and/or external event, and describing a person as being drained by a stressful interaction may be something more than simply a metaphorical description (Locke & Colligan, 1986). The significance of the stressful experience may be influenced by one's perception of the event, e.g., by one's degree of control, capacity to manage the situation, and past experiences. The meaning of an experience modulates a stressor in myriad ways, any one of which may make a profound difference on the outcome, even at the cellular level. The significance of a stressful event is that it occurs in an embodied, lived world, and has meaning for the individual. It is obvious from this review that examining physiological variables involving immune system function, stress, and the effect of these factors on cancer incidence and progression is of major importance. Whether those relationships can ever be clearly defined, however, remains a mystery.

Psychosocial Support and Coping with Cancer:

Cancer patients experience intense physical pain often associated with the disease and/or its treatment. It may be difficult to accept that one's life may soon end or the helplessness and inability to do much for oneself to influence the disease. There may be uncertainty about treatment outcome, physical changes in one's body as well as catastrophic financial burdens with associated alterations in family patterns and roles. All these are consequences of cancer that cannot be avoided to any great extent. Added to this may be the cancer patients' maladaptive coping style (Speigel, 1991). Often, connections between ideas and feelings are severed and persons with cancer may remain calm in situations where strong emotions might be appropriate and expected (Singer, 1983).

Coping does not occur in isolation from the emotional makeup, cognitive predispositions, and social environment of the patient (Reardon & Buck, 1989). There is evidence to indicate that the interaction between coping styles and disease processes involve the immune system and that immunosuppression is particularly important in cancer (Bammer & Newberry, 1982). Indications are that the inhibition or suppression of overt emotions may be disruptive, and related to increased autonomic and endocrine system responding, with the resulting arousal having negative effects on the immune system.

In 1979, Goldstein & Antoni reported more repressive coping styles among breast cancer patients than controls. In 1984, Kneier & Temoshok described repressive "copers" as subjects who reported little upset during stressful situations and demonstrated high physiological arousal on skin conductance tests. This "type C" personality style among malignant melanoma patients was subsequently described as cooperative, unassertive, compliant, and unexpressive of anger. As "repressive copers" these patients had greater tumor thickness and level of invasion than more assertive

patients, especially under age 55 (Temoshok, 1987). Repressive coping was demonstrated significantly more often among Type C patients in stressful situations than among controls (Kneier & Temoshok, 1984). Type C coping style has since been described as a constellation of emotional, cognitive, and behavioral tendencies that include non-expression of anger, compliance with others' demands or requests, and a stoical facade of strength (Fox, Temoshok, Dreher, 1988). This coping style is viewed as a fragile accommodation to the world; homeostasis with the environment may be achieved to some extent but, at the same time, biological homeostasis is severely strained.

According to Haney (1977), life events and personality help determine the extent to which one attends to his or her body. The nature of one's behavior in illness is determined in part by the way in which the individual perceives, evaluates, and acts upon messages and sensations of the body. Emotional expression has been viewed as contributing to a healthier, more adaptive way of coping. When needs and feelings are expressed, genuine social support is recruited and people are likely to achieve a more positive state of mental health and more balanced interpersonal relationships with better bodymind equilibrium obtaining (Fox, Temoshok, & Dreher, 1988).

Spontaneous emotional expression, however, is felt to be related to deficits in verbal expression of emotions which in turn, is related to disease (Reardon & Buck, 1989). Sifneos (1973) coined the term "alexithymia" to describe the inability to express one's feelings verbally. The literal meaning of the term is, "no words for mood." Although the term is relatively new, a large body of clinical observations exist to ground this concept in psychoanalytic theory (Lesser, 1979). Alexithymic patients show an inability to associate freely or to produce fantasies and emotions. They are customarily preoccupied with details of objects, events or actions. Alexithymia has come to refer to a behavioral syndrome characterized by the incapacity to describe and differentiate

among feelings (Nemiah & Sifneos, 1970; Nemiah, 1975; Nemiah, Freyberger & Sifneos, 1976; Nemiah, 1977). Several studies have described personality traits which fit with descriptions of alexithymia in patients with cancer (Leshan, 1959; Blumberg, 1954; Kissen, Brown, & Kissen, 1969; Bahnson, 1970; Greer & Morris, 1975; Grissom, Weiner, & Weiner, 1975; Wool, 1986). A prospective survey of 200 women undergoing mammography in Italy (Todarello, LaPesa, Zaka, Martino, & Lattanzio 1989) revealed breast cancer patients to have constrained imagination and fantasy, coupled with associated difficulty in verbalizing emotions. These patients were described as having a tendency to express their emotions at "motor or imaginary levels" but no description or example of that level was given. Unfortunately, no other comparable studies evaluating alexithymia among cancer patients have been reported to date.

Successful methods of adaptive coping have been suggested for cancer patients. Borysenko, (1987) advocates coping through elicitation of the relaxation response as a means of influencing affective and physiological states which may have particular relevance to cancer. Such interventions reduce anxiety and enhance the patient's sense of control. This "immunization" against helplessness helps forestall depression. Elicitation of a relaxation response reduces physiological alterations consistent with decreased arousal of the sympathetic nervous system. By reducing fear and helplessness, physiological changes related to dysphoric states may be minimized.

Levy (1984) reports that patients who use the relaxation response would likely see it as a way of exerting control over the illness and, in this sense, could provide a useful method for improving one's personal sense of control (Levy & Wise, 1987). In addition, relaxation affects perceptual awareness, sympathetic arousal, and hormonal changes. The course of cancer, therefore, may, in part, be altered by changing emotions, cognitions, and behavior. When relaxation induction is performed by someone perceived as caring and compassionate, the perceived quality of social

support may improve as well. Identifying specific cognitive components helps to identify, challenge and rework negative beliefs about self-efficacy, expression of emotions, and interpersonal relationships. Lerner & Remen (1987) instituted an intensive program of yoga and meditation, using touch, imagery and artistic expression to help cancer patients reduce stress and learn to cope with the effects of their disease. Many participants report having found a deeper meaning in life. Whether or not the program extends life, cancer patients do experience an ability to expand and improve the quality of life.

Psychosocial support groups have also been found to provide effective method to help cancer patients and their families cope with issues involved in living with cancer (Singer, 1983, Speigel, 1990). Support groups provide cancer patients permission to be open: personal experiences are valuable and rewarded. Fears of honest communication and being unacceptable may then be experienced as unfounded; instead of being rejected, ridiculed, or losing control, shared sentiments are accepted and patients who may have been reluctant previously to express thoughts and fears are allowed to reveal and discuss whatever they choose.

A number of recent studies have explored the benefits of psychosocial intervention with cancer patients. Grossarth-Maticke, Schmidt, Vetter, & Arndt (1984) studied 162 women with metastatic breast cancer. Those who received a combination of psychotherapy and chemotherapy survived twice as long on the average as those who received neither treatment. Groups receiving one or the other treatment had intermediate survival times. Forester, Kornfeld, & Fleiss (1985) reported mood disturbance and physical symptoms of anorexia, fatigue, nausea and vomiting among cancer patients to be significantly improved with psychosocial intervention. Hislop, Waxler, Coldman, Elwood, & Kan (1987) found extroversion and social activity to be predictive of longer survival while lower rather than higher levels of anger served as

predictors of better outcome. Spiegel, Bloom, Kraemer, & Gottheil (1989) demonstrated that participation in psychosocial group treatment prolonged survival time two fold from the point of randomization; an average of 18 months for 86 metastatic cancer patients. Time from first metastasis to death was also significantly longer in the treatment (58 months) group than in the control group (43 months).

Spiegel (1990) evaluated coping strategies among breast cancer patients in a psychosocial support group and found that talking about the worst somehow "detoxified it." In randomized prospective studies (Spiegel, Bloom, Yalom, 1981) it has been demonstrated that patients who participate in group discussions about their illness show significant reductions in mood disturbances on the Profile of Mood States (McNair, Lorr, & Droppelman, 1971). Previous studies indicated married cancer patients survive longer than matched patients who were not married (Goodwin, Hunt, Key, & Samet (1987). Spiegel (1990) suggests, however, that social isolation may be more than simply another metaphor for death, since patients in the social intervention group did even better than married patients in the control group. Support groups for cancer patients help create social networks. The disease which separates cancer patients from the rest of the world is the admission ticket to the support group. The cancer patient's greatest weakness -- social isolation -- becomes a source of strength that may help to counter negative effects. Longer survival may indicate, therefore, the efficacy of psychosocial interventions (Spiegel, 1986).

In a prior study, Morgenstern, Gellert, Walter, Ostefld, & Siegel (1984) found that beneficial effects of psychosocial support on cancer survival in 34 breast cancer patients disappeared when time from cancer diagnosis to program entry was controlled. It has also been suggested that programs of short-term intervention may provide limited benefits or may be ineffective (Maguire, 1980). Some initial anxiety may be a "normal" response to a cancer diagnosis and many patients will recover from the stress of this

initial period without receiving support other than that provided by family and friends (Watson, 1983). Regardless of type of therapy, intervention can shift transient mood states but may be less effective in changing entrenched behavioral responses and disturbances.

SUMMARY OF FINDINGS

Retrospective and Prospective Studies:

Prospective studies have long been considered more "objective" and reliable than retrospective studies, although findings obtained from both now seem to be converging (Levy, Temoshok & Dreher, 1988). Although the rationale for the view of cancer patients proposed by retrospective studies is different than that provided in more recent prospective reports, the findings remain essentially the same. As Temoshok (1987) pointed out when people are diagnosed with a disease, they do not suddenly change their usual way of coping with stress and develop entirely new patterns.

Given methodological limitations in studies by Greer & Morris, & Pettingale (1979), reported by Locke & Colligan, (1986), and criticisms of Grossarth-Maticek, Kanazar, Vetter, & Schmidt (1983), cited in Fox, Temoshok, & Dreher (1988), we are left with a body of current research on cancer and the emotions that appears poorly organized, inconsistent, and contradictory. There is a lack of uniformity among studies, across populations, between measures, and within methods of interpretation. Overall, however, several themes emerge from this analysis. The cancer patient experienced a **bleak, emotionally impoverished childhood** (LeShan, 1959; Bahnson, 1969; Kissen, 1966; Thomas, 1988) characterized by **lack of closeness** to either one or both parents (LeShan, 1959; Thomas, 1988) in an environment experienced as tense or hostile (Thomas, 1988). Life was **lonely**, the individual felt **socially isolated** and subsequently

continued a long history of experiencing **difficulty in relationships** (LeShan, 1959; Bahnson, 1969; Grossarth-Maticek, Kanazar, Vetter & Schmidt, 1983; Kaplan & Reynolds, 1988; Thomas, 1988). From such childhoods, these individuals develop into adults who are **out of touch with their wants and needs**, who tend to allow **feelings to remain bottled up inside**, and, as a result, become **emotion suppressors** (Bahnson, 1969; Greer, Morris & Pettingale, 1979; Grossarth-Maticek, Kanazar, Vetter, & Schmidt, 1983), who appear detached, inaccessible, and may be prone to sudden, unexpected emotional outbursts (Wirsching, Stierlin, Hoffman, Weber, & Wirsching, 1982; 1985). The majority of these patients are typically **extreme suppressors of anger**, (Pettingale, Greer, & Tee, 1977; Greer & Morris, 1978; Greer, Morris, Pettingale, 1979; Morris, Greer, Pettingale, & Watson, 1981). Prospectively cancer patients demonstrate both low levels (Thomas & Greenstreet, 1973) or elevated levels of **depression** (LeShan, 1959; Shekelle, Raynor, Ostfeld, Garron, Bieliauskas, Lui, Maliza, & Paul, 1981; Persky, Kempthorne-Rawson, & Shekelle, 1987) although the elevated levels are not high enough to be considered pathological (Shekelle, Raynor, Ostfeld, Garron, Bieliauskas, Lui, Maliza, & Paul, 1981). **Feelings of helplessness/hopelessness** lead to a lack of autonomy and diminished levels of optimism which have also been associated with the development of cancer (Greer, Morris, & Pettingale, 1979; Wirsching, Sterlin, Hoffmann, Weber, & Wirsching, 1982, 1985; Grossarth-Maticek, Kanazar, Vetter, & Schmide, 1983). A pattern of dealing with events through **rationalization** (Wirsching, Stierlin, Hoffmann, Weber, & Wirsching, 1982, 1985; Grossarth-Maticek, Kanazar, Vetter, & Schmidt, 1983) and a style of **"being respectful"** develops along with an attitude of **stoic acceptance** (Greer, Morris, & Pettingale, 1979; Pettingale, Philalithis, Tee & Greer, 1981).

Post-Diagnosis Studies:

Again, despite vast differences in methodology, population samples, age,

gender, type/stage of cancer, and varieties of measuring instruments, certain commonalities exist between different studies that provide a post-diagnostic characterization of someone with cancer. The two most salient personality characteristics seem to be **depression and anxiety**, with various studies demonstrating a greater or lesser effect of one or the other (Schonfield, 1977; Plumb, & Holland, 1981; Payne, 1989). A high correlation was demonstrated between the two by Cassileth, Lusk, Hutter, Strouse, & Brown (1984). No differences were found in levels of depression in comparisons of cancer patients and their spouses (Leiber, Plumb, Gerstenzang, & Holland (1976), or their next of kin (Plumb & Holland, 1977). Significant differences were found in levels of depression (Plumb & Holland, 1977; Fox & Newberry, 1984) and anxiety (Plumb & Holland, 1981) when cancer patients were compared to psychiatric patients. Physical impairment and somatic symptoms also positively correlate with depression (Bukberg, Penman, & Holland, 1984; Robinson, Boshier, Dansak, & Peterson, 1985; Levy & Wise, 1987). In a representative national sample, however, Zonderman, Costa, & McCrea (1989) found depression a poor indicator of mortality and morbidity risk in cancer. With regard to anxiety, Margarey, Todd, & Blizard (1977) found women who were later diagnosed with breast cancer to be less aware of anxiety pre-operatively.

A characteristic description of post-diagnosis cancer patients also includes **abnormal emotional expressions** e.g. concealment of emotions (Bageley, 1979; Goldstein & Antoni, 1989; vanDerPloeg, Kleijn, Mook, vanDooge, Pieters, & Leer, 1989), denial of dysphoric emotions (Plumb & Holland, 1981), negative affect (Kirkcaldy & Kobylinska, 1987; Levy & Wise, 1987), and a lack of optimism (Kirkcaldy & Kobylinska, 1987). **Helplessness/hopelessness** characterized cancer patients in studies by Voth (1976), and Kirkcaldy & Koblinska (1987), while **fatigue and somatic symptoms** affected both immune function (Levy, Herberman, Malusih, Schlien, & Lippman 1985) and disturbances in mood (Holland, Korzun, Tross, Silberfarb, Perry, Comis, & Oster,

1986; Stanwyck & Anson, 1986). Such somatic complaints were felt to be a symptom of depressive illnesses probably unrelated to the cancer diagnosis (Robinson, Boshier, Dansak, & Peterson, 1985).

Bukberg, Penman & Holland (1984) argued that depressive states among cancer patients exist on a continuum from depressive symptoms at one end, to states resembling major depressive disorders at the other. The qualitative nature of depression may thus be viewed as an adjustment reaction rather than as evidence of major affective illness. Depressive symptoms in cancer patients may simply reflect the effects of adjustment to or advancement of the disease. It would appear given these findings that when a person is given a diagnosis of cancer, the belief that one is going to die shatters adaptive illusions. Optimistic expectations for valuable rewards cease, motivation for reward drops, and one becomes a victim of adjustment reaction with an accompanying depressed mood.

Stress and Cancer:

One's ability to adapt to adverse life events cannot be taken for granted. Some patients have little hope of recovery and yet are far from despondent whereas others, regardless of prognosis, are prepared to become victims (Weisman & Worden, 1976). It has been demonstrated that individuals who score high on emotional control adapt to increased life stress at the expense of increased autonomic arousal (Pettingale, Watson, & Greer, 1984). Stress man be either immunosuppressive or immunoenhancing (Locke, 1982) as a result. The effect of these stressful events is determined by critical factors which include, in part: (1) natural killer (NK) cell activity (Levy & Wise, 1987), cell mitosis or lymphocyte count (Fox, Temoshok, Dreher, 1988); (2) duration and timing of the stressor as mediated by host factors (Fox, Temoshok, & Dreher, 1988; Nieburgs, Weiss, Navarrete, Strax, Teirstein, Grillione, & Siedleck, 1979); (3) coping ability, e.g. the

importance and meaning of the experience to the person (Locke & Colligan, 1986) and (4) personality traits and behavioral factors, e.g. depressive personality traits previously mentioned (Shekelle, Raynor, Ostfeld, Garron, Bieliauskas, Lui, Maliza, & Paul, 1981; Persky, Kempthorne-Rawson & Shekelle, 1987).

Overall, **predisposing personality factors** are integral to the development of chronic patterns in the cancer patient's approach to life (Bahnson, 1980; Achterberg & Lawlis, 1979). **Adverse life events** (Rameriz, Craig, Watson, Fentiman, North, & Rubens, 1989; Holland, 1984) also contribute to the level of stress that affects the adjustment of the cancer patient to the disease. When **emotional stress** (Lehrer, 1980) and/or an inability to get in touch with emotions (Conti, Biondi, Pancheri, 1981) is coupled with the effects of **psychosocial factors** such as tension, fatigue, anxiety and depression (Levy & Wise, 1987), the cancer patient's vulnerability to stress is increased. Stress, in turn, suppresses immune function and increases vulnerability to disease onset.

Coping and Psychosocial Support:

Coping style may have harmful effects on persons with chronic disease (Kneier & Temoshok, 1984; Fox, Temoshok, & Dreher, 1988; Speigel, 1991). Two styles of coping negatively affect one's ability to deal with cancer: **A repressive, 'Type C" coping style** (Goldstein, & Antoni, 1979; Kneier & Temoshok, 1984; Temoshok, 1987; Fox, Temoshok, & Dreher, 1988), and a personality construct known as **alexithymia** (Sifneos, 1973), is best be described as a constellation of characteristics related to an inability to express emotions verbally with feelings experienced as diffuse states of somatic arousal not associated with words or symbols (Nemiah & Sifneos, 1970). A more adaptive coping style allows for **emotional expression** (Hislop, Waxler, Coldman, Elwood, & Kan, 1987; Fox, Temoshok, & Dreher, 1988). Such expressive coping may be provided by crying which enables the cancer patient to experience new levels of self-

acceptance and autonomy during social interactions with supportive others (Singer, 1983; Speigel, 1991) or may lead to further social isolation and alienation when crying is rejected by significant others (Redd, 1982). Tools for developing successful coping strategies include eliciting a **relaxation response** (Borysenko, 1982 & 1987; Levy, 1984) which helps improve physiological response to stress, provides a sense of control, and lessens feelings of helplessness and anxiety. Intense programs of yoga, meditation and imagery may help enhance the quality and meaning of life for the cancer patient (Lerner & Remen, 1987). Recent reports of **psychosocial intervention techniques** (Speigel, Bloom, & Yalom, 1981; Grossarth-Maticke, Schmidt, Vetter & Arndt, 1984; Forester, Kornfeld, & Fleiss, 1985; Spiegel, Bloom, Kraemer, & Gottheil, 1989; Speigel, 1990) indicate participation in programs of this type enhances survival, lowers mood disturbance and decreases physical symptoms of disease even though earlier studies demonstrated contrary findings (Maguire, 1980; Watson, 1983; Morgenstern, Gellert, Walter, Ostfeld, & Siegel, 1984).

DISCUSSION: EMOTIONS, CANCER AND THE BODY

Subtle differences in self-concept, motivation, and sense of personal being are all apparent among cancer patients (Cella & Tross, 1986). Derogatis (1986) noted that patients who survive cancer experience an existential disruption they relate directly to their illness. We learn about suffering, frustration, and our personal limitations directly; through the body. The body and its meanings are integral to the organization of "self" which is discovered in action-in-the-world. Fear of losing control or mastery over one's body -- through illness or disability -- is a threat to a person's experience of wholeness (Zegans, 1986). It is little wonder then that a person's coping mechanisms and ability to handle stress are probably more important to health outcome than the stressors

themselves (Fox, 1989). A sense of rootedness in the body and the ability to remain connected in the face of life stressors is both characteristic of and at the same time, unique to each person's life situation. The coping process involves reflection --thinking about-- emotional phenomena. This process results in decisions about emotion which Reardon & Buck (1969) suggest are either maintained or changed by feedback from the body --bodily consciousness-- and communication with others. The contextual nature of behavior, though flexible, remains stable for as long as the body and surrounding social situations remain stable. Disorder disrupts the stability of both body and surround. Disruption may occur as a result of changes in situations that exist between the individual and the surrounding world or within the body, i.e., as a result of disease.

Spontaneous emotional expression may provide an outlet for stressors through an effort of the body to minimize harmful physiological effects of stress -- a measure of self-preservation. Persons who view physical and emotional symptoms as part of the natural order may seek help easily. Conversely, persons who regard symptoms as a personal weaknesses will avoid help. Avoiding help and not seeking affiliation may be detrimental to health, leading to isolation and depression. A chronic pattern of avoiding help and/or not seeking affiliation may be one source of maladaptive coping responses among cancer patients.

We construe our world and to some extent ourselves by recognizing and responding to repeated themes which James (1950) referred to as "pulses in the stream" of consciousness. Conditions of the body are neither externally caused events for which the person bears no personal responsibility nor are they internally caused events. Rather both emerge at the same time. Our unique relationship with our body necessitates the understanding, that "I have a body" and "I am a body" (Plessner, 1970). I may bear no personal responsibility for the effects of physical symptoms, e.g. although they are in my body, I did not place them there, while at the same time they are

inescapably mine; I have sole access to them. A bodily consciousness, our awareness of our body as both object-in-the-world and as essence-of-being-connected-in-the-world develops out of our own experience of the world (Merleau-Ponty, 1962). Differences do exist, however, in the extent to which each person is aware of bodily events. These differences often reflect the extent to which the individual perceives his or her ability to control such events (Reardon & Buck, 1989). At the same time bodily consciousness is developing, human beings emerge from a world of involvement with action and objects into a world of self-reflection; a thinking about one's identity and about what might be possible within and beyond the boundaries created by that identity. This transition has been described by Pollio (1982) as moving from "as is" to "as if," and it seems as if this self-reflective aspect of awareness is problematic for cancer patients (LeShan, 1959; Blumberg, 1954; Kissen, Brown & Kissen, 1969; Bahnson, 1970; Greer & Morris, 1975; Grisson, Weiner, & Weiner, 1975; Wool, 1986).

People who demonstrate a repressive coping style may be described by others as "nice;" that is, as cooperative, unassertive, and compliant. With the exception of unassertiveness, these characteristics are commonly viewed as desirable. Again, personality characteristics normally associated with desirable health conditions also are associated with cancer. From the point of view of effective coping, however, the failure to express needs and feelings results in isolation since others do not know how to meet our needs if we do not express them. It has been suggested that people with breast cancer simply have difficulty expressing all their emotional needs verbally (Todarello, LaPesa, Zaka, Martino, & Lattanzio, 1989).

If findings from current research are accepted, the cancer patient begins life in an environment in which they engage in unfulfilling relationships with parents and feel lonely and isolated. Perhaps a chronic pattern of avoiding help and/or not seeking affiliation with others is set up as a way of coping with a world in which the only

available style of affiliation is through alienation. A chronic state of distress comes to reflect this style. When emotions are suppressed a continual state of anxiety-depression is set up. The difficulty cancer patients experience in attempting to verbalize emotions (in other than motoric actions or events) suggests a lack of self-reflection much like a child whose language has yet to reflect the "thought about" self. Self-reflection is normally differentiated through interaction with significant others -- interactions that may have been attenuated in the early environment of the prospective cancer patient. It has been suggested that connections between ideas and feelings are severed and that persons with cancer often remain calm in situations where strong emotions might be appropriate and expected (Singer, 1983). Another possibility might be that cancer patients experience their emotions in an unreflected manner -- not as something to think about or say but as something to do; in which case verbalizing "un-thought about" experiences might be more difficult. The question is whether cancer patients are absent of emotions (Eysenck, 1985), or simply experience difficulty expressing them, particularly on a verbal level (LeShan, 1959, Blumberg, 1954; Kissen, Brown & Kissen, 1969; Bahnson, 1970; Greer & Morris, 1975; Grisson, Weiner & Weiner, 1975; Wool, 1986).

The presence of others may also have a direct impact on the bodily response to stress which is potentially protective or disruptive to the body, e.g., the presence of others may increase physiological response to stress in certain situations (Reardon & Buck, 1989). Expressive behavior reveals bodily events and when the presence of others comes to be experienced as a constant source of stress -- perhaps as a result of a chronic tendency avoid help and not seek affiliation -- a bodily response to the stressor occurs. The body thus becomes a rich field, continually bombarded with environmental and interpersonal stressors, constantly adapting in myriad ways to changes any one of which may disrupt the fragile stability of the unique being embodied therein. All too often, the change that disrupts the hard-won equilibrium is cancer.

CHAPTER 3

PHYSIOLOGICAL, PSYCHOLOGICAL, PSYCHOSOCIAL AND RELIGIO-HISTORICAL COMPONENTS IN THE EXPERIENCE OF CRYING

OVERVIEW

This chapter will address physiological, psychological, psychosocial and religio-historical components in the experience of crying. A review of the literature will be undertaken and an attempt will be made to incorporate findings into current views of crying as they apply to emotional expression among cancer patients. Weeping is a more precise term for the object of our scrutiny since it involves the appearance of tears in addition to vocalizations (Mish, 1987; Lofgren, 1966) whereas crying refers to a number of different vocalizations (Cornelius, 1981). An etymological analysis of the verb "weep" in the English language reveals its origin in the Old English term *wepan* meaning to shed tears. This term evolved from Old Saxon *wopian* - to bewail; the Old Norse *œpta* - to scream or shout; and Old Frisian terms imitative of the Old High German *wuof* - indicating "lamentation" (Onions, 1966).

The term tears is derived from the Greek term *dakry* and the Latin *lacryma*. The root form cryma is, in turn, related to the Greek *crism* meaning to anoint. The prefixes *da* and *la*, in various forms refer to both quickness and surprise (Onions, 1966). To weep is to shed tears; a quick or surprise annointing. The connotations of this term include a divine or spiritual aspect as well as a physical sense of applying healing ointment or salve to make things "smooth." Since the intent of this research is to undertake a broad, comprehensive examination of the experience of shedding tears and the term weeping has become nearly anachronistic in everyday usage, the terms "crying" and "weeping" will be considered interchangeably within the present context.

People report crying when they feel grief or sorrow, when relationships end, or when they feel compassion, e.g., on leaving the hospital room of a friend or relative. Tears may also result, when we see a sad movie or play. During times of emotional stress we often cry; during anger or arguments; when we are the target of critical remarks; when overworked, under appreciated, and/or exhausted. During times of despair or disillusionment we cry. Annoying events such as parking tickets or burned toast may bring tears. A beautiful sunset, a sensitive piece of artwork might also bring tears to our eyes. Music, church or religious services, pleasant experiences such as winning an award, a medal, and various other moments of triumph may elicit tears. Human beings cry at weddings, at births, in sincere appreciation, or as an expression of love, thoughtfulness, or upon receiving or giving gifts. Tears express a myriad of emotions in human beings from joy and sorrow to anguish and ecstasy. Frey & Langseth (1985) estimate that sadness accounts for about 49% of our tears, happiness about 21%, anger 10%, sympathy 7%, anxiety 5%, and fear 4%.

In considering the historical usage of the terms crying and weeping, the effect of Cartesian dualism is apparent. Modern medicine since Hippocrates has excluded the spiritual-religious meanings of both weeping and crying from scientific study. Studies have been directed more toward the physical anatomy of the eye and/or of the eye afflicted with disease. It has commonly been assumed that crying and weeping strongly suggest psychological disturbance or psychiatric illness (Green, McAllister & Bernat, 1987). Studies of crying, where they exist, tend to be directed by a reductionist methodology to either behavioral, psychological, or psychosocial aspects of the experience rather than to a consideration of all three as these are experienced by the crying person.

Historical and Religious Views of Crying:

Ancient texts from the early Phoenician-Canaanite culture spoke of crying, lamenting and/or weeping in terms of everyday experience as well as in terms of ritual religious practices. Words and actions of the ancients at festivals celebrating the god Baal included enactments and experiences of death, ritualized at the grain harvest, and of renewal, ritualized in Spring rain and grass festivals. These celebrations included rites of weeping and laughter (Hvidberg, 1962). In the enactment of the god's defeat and ultimate triumphant return, weeping precedes laughter. The god's death and burial occurred during the autumnal festival amid violent mourning rites and weeping. Weeping was a sacred rite in pagan cultures just as it was within the ancient Hebrew tradition. Moments existed when "one could not discern the noise of the shouts of joy from the noise of the weeping of the people" (Ezra 3:12).

Early Phoenician-Canaanite cultic texts originated in an area later inhabited by Israelites. Hvidberg (1962) argues that the Israelite God Yahweh's nature was changed by the influence of the cultic traditions in such a way that weeping and rejoicing over Yahweh began to take place as they had previously occurred in connection with the dying and resurrected god Baal. When the northern Israelites conquered the region, the divinity of the Canaanite god Baal was assimilated into Yahweh. In other words, Baal was absorbed into Yahweh along with the pagan rituals celebrated in yearly seasonal festivals with feasting, weeping, and laughter. Early Canaanite and Phoenician cultures shared innumerable rituals and festivals of weeping followed by laughter with later Israelite inhabitants of the same regions. These social, religious and cultural displays of emotion took place as an expression of devotion to and celebration of their religion. Over time, these social, cultural, and religious rituals became intertwined.

The first mention of weeping in the Hebrew Bible takes place when Abraham's wife, Sarah died (Genesis 23:2). The second instance occurred when Joseph's brother

Benjamin joined him in Egypt (Genesis 42:24; 43:30; 45:2). Joseph wept again at his father Jacob's death (Genesis 50:1), where he engaged in both public and private weeping; the public, a demonstration of the ritualistic or "expected" weeping and the private, a demonstration of his experience of yearning (Genesis 43:30). Weeping is not mentioned again in the Bible until Hannah wept over Samuel (2 Samuel 1:24) during a time which coincides with the beginning of the prophecy of the Messiah and signifies a completed integration of the pagan ritual of cyclic renewal in the death and re-birth of the god into the Hebraic tradition.

Weeping in the Old Testament allowed people to gain the attention of God. According to Isaiah (17:10), Israel had forgotten the God of their salvation and the Israelites wept. As they repented, their lamentations were turned inward; then the people wept for their own sinfulness. God turned away from them and after two days, they were "revived." A great celebration and exaltation resulted (Hosea 6:2) when God again turned to "face" the repentant nation. Numerous other functions were served in the ancient Hebrew tradition by weeping and are exemplified in the mourning rites of David (Samuel 12:15), weeping for the disaster of the locusts experienced in Judah (Joel 1:2-12) and in various other individual laments, i.e., when stricken with mortal disease (2 Kings 20:1; Psalms 6:7; 2 Kings 22:19). Weeping for joy took place as well, as, for example, when Yahweh redeemed Israel and gathered the dispersed people together again (Jeremiah 31:7-9). Ritualized weeping in combination with fasting was believed to be necessary in order to receive revelations from God (Ezra 5:13,20; 6:31) and the Old Testament promised that at the time of creation of the New Jerusalem, weeping and lamentation would be heard no more (Isaiah 65:19; 60:60; 35:10; 30:19). Weeping to express grief is evident in the New Testament gospels as well, most notably when "Jesus wept" upon learning of the death of Lazarus (John 11:35).

The Lamentations of Jeremiah recount a tale of mourning for the loss of an entire nation; the story of Israel's complete ruin. It was a time of devastation, a complete and overwhelming loss of group and personal identity. Interestingly enough, the account of this incident is presented in the most ordered linguistic style in all the Hebrew texts. The rhythm and cadence of the verse exemplifies a strict internal control over the language, even as external chaos and disorder are being reported. A strictly concrete, ordered, alphapoetic textual style led the people through a ritualistic languaging of woe, grief, and mourning. Through repetitive expression, the Hebrew people were drawn out of the midst of ruin, chaos, and devastating personal loss into hope and a sense of renewal. The rhythmic, repetitious ritual of grief allowed the Israelites to reset the balance, the equilibrium of their lives.

In Islamic and Syrian Christian traditions, the ascetic and mystic author Isaac of Niniveh spoke of weeping as a rite and a gift of grace (Hvidberg, 1962). Tears hold a definite place in various stages of spiritual experience. Men of a certain class in the Islamic culture are devoted to ascetic practice; these men are known as "the weepers" (ibid, p 146). Their fervent contemplations give rise to a glow of heat. A vision which is given from grace arises out of this. An out-break of tears then follows.

William James (1902) wrote of the relation of crying to religious experience in the Western tradition:

> The (one) who lives in the religious center of personal energy, and is actuated by spiritual enthusiasms, differs from the previously carnal self in perfectly definite ways. The stone wall inside has fallen, the hardness of the heart has broken down. The trials of real life or the theater, or a novel sometimes throw us into this, especially if we weep. In these "melting moods" it is as if our tears break through an inveterate inner dam, and let all sorts of ancient peccancies and moral stagnancies drain

> away, leaving us now washed and soft of heart and open to every nobler leading (p 267).

Many saints, according to James possessed this gift, a special grace which he calls "the gift of tears." The difference between ordinary people and these gifted saints, is that "with most of us the customary hardness quickly returns" whereas with saints, whether they come by their growth gradually or in a time of crisis, the "melting mood" holds almost uninterrupted control and in all cases "comes to stay" (ibid p 268).

Crying in the History of Medical Science:

Scientific explorations of the eye are as recent as the Renaissance; superstition, myth, and legend, however, have surrounded the eye from the dawn of history (Marti-Ibanez, 1964). Exploratory dissections of the eye were not permitted for centuries for fear of offending the gods. The eye itself was considered a symbol of god's omnipresence. In prehistoric paintings the eye portrayed a mysterious organ which, at night, winked down with a menacing fiery glint from distant heavens and during the day blazed forth from a single, all encompassing source. More than five thousand years ago the eye of the god Horus made its appearance as a healing symbol used primarily as a protection against eye disease. This symbol was adapted in the middle ages as a sign written on prescriptions to invoke divine aid. Combined with certain historical alterations, it has evolved into the ℞ symbol used by physicians today. Diseases of the eye that produce photophobia, pain and excessive lacrimation were common in ancient Egypt. Yet, the eye and its functions remained a mystery until the time of the Greek Ptolemies when -- much to the horror of the Egyptians -- vivisection of the eye was conducted at the school of Alexandria (Marti-Ibanez, 1964).

Ancient Christian Gnostic images also portrayed the eye as a symbol of God. During the Middle Ages, the eye became an allegory of god and of the powers of

darkness. This notion of humanity's connection to godliness through the sacred avenue of the eye, prevailed undisturbed in the history of medicine from the time of the ancients until recently (Marti-Ibanez, 1964); in fact as recently as the time of Paracelsus. Paracelsus (1493-1541) attempted to discover the place of human beings in the world and to determine their relation to god. Symptoms of melancholy, i.e. tearfulness, depression, etc could be treated, according to Paracelsus through the use of "contraria" (Sigerist, 1941). For despondent persons, he recommended a "gay medicine" to make people laugh and make their mind happy, to remove all diseases having their origin in sadness. The effectiveness of contraria is not incidental, said Paracelsus. "It is not just laughter in sadness; the entire sadness is removed."

It would be difficult to find a greater contrast than exists between the mystical, philosophical doctrine of Paracelsus and the purely rational thought of Rene Descartes (1596-1650), whose view of body as separate from mind has prevailed in medicine through the modern era. In actuality, modern Western medicine began with Hippocrates (460-377 BC) who viewed health and disease within the framework of the patient's life. In the Hippocratic Corpus, primarily the Prognostic, physicians were advised to examine the face of the patient and compare it either with faces of healthy people or with the patient's usual facial appearance. Physicians were encouraged to notice the eyes, "particularly if they shun the light, weep without reason, or are distorted or of unequal size" (Phillips, 1973). Doubtless, eyes with "reason to weep" were considered normal in Hippocrates' day. We find scant mention of tears, weeping, or crying in the medical literature except as postscripts to anatomical descriptions or from the perspective of eye malformation and disease up through the modern era. Leonardo da Vinci (1452-1519) alone presented the eye in a more ancient, less clinical perspective when he described them as "windows of the soul" in his Codex Atlanticus (Marti-Ibanez, 1964).

THEORETICAL PERSPECTIVES ON CRYING

From a psychobiological point of view, crying has been considered simply communicative in purpose, providing a signal representing sorrow, pain, or discomfort (Delf & Sackeim, 1987). Darwin (1872/1965) speculated that crying (weeping) also serves a protective function by preventing facial muscles, especially those around the eyes, from becoming too engorged with blood during intense reactivity in infancy (Delf & Sackeim, 1987; Frey & Langseth, 1985). Based on Darwin's observations of animals and later confirmations provided by modern observers, we know that some animals, most notably elephants, seals and otters have been known to weep when restrained or when their young are taken from them (Darwin, 1872/1965; Carrington, 1958). Human beings are the only known weeping primate (Morgan, 1972). During moments of stress, other carnivorous mammals, e.g., seals and sea otters, have been known to weep. Smith (1953) described the albatross weeping during fighting, ritual dancing, and in the excitement of feeding.

In the psychoanalytic tradition, weeping serves a regressive function. Tearfulness and weeping characteristically fall into Freud's early formulations of anxiety neurosis and hysteria (Breuer & Freud, 1895/1951). Without adequate or acceptable outlet, unhealthy sexual practices were believed to result in the damming up of the libido (Freud, 1898). Based on Freud's theory of narcissism, weeping was felt to be an enhancement of regression to the prenatal existence in response to stimuli injurious to the individual's vital libidinal complement to the egoism of the instinct of self-preservation. This regression manifests itself when adults and children cry themselves to sleep (Heilbrunn, 1955). Such actions represent a temporary return to the intrauterine state. Regression in the function of the ego can have positive implications for adult functioning (Kris, 1935) returning us to the foundations of our self-formation in the psychic interactions with our earliest representational (symbolic) world (McDargh, 1983).

Greenacre (1945) described weeping as a defense against, and a symbolic expression of, phallic urethral drives; in other words, urination was believed to represent a symbolic expression of repressed impulses to weep. Weeping is thus a part of the development of emotional reactions connected with "seeing the strange or missing the familiar" (Greenacre, 1965). Krystal (1982) emphasizes the importance of getting past phallic and urethral identification to issues related to identification with the mothering parent. Conflicts and inhibitions in the sphere of self-regulating functions involved in self-soothing, self-care, and attaining a general state of tonicity and vitalization need to be added as well. "The enduring meaning of the "oedipus complex" in its broadest sense (is) that the growing child is possessed of yearning and desires and a sheer energy for activity which confronts the invincible authority and physical supremacy of those more powerful persons on whom the child is dependent not only for the physical necessities of life but, more importantly, for the love and recognition that is life itself for the human child" (Becker, 1962). Crying and weeping, as well as laughing, may be employed to block instinctual drives according to Sachs (1973), and Sadoff (1966) linked tear development to the original reflex cry of the infant which is conditioned to purposive behavior as a call for help. As object relations develop, separation anxiety and grief reactions result. Just as weeping functions to expel painful affects from the body, it might also function to expel a bad internalized object. According to this model, weeping may be considered a call for help from within; vocalization is a call for aid from without.

Developmental psychologists view crying as an opportunity for communicative social interaction between parent and child; when successfully managed, the parent is doubly rewarded -- crying stops and playful interactions occur. Moreover, crying is a young infant's primary means of communication; hence it is the sound of the cry that parents listen to in order to determine what the infant needs (Lipe, 1980). Parents tune into this channel, learn to understand what the infant is trying to say -- how to

understand their baby. Rhythm and other qualities of the cry, help establish a foundation for later communication. (Lester, 1985). Temporal patterning in the parents' response provides a structure enabling infants to organize cognitive and affective expressions and to learn rules of communication. Symbolic functions underlying language development are believed to be formed through expectancies and structures provided by early temporal patterning stemming from parent-infant interactions (Stern, Beebe, Jaffe, & Bennet, 1977; Garland, 1972).

Adlerians refer to crying as "water power" turned on to get what is wanted (Adler, 1964). When tears are used in such a manipulative fashion, they may be associated with misbehavior. Crying involves control both from the infant and from the parent(s). The infant is learning self-control in the process of learning to inhibit arousal and control crying. The child may need to cry to release tension. Parents want to stop the crying and may intervene even though the baby needs to learn self-control. Control can, therefore, become a problem in the parent-infant relationship. We often think of the separation/individuation process as taking place during the second year of life; it may be, however, that these issues begin even earlier, particularly around the management of crying. The control the infant is learning with help from the parents may become externalized and develop into psychodynamic issues that no longer relate to crying. These issues may then be played out in other areas, such as feeding, sleeping, or perhaps even in tantrums. When attempts at coping are unsuccessful and resolution of issues inadequate, guilt may spill over into other areas where parents and infants must negotiate limits with both infant and parents seeking to maintain control (Lester, 1985).

Crying is really the first test for parents -- the first real expression of a demand from the infant. It is the first time or issue around which the parent is faced with saying "no" or placing limits; perhaps the first issue around which the parent feels angry because of something the baby did, and the first stress and challenge to successful

child rearing. Thus, crying is likely to bring up many problems parents will have to face throughout child rearing and particularly those that are issues for the parents themselves. Crying becomes a microcosm for other aspects of the parent-child relationship and, when unsuccessfully resolved, may be transferred to other areas where control is prominent. Crying may thus serve as a cause or a symptom of problems in the parent-child relationship (Lester, 1985; Sullivan, 1951) and consequently may form the basis for interpersonal conflicts later in life.

The formation and maintenance of a sense of self is a life achievement that takes place first in the complex interactions between the human child and the interpersonal environment into which he or she is born (Mahler,1972). Although the critical experience of separation in the process of individuation presumably takes place in the first three years of life, throughout the life cycle, the human being faces challenges to the cohesiveness and coherence of his or her sense of self. At various times and under various circumstances, the human being re-encounters, in new and different ways, the tensions that characterized the beginning of life -- tensions between affiliation, community, closeness -- and separateness, individuality, uniqueness and difference (McDargh, 1983).

From an experiential perspective, the most common experience accompanying feelings of weeping and tearfulness is that of loss (Lipe, 1980). Such experiences have been described fundamentally as a loss of equilibrium (Wood & Wood, 1984); a temporary loss of balance among external and internal conditions sets up the tearing, weeping state (Lipe, 1980). Persons who feel weepy or tearful often report only general or vague thoughts that preceded the tearful reaction (a feeling of inner fullness at the brink of tearing accompanied often by moist eyes). Pauses, feelings of being preoccupied or characteristics of "an altered state of consciousness" may also be included in descriptions of the experience (Wood & Wood, 1984). People may have

difficulty articulating their experience and often report being "filled with feeling," "overwhelmed," feeling "too much for words," and needing time to gain composure. These descriptions suggest a struggle to retain or regain control over feelings. Some weepy, tearful states express emotional impotence, inadequacy, failure, angry frustration, or even fear of anger. On the positive side, tears and weeping may serve as a protective device, insulator, or vehicle for catharsis (Frey, 1980; Frey & Langseth, 1985).

From the physiological perspective, emotional tears play a role in one's ability to tolerate stress (Frey & Langseth, 1985) and crying is believed to serve an adaptive function in stress relief (Choti, Marston, & Holston, 1987). McCarthy (1930) explored self-healing aspects of crying, and noted the importance of the birth cry in establishing normal respiration and oxygenation of the blood. The associated air ventilation is believed to relax one in a manner similar to Gestalt or meditative deep breathing exercises (Harrigan, 1981). Respiratory changes that accompany emotional crying have been described by Halverson (1941) as irregular with sudden, deep inspirations and prolonged expiration. Such respiratory changes are believed to be responsible for the reddening of face, eyes and ears, eventual edema, and perhaps even eye closure (McGreevy & Van Heukelem 1976).

A biochemical analysis of tears reveals emotional tears to be chemically different from tears caused by pollution, cutting up onions, etc (Frey & Langseth, 1985). Significantly, emotional tears contain chemicals useful in mediating the response of the immune system to stress. In addition to possible mediation of immune response to stress, tears serve to enhance emotional self-maintenance (Nystul, 1982). When stress and tension have been released, we feel cleansed from weariness, hurt or discomfort and a degree of emotional equilibrium is restored (Nystul & Garde, 1979).

Results of empirical studies by Kraemer & Hastrup (1988) indicate that although there is a significant increase in sympathetic nervous system activity prior to crying,

tears do not appear to reduce depressed affect. In other contexts, weeping has been described a means of discharging emotion to relieve physiologic and psychologic reactions to both anxiety and depression. Heilbrunn (1955) describes crying as a release of energy which reduces tension:

> Whenever grief, disappointment, anger, or overwhelming joy exceed the tolerance of the organism, the ensuing state of tension is alleviated by a release of energy...which abolishes the tension. The shedding of tears furthers the homeostatic principle so well that it is the favorite mechanism of release in childhood. Probably it would continue throughout life were it not suppressed by the demand of society for emotional restraint and replaced by other means of discharge (ibid, p 245).

The notion of homeostasis is used here as an active, dynamic concept and includes behavioral as well as psychological mechanisms. The importance of homeostasis as a dynamic concept is that it includes change as well as stability. We equate homeostasis with stability or status quo, as though the goal were to stop change. Homeostasis is constant change, but it is keeping the change in balance without jeopardizing vital processes; it is controlled change, stability in the face of change. The constant dialectic between stability and change enables the individual to maintain basic organizational structure and process and to grow, adapt, and develop. There is a constant interplay between endogenous and exogenous demands as the individual seeks to maintain homeostasis.

In autonomic homeostatic functions, such as cardiac and respiratory activity, balance is partially maintained by oscillating timing mechanisms or biological rhythms. It has been suggested that there are rhythmical patterns in crying as well. Lester (1985) investigated the fundamental frequency of crying using a fast Fourier transfer EEG

tracking mechanism and found a major peak in crying intensity and frequency that follows an 8-10 second cyclic pattern. Based on such studies, crying may be viewed as a behavioral control system mediating physiological and environmental demands. Such mediation is accomplished by the presence of a biological rhythm that seems to underlie crying, linking it with physiological activity and signaling the needs and status of the individual to the environment (Lester, 1985).

Homeostatic imbalances may be essential for cognitive and affective development (Lester, 1985). Emotional lability and irritability signal a process of change during which talking may momentarily be impossible. The individual then has "time" to gain perspective and develop some degree of detachment and control. Reorganization may take place when there is a temporary withdrawal from the presentness of the emotional object. Attention changes from a focus on the world to a focus on the emotion felt. By taking advantage of a tearful period, one gains a "respite", a rebalancing time, and emerges from the "choked up" silence with somewhat reordered and re-organized sense of worth and a more cohesive sense of self (Nystul & Garde, 1979).

Spitz's (1935) theory distinguishes four groups or principal forms of crying with the degree of tension precipitating the crying episode determined by basic emotions and feelings. A tense emotional state associated with feelings of being choked up, sluggish, and easily exhaustible is associated with (1) tense and (2) predominately tense crying. A more relaxed emotional state is associated with fluid, freely oscillating feelings expressed in (3) predominately relaxed and (4) relaxed crying.

Plessner (1970) challenged the "limitations in Spitz' theory" and described crying as having physical reflexive components as well as purely psychical ones. According to Plessner, we do not simply burst out crying but rather feel a weakness, a yielding, coming on which we either master or can no longer master. Some internal loosening,

detachment, and/or capitulation in the face of an overwhelming occasion must already have preceded crying, otherwise we would not feel ourselves growing weak. This mediated character of crying presents a disorganized relation of the individual to the body. As Plessner states, "in laughter, the dominant relation to the body is disrupted, in crying, on the other hand, one gives it up."

Plessner (1970) defined three occasions and varieties of crying; (1) Purely physical occasions in which pain, shock, fatigue, weakness following exertion, hunger, excitement, etc. become focal; (2) Purely mental or intellectual occasions consisting of deep emotion before a work of art, a person, an event, during prayer or devotion; (3) Affective occasions in which the inner life of the person or excitations, feelings, emotional states are made manifest.

When one cries in pain, the experience is of being thrown back from the world onto the body. We exist only as the painful component -- the tooth, stomach, head. This leads to a loss of equilibrium that stems from our own disturbance or the perception of our own suffering. There may be a feeling either of exhaustion or overstimulation; one may experience helplessness as if before some external force; rage, fury, defiance, and despair all lead to feelings of futility. These rising emotions are penetrated and reveal the hopelessness of resistance; one cannot cope and is out of balance. When we experience joy, compassion, love, prayer the world ceases to exert pressure on us. A burden is lifted and the pressure is slackened. An unmistakable sense of grandeur may transcend everything during this experience, i.e., in the simplicity of children or the beauty of the earth. Ordinary existence may become figural in a totally new and different way. A sudden easing of the world's accustomed pressure ensues. Emotional crying of this type springs from a momentary sense of unearned peace in the battle with the world which Plessner believes is the source of tears in men more often than in women (ibid, p 134).

Plessner (1970) points out that we weep for ourselves through the other. We see the other's pain and weep, perhaps saying, "I weep for him in his pain" when, infact, we weep for ourselves. We acknowledge the pain, joy, or sorrow of the other because we empathetically identify with the other. This empathic connection draws the pain back to us and we weep. It is, in fact, "my own suffering which I sympathize with as alien (ibid, p 119). " We weep because we weep for ourselves as sufferer. In this manner, weeping functions to draw us out of ourselves and into communicative interaction with the other and from interaction with the other back into ourselves through empathic reactions.

McGreevy & Van Heukelem (1976) like Plessner, stress the importance of crying as an expression of physical, emotional and spiritual needs. Spiritual needs may be directed toward a Supreme Being and involve a person's relationship to God. Out of this basic need for relationship we find forgiveness, hope, meaning, and purpose in life (Breland, 1975). The loss of one's relationship to God, a real or perceived lack in this area, can represent a deeply troubling experience and arouse much anxiety. Crying can also be an expression of one's struggle to deal with God in relation to some life crisis, i.e., illness, tragedy, etc.

Koestler's (1975) theory of crying describes five types of tears. (1) Tears of raptness are self-transcending emotions that do not tend toward action but rather toward quiescence, tranquility, and catharsis. (2) Tears of mourning occur when nothing purposeful can be done. They indicate a passive surrender, giving in to grief, with an underlying sense of communion that transcends the boundaries of self. (3) Tears of relief indicate a juxtaposition of reality with illusion, e.g. tears of joy after anxiety, alternately laughing and weeping. (4) Tears of sympathy are an act of projection, introjection, or empathy. These are vicarious emotions, experienced on behalf of someone else but nevertheless belonging to the self. (5) Tears of self-pity imply a sense

of helplessness after rage has been exhausted and a feeling of being abandoned has set in. This is experienced as a yearning for sympathy or consolation. When acute pain or rage has abated, or after a severe fright, the tears come.

Empirical Studies of Crying:

Over the past 20 years, a number of studies related to crying have appeared; a summary of findings is presented in Table 7. Ten of the studies reviewed provided results for both men and women; four addressed crying in women only.

Gender differences in crying frequency were noted in every study involving both men and women, with women crying significantly more frequencly than men. When men and women were asked to estimate global frequency of crying, however, no significant differences were found (Crepeau, 1980). Kraemer & Hastrup (1988) found no significant differences between global estimates of crying frequency and the occurrence of crying in a laboratory setting. Labott & Martin (1987) were able to differentiate high and low weepers (within gender category) based on a scale of the tendency to weep in certain situations. Results indicated that weeping increases mood disturbance overall when associated with negative events, especially among those who weep frequently. Although gender differences in weeping and emotional expression are interesting, the focus for the present study concerns crying in women and results applicable to men will not be directly addressed, except when contrasted to findings for women.

Several factors of interest emerged from this review. The first involves a recurrent characterization of weeping as a transitional state. According to Bindra (1972) weeping begins when adjustments to normal situations are impossible due to overpowering emotions. Along similar lines, weeping has been characterized as a "shift" (Efran & Spangler, 1979), change, or interruption that recontextualizes the situation (Cornelius, 1981). A second factor of interest involves reports of tension reduction

TABLE 7

EMPIRICAL STUDIES OF CRYING/WEEPING

STUDY	SUBJECTS	METHODS	EVENTS	RELEVANT FINDINGS
Bindra, 1972	University Students N = 50	Questionnaire	Typical weeping episodes	Weeping occurs when emotional state becomes too overpowering to allow normal adjustive behaviors to proceed. Weeping is a feature of an acute transitional state, different than both the initial and the resulting emotional state.
Efran & Spangler 1979	Adults N = 11	Text of The Miracle Worker	Points in the text when subjects felt like weeping	Weeping occurs when some barrier which has been placed in front of a character is removed. Weeping is the event that occasions the shift from arousal to recovery.
Crepeau, 1980	Healthy men & women vs men women with colitis or ulcers N = 150	Self-report questionnaire	Hypothetical assessment of behaviors in specific situations	Healthy men and women tend to cry significantly more than men and women with ulcers or men and women with colitis. Females report crying significantly more often than males.
Cornelius, 1981	Adults Males = 18 Females = 20	Self-report descriptions	Happy and sad occasions of weeping in the presence of another person	Weeping brings about change in the interpersonal order of the situation. Weeping interrupts the flow of dyadic interaction and ushers in a new focus and frame for interactions. Weeping recontextualizes the acts performed in the episode.
Frey, 1983	Adults N = 476	Self-Monitoring of behavior	Frequency of weeping episodes	Frequency of crying was significantly higher for women than for men.
Ross & Mirowsky, 1984	Adults Males = 680 Females = 680	Telephone Interviews	Questionnaires	Men are less likely to report crying. Correlations between crying & sadness are smaller for men than women. Women cry more when they are sad.
Kraemer & Hastrup, 1986	College students Males = 181 Females = 316	Questionnaire, self-monitoring behavior	Global estimates of crying frequency & diary of self-monitored incidents	Global estimates of crying frequency were significantly different for men than women. Men report fewer crying incidents. Ss did not feel significantly better after crying than after feeling like crying and inhibiting it.
Choti & Marston, 1987	College Students Males = 58 Females = 56	Self report questionnaire, sad movie	Crying, feelings of sadness before, during and after film.	Women reported more crying than men overall. Stereotypical patterns of emotional expression were reported in the presence of the opposite sex. The experience of anger inhibited crying in men but not in women.

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STUDY	SUBJECTS	METHOD	EVENT	RELEVANT FINDINGS
Labott & Martin, 1987	Undergraduates Study 1: M = 161 F = 219 Study 2: M = 135 F = 199 Study 3: M = 89 F = 95	Self-report questionnaires	Tendency to weep in certain situations. Cry-coping. Humor-coping.	Study 1: Weeping in response to negative events was associated with increased rather than decreased mood disturbance. Study 2: Stronger relationships between negative events and mood disturbance among high weepers than low weepers. Using humor to cope buffers the effects of negative events on mood disturbance. Study 3: Cry-coping in response to negative events produces an interaction similar to that of general crying.
Egerton, 1988	Adults Males = 22 Females = 23	Questionnaires	Hypothetical situations, "act as if it happened to you."	When weeping occurs, women cease to be agents. They gain the available goal by presenting themselves as powerless. Women's emotionality is affected by their occupation of subordinate and undervalued roles in society.
Kraemer & Hastrup, 1988	Adults N = 48 (F)	Viewing sad movies, questionnaires, heart rate and skin conductance	Global frequency estimates, inhibition or trying to express emotion.	The occurrence of crying in the laboratory did not differ for subjects with high or low global frequency estimates. Heart rate became elevated in the minute prior to crying and continued elevated during the episode. During the minute Ss began to cry, they had significantly more fluctuation of skin conductance than noncriers
Labott & Martin, 1988	Adults N = 47 (F)	Sad movie, questionnaires	Weeping and feelings of "closure"	Incongruity was associated with increased stress and depressed mood. Resolution of incongruity resulted in greatest amount of weeping. Closure - the degree Ss felt "finished" with the story – had a significant effect on reports of stress reduction. Ss who cried rated themselves as less stressed but differences were not significant.
Labott & Martin, 1990	Adults M = 225 F = 285	Telephone interviews, questionnaires	Physical disorder; stressful and upsetting events; coping with crying or humor	Age and income level were significantly correlated with physical disorder. Cry coping was associated with increased physical disorder among women and low income subjects. Higher incomes were associated with less physical disorder and less cry coping. Tendency to use cry coping decreased as age increased.
Labott, Ahleman, Wolever, & Martin, 1990	Adults N = 39 (F)	Questionnaires, saliva, movies	Salivary IgA, expression/ inhibition of laughter or crying	Salivary IgA levels were lowest in the expressive condition, and highest after the humorous video. In the inhibition condition S-IgA changed little to either condition.
Cornelius, DeSteno, Labott, 1992	College Students Males = 52 Females = 68	Questionnaires, crying frequency questionnaire	Experience of crying e.g. felt better, did not feel better.	Ss reports of tension reduction following weeping episodes are related (1) episode outcome, (2) How pleased Ss were with the behavior of others involved, (3) How much Ss see their weeping as contributing to the resolution of the situation. Episodes in which Ss feel better are characterized by resolution of the issues that led Ss to weep in the first place. Happy episodes reflect acceptance and strengthening of ties, sand weeping reflects rejection and severing of ties.

and/or feeling better following crying episodes. Although crying has been characterized as a respite (Wood & Wood) or vehicle for catharsis (Frey, 1980, Frey & Langseth, 1985), studies evaluating physiological effects of crying demonstrate increased skin conductance, increased heart rate (Kraemer & Hastrup, 1988), increased physical disorder (Labott & Martin, 1990), and lower immune system function based on levels of salivary IgA in the midst of weeping episodes (Labott, Ahleman, Wolever, & Martin, 1990). In contrast to reports of feeling better obtained from subjects following weeping episodes, physiological measures often indicate arousal (Kraemer & Hastrup, 1988; Labott & Martin, 1988).

Other contradictions in the literature may be noted with regard to reports of crying among men and women with physical disorder and healthy men and women. Healthy men and women experienced more frequent episodes of crying and higher estimates of global crying frequency than do men and women with either ulcers or colitis (Crepeau, 1980). In a more recent study by Labott & Martin (1990), however differences in crying among healthy men and women and men and women with ulcer or colitis were not significant. Both studies utilized a hypothetical method to obtain information on which results are based, e.g. "how would you be most likely to respond in situation X."

The subject's attitude toward weeping in different situations depends on whether the person actually weeps or simply feels like weeping but does not. Subjects who feel like weeping but do not report more ambivalent or negative views of weeping. Their attitude is most likely to take one of two forms: (1) they are unsure of the appropriateness of weeping in the situation -- the situation offers few cues as to what is expected of them, and (2) they perceive weeping to have a negative or undesirable effect in terms of their interactions with others. People who feel like weeping but do not, feel stronger and less submissive in those situations than in situations where they do

weep (Cornelius, 1981). Kraemer & Hastrup (1986) reported subjects did not feel significantly better after crying than after feeling like crying and inhibiting it. When Labott, Ahleman, Wolever & Martin (1990) sampled salivary IgA levels among people who inhibited crying while watching sad videos or inhibited laughter during humorous videos, they found little change in S-IgA levels in either condition.

Since 1981 Cornelius has investigated the phenomenon of weeping in a series of excellent empirical studies in which crying is viewed within a larger framework of social interactions. In interpersonal relationships, contrary to the theoretical formulations of Koestler (1975), sad weeping proved quite functional, i.e. was purposeful in bringing about some desirable end. Sad weeping is characterized by rejection and a severing of group ties and occurs when attachments are in danger of being broken. On the other hand, happy weeping is characterized by acceptance and the strengthening of group ties, and is bound up in acceptance, integration, or re-integration within a group.

Cornelius' study is of primary significance here in that the person who cries describes some actual rather than some hypothetical expression and descriptions concerned episodes which occurred within some relational context. Results of this study indicate persons find weeping to be meaningful, relatively positive, and largely uncontrollable. Cornelius reports, somewhat paradoxically, that "people seem to know that weeping is controllable but, nevertheless, perceive it and report it to be uncontrollable." Cornelius concludes that "weeping allows individuals to accomplish certain ends without being held responsible for them because the actions that accomplish them are seen to be involuntary and uncontrollable" (ibid, p 139).

Egerton (1988) reported that when women weep they give up agency and present themselves as powerless in order to achieve goals as a result of their role as subordinate and undervalued members of society. Cornelius (1981) has reported that in situations involving conflict, weeping allows the person to confront issues head on "by

appearing to give in" whether this "giving in" is deliberate or not. This action forces the other person to consider the weeper and his/her needs and demands in a dramatic fashion. Both men and women participated in each study. Two significant differences stand out between these studies. One group (Egerton, 1988) was asked to respond to a hypothetical situation, e.g., act as if this happened to you" while the other (Cornelius, 1981), as previously mentioned, was asked to describe situations that had actually occurred. The characteristics of interest are noted only among females in Egerton's study and are cast by the author as a loss of agency resulting from inequalities imposed by the society at large. Similar characteristics were noted among men and women in Cornelius' study and were presented as being efficacious given the situation.

A Review of Literature on Crying in Cancer Patients:

Although it has been suggested that cancer patients have difficulty expressing emotions (Eysench, 1985, 1987) the current literature on crying among cancer patients is practically nonexistent. In one exception, Redd (1982) treated a cyclic pattern of excessive crying in a terminal cancer patient with time out from social stimulation. Analysis demonstrated initial elimination of crying in the presence of hospital staff and a gradual diminishment of crying with family members. The frequency and duration of family visits as well as of conversation subsequently increased. This study graphically demonstrates the extreme to which chronically ill patients go to control their emotional expressions to avoid social isolation and to continue to be accepted by significant others.

Even though some cancer patients experience difficulty crying, when cancer patients or family members begin to get in touch with feelings and deep concerns about the seriousness of the illness in groups where psychosocial interventions have been instituted, crying sometimes does occur (Singer, 1983). It has been suggested that

crying in cancer patients and/or the inability to cry may be related to fears of loss and separation, e.g., dread of what life will be like without the loved ones. Holding back tears may result from rationalizing fears, e.g., not wanting one's spouse to find out how depressed one is for fear the spouse will be upset and frightened. In this way, feelings are cut off from direct awareness. Closer, more effective, communication is inhibited and certain aspects of reality are distorted and not dealt with adaptively. A case history provided by Singer (1983) exemplifies this process:

> Mr. G., a markedly counter-dependent and inhibited man, stated in his initial group session that he had only cried a few times in his life; he strenuously tried to control himself when he did get upset: "Crying never helps and only upsets my wife." Even though he had repressed and denied painful feelings about his illness for a long time, he had begun to experience a strong welling up of emotion when the conversation in the group became personal, touching on sensitive areas like unendurable pain or death. He could identify with and empathize with others who were also struggling with these issues. However, he still avoided communicating with his wife about his worries, especially his financial ones. Mrs. G. admitted that she usually tried not to discuss her feelings and fears of the future with her husband because whenever she did talk about them, she started to cry and she knew this threatened and annoyed him; she kept most of her apprehensions from him. As the couple began to explore this block in their communication and shared their feelings with other group members, Mr. G. started to get upset and had some tears in his eyes which he seemed to be trying to control. Mentioning this to him resulted in his crying more spontaneously and sharing his distress with the group. Usually his

> conversations were highly intellectualized. However, drawing his attention to his few tears and his efforts to suppress them, appeared to give him permission to release the feelings. He could experience an aspect of himself that he rarely allowed himself to feel; he explained how he had always been afraid to "let go" because he feared he would be too weak and too helpless to control his emotions at all. Not only did he sense the safety and acceptance of the group members, but more importantly, he felt the relief and love from his wife who was happy to be relating to him at this level of emotional interaction (Singer, 1983, p 20-21).

It has also been demonstrated that more open and expressive communication within families where problems exist results in cancer patients being less anxious and depressed (Spiegel, Bloom, Kraemer, & Gottheil, 1983; Friedman, Baer, Nelson (1988). Spiegel (1991) reported a series of disturbing dreams in one patient who "had a very competent oncologist who would sit behind a typewriter and type while she was talking. If she began to cry, he would dismiss her from the office. Through group work she was able to go into her doctor's office and tell him, "Look, I respect your opinion, and you will decide when I need a course of chemotherapy, but on any given week, I will decide whether I will take it then so I will have some control over how sick I'm going to be over the next few days. The second thing is that I'm going to cry from time to time, but I will also stop crying, so please don't ask me to leave the office." Following this encounter, the patient's nightmares went away and she got on much better with her physician" (Spiegel, 1991, p 14).

In all three cases, interactions between the cancer patient and significant others improved whether as a result of cessation of crying (Redd, 1982) of being allowed to cry

by giving permission to oneself, or by receiving it from others, (Singer, 1983; Spiegel, 1990). In each instance, meaningful interactions with others were facilitated. The question remains whether crying serves a more meaningful purpose than as a bridge of communication -- either desired or undesired -- between the person and significant others in their lives.

Crying as a coping mechanism for cancer patients has been indirectly addressed by Labott & Martin (1990) whose work supports the position that weeping is associated with increased physical and psychological disorder. Overt crying resulted in a significant decrease in salivary IgA levels compared to subjects who inhibitited overt weeping. These findings are provocative when considered in view of studies of anger expression and serum IgA in breast cancer patients (Pettingale, Greer, & Tee, 1977). Increased levels of serum IgA were found among "extreme suppressors" of anger but continued to be elevated over a two year period only among women who expressed their anger within the first three months of diagnosis. Unfortunately, neither the relationship of salivary IgA and/or serum IgA to weeping nor the relationship between anger and weeping has been addressed in the current literature.

DISCUSSION: CHARACTERISTICS OF CRYING

Based on findings from previous empirical and theoretical investigations of crying, several conclusions seem warranted: Behaviorally crying consists of watery eyes, red nose, some associated vocalizations (e.g. shouts of joy, pain, lamentation) accompanied by an emission of tears from the eyes (Labott & Martin, 1987). Considerations of psychological aspects of weeping or crying usually include many forms of emotional expression such as sorrow, pain, or empathy. Modern considerations of psychosocial aspects focus on crying as a retreat from others.

Withdrawing or going inside oneself has been equated with disorders in relationships, and/or depression, or melancholy (Wood & Wood, 1984). Crying also has been viewed as a method of pulling others toward oneself for comfort and solace; this view may also be extended to more negative psychosocial purposes such as manipulation (Adler, 1964). Religio-historical components of crying are rarely discussed in modern society, and we are unlikely to think of crying as a mode of connection to God or as a lamentation brought on by a realization that one is separate from God. Modern considerations rarely entail religious or spiritual aspects of crying with the notable exception of McGreevy & Von Heukelem (1976), whose analysis of crying/weeping/tearfulness attempted a more holistic view of the phenomenon.

We may characterize crying in terms of physical, emotional, and spiritual aspects that occur most commonly when there is an experience of loss, i.e., of relationship, role, status, etc. and/or when the individual needs to regain control over feelings and physiological states (Choti, Marston, & Holston, 1987). In such instances, emotional tears play a role in one's ability to tolerate stress (Frey & Langseth, 1985) and maintain equilibrium and homeostatic balance (Lester, 1985). Tears appear to promote self-healing and self-maintenance (McCarthy, 1930) and to result in a more cohesive sense of self (Nystul & Garde, 1979). After crying, feelings of relief and relaxation (Spitz, 1935) seem to be prominent and yield a calmer frame of mind, possibly even a desire for rest and sleep (Lofgren, 1966; McGreevy & Von Heukelem, 1976). Weeping has also been viewed as a "giving up" or a "giving in" to a stressor; a maladaptive response that precludes effective action and emotional coping (Labott, & Martin, 1987). Conversely, Tompkins (1963) hypothesized that one effect of crying is to increase distress in order to motivate action. In some situations, healthy people are more likely to cry and possess a more positive attitude toward tears than people with disease conditions which appear to be stress related (Crepeau, 1980), although these findings do not obtain across

populations (Labott & Martin, 1988). A number of incidences of illness have shown tendencies toward recovery after crying (Foxe, 1941).

As a method of communication crying signals a change, either directly or in an empathic sense. Crying provides opportunities for direct communicative psychosocial interaction between parent and child (Lipe, 1980) or between an individual and the surrounding environment (Garland, 1972; Stern, Beebe, Jaffe, & Bennet, 1977). Crying sets up a dialogic interchange between person and world providing a signal to express pain, sorrow, frustration, anger, discomfort, or even joy and happiness. When crying is used as a manipulative communication, it may signal an imbalance in the parent-child dyad (Lester, 1985; Sullivan, 1951) that later may be transferred to other relationships where control is an issue. The primary function of crying as communication is either inter-personal (between child/parent and/or self/other) or intra-personal with the self as agent (Lester, 1985). Empathic crying allows us to experience joy, sorrow, and/or pain through the other. Through empathic relationships we move out from ourselves to meet the other in their expressions of joy or sorrow and return again to the joy or sorrow reflected in ourselves (Plessner, 1970).

Crying connects us to our physical world by aiding in the maintenance of homeostatic balance (Lester, 1985; Heilbrunn, 1955). In the midst of continual flux and change we experience a sense of equilibrium. From time to time, we may need to let go of the stressors in our lives and just give up (Choti, Marston, & Holston, 1987). Crying releases tension and stress and allows us to relax and regain control. If the situation is extreme or chronic, we may end up feeling helpless or hopeless and giving in to the overwhelming feeling of distress and losing control. Tears may occur in an effort to rebalance necessary energies and regain equilibrium (Nystul & Garde, 1979).

Empirical studies by Labott & Martin (1987; 1988), Kraemer & Hastrup (1988) and Labott, Ahleman, Wolever, & Martin (1990) seem to contradict reports of tension

relief and stress reduction as a result of weeping. Such conclusions are based on comparisons of self-reports to physiological measures which indicate increased arousal, e.g., heart rate, skin conductance, and lower immunity, e.g., salivary IgA levels among weepers. These contradictions, however, may simply point out a misunderstanding of the complexity of mind/body interactions which result from falsely equating homeostatic balance with low arousal. Alternatively, physiological arousal may simply "feel better" to some people.

We may experience daily stresses in our lives that motivate us to action or create change (Tomkins, 1963). Change may occur in many ways; a physical state characterized by high arousal and lowered levels of immunoglobulins acting to defend against invasion may simply indicate a temporary retreat from a hostile world -- like a period of calm in the midst of a storm. Feelings of arousal may not mean discomfort, especially if crying serves to mediate between physiological and environmental demands as suggested by Lester (1985). Finally, stating that increased weeping is associated with increased physical discomfort (Labott & Martin, 1990) has a somewhat different meaning than stating that increased physical discomfort is associated with increased weeping.

In crying we express a basic need for personal relationships with others, with ourselves, and with the source of our faith and religious beliefs. Crying, therefore, may provide a source of inter or intra personal connectedness. The interpersonal experience connects us to spiritual aspects of being human (McGreevy & Van Heukelem, 1976). We achieve a sense of freedom from the human condition through forgiveness, love, trust in god or in others as we explore the meaning and purpose of our life (Breland, 1975). Connections to the surrounding world, to others, or even to our selves may become constrained when we experience anger, pain, or frustration. Crying provides a time of retreat from the constricted, bound up aspects of our human existence (Nystul & Garde, 1979) which may be experienced as a withdrawal from the world, from others, or

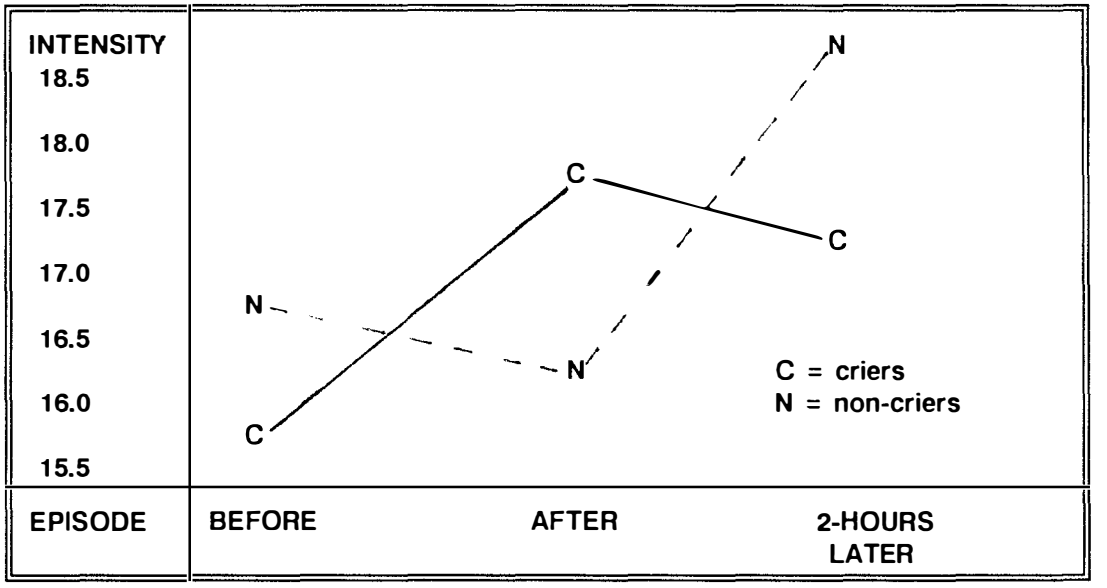
even from ourselves. One may experience a sense of denial, of alienation or even isolation or retreat may be experienced as a renewal, useful for self-maintenance, reflection, self-regulation or even self-healing (McCarthy, 1930).

When the physiological effects of crying are monitored, weeping does not seem to buffer the effects of stress on mood, often increasing distress instead of releasing or reducing it (Labott & Martin, 1988). Fluctuations in skin conductance also have been demonstrated in direct contrast to expectations that conductance would decrease when crying begins (Kraemer & Hastrup, 1988). Although the study by Kraemer and Hastrup presented results obtained before, immediately after, and 2-hours after crying episodes were initiated among subjects who watched sad films in the laboratory, only those results obtained before and immediately after the episode were discussed. Skin conductance following the episodes decreased to levels below baseline at the 2-hour post crying episode. Perhaps these findings indicate that crying episodes facilitate a delayed relaxation response (Benson, 1974).

Self-reports of mood, measured on the Multiple Affect Adjective Checklist (MAACL; Zuckerman & Lubin, 1965) were taken immediately before, immediately after and two hours after the movie. Although mood ratings of criers and noncriers were not significantly different before or immediately after the movie, pre and post ratings for criers were significantly different. Results from the two-hour post crying episode were not discussed for either group. When these figures are plotted as in Fig 1 below, however, an interesting trend is noted.

Criers show a buildup of negative mood and a slow release. Noncriers, on the other hand, show a nearly opposite effect. Looking at the results in this manner might suggest that inhibiting crying in the context of a negative event decreases mood disturbance at the time of the event but results in increased disturbances over time. Differences in level of disturbance were significant for criers when before and

after conditions were compared (15.5 to 17.9), -- according to Kramer and Hastrup's report. It seems the difference between ratings for noncriers immediately after and 2-hours post episode could also be significant (16.1 to 18.7) although the 2-hour post finding were not addressed in the authors' discussion.



* Results derived from report of findings published in Kraemer & Hastrup, 1988.

Figure 1

PLOT OF SELF REPORT OF MOOD (MAACL)*

Weeping is a meaningful social activity that cannot be fully understood outside the social context within which it occurs; tears mean something to the person who sheds them. Regardless of contradictions between findings from empirical studies, theoretical formulations, or philosophical perspectives, we need to take into account the meaning of tears and the relationships within which crying is embedded. How people render acts of crying meaningful has never been fully explored. Crying has at its foundation the captivation of an individual by some thing. The emotional expression binds one to something and allows far less independence from people, events, and

thoughts than we care to imagine. Certain events call to us strongly and we become engaged. These events have been called "central to us," (Plessner, 1970) and are deeply rooted within us. These feelings are pre-reflective; they occur before we think about them (James, 1890/1918) even though thinking about them may make them present again either in a similar or in an entirely different way. Crying is both a connection to the world and retreat from it. As such, crying might more appropriately be considered an expression of the dialectic interchange taking place between person and world than as an expression of emotion standing at the interface between body (physical) and mind (psychological).

Philosophical assertions by Descartes notwithstanding, experiences of crying clearly involve the whole person and seem to indicate that an interface between body and mind is unnecessary since -- at least with regard to crying -- no such division exists. Our great difficulty has been in understanding the meaning of mind/body relations as expressed through our emotions. Although a one-to-one correspondence is often expected, such does not occur. In fact, although it seems to occur more directly and immediately with arousal, the same is apparently not true for experiences of tension release. Although this expectancy seems false, it forms the basis of a continuing controversy between theories of emotion. The difficulty may have resulted from our failure to recognize the importance of placing people in the context of the personal world as experienced with all the associated contradictions and discrepancies inherent in being at the same time, a body that is "me" as well as "mine." Standing at this juncture between person and world may enable us to clarify the seemingly paradoxical relationship human beings experience with regard to emotional expression.

Among the givens of life that are often taken for granted is the experience of being both fully "in" and at the same time "separate from" the world out there. Consciousness of self and absorption without awareness of self are the two polarities

between which we move with varying degrees of alteration or simultaneously throughout the life cycle. This process is never finished and can always become reactivated; new phases of the life cycle witness new derivatives of the earliest processes still at work (Mahler, Pine, & Bergman, 1975). Between these two possibilities is the problem of being a self: the problem of claiming the integrity of one's own experience and knowing its power while also remaining a part of the greater whole. The body is the sole means we have of going into the world, into the heart of things. One's self is made the world, and the world is made flesh (Merleau-Ponty, 1968). The body as both sentient and sensitive is the abyss that separates the experience of being "in" from the experience of being "for." Our body unites these two properties within itself, a double belongingness to the order of the "object" and to the order of the "subject" not by some incomprehensible accident nor as two separate things but each "as an archetype of the other, because the body belongs to the order of things as the world is universal flesh" (Merleau-Ponty, 1968).

Whether our tears spring from physical, emotional or spiritual sources, or all of these, they color our encounters with the world as they arise from risking ourselves in the world (Plessner, 1970). We encounter the paradox of our own nature in reaching beyond ourselves. Whether our stretching is toward some physical limit, some emotional or spiritual edge, matters not. As we extend ourselves fully in human freedom, we become aware of the boundedness of being human as well. It is at the juxtaposition of freedom and boundedness in human being that crying occurs. Joy, gladness and ecstasy free us from worldly constraints even as pain, sorrow and anguish bind us again.

CHAPTER 4

METHODS AND PROCEDURES

OVERVIEW

Method is a term derived from the root words *"meta"* meaning something like with, or across and *"hodos"* a meaning path(s) (Onions, 1966). Thus, a method may be understood best as a path to some goal. A distinction must be drawn, however, between the customary use of the terms "method" and "methodology." Method commonly refers to ways of gathering data while methodology refers to some epistemological position or stance of the investigator (Bryman, 1984). Since crying may be understood as an activity that encompasses physical, psychological and social aspects of being human it lends itself equally well to quantitative and qualitative methodologies. One purpose of this study is to understand crying and its meaning as experienced by women who cry and to determine when and how frequently they cry. It seems most appropriate, therefore, for the research method to encompass many different aspects of the experience rather than be confined to specific elements whose importance is pre-determined by the philosophical stance of the investigator, the importance of that stance notwithstanding.

Purpose of the Study:

The purpose of the present study is to describe the experience of crying and its meaning for women with and without cancer. A primary focus is to describe crying as it occurs in everyday life and to articulate its meaning from the point of view of the woman herself. One premise of this study is that crying has some meaning for the crier. It is both privately "felt" and, at the same time, observable to oneself and/or to others.

The first phase of the present study used data gained from the Personal Attributes Questionnaire (PAQ) (Spence & Helmreich, 1978), the Toronto Alexithymia Scale (TAS) (Bagby, Taylor & Parker, 1990), and the Body Cathexis Scale (BCS) (Balgoun, 1986). Demographic and information regarding each participant's past medical history also were collected and participants were asked to record every occurrence of crying during a 30-day period. Data for these measures were subjected to statistical analysis using Analysis of Variance technique (ANOVA), Pearson Product Moment Correlations, and t-tests. During the second phase of the study, each participant was asked to provide a detailed, written description of one crying episode from the 30-day period; these data were subjected to a content analysis. The third phase of the study consisted of an open-ended phenomenological interview in which participants were asked to describe experiences of crying. These interviews covered any and all experiences the participant chose to describe regardless of when they might have occurred over the life span. Data from verbatim transcripts of these interviews were analyzed using hermeneutic techniques.

Participants:

Participants with cancer were self-selected volunteers initially solicited through letters sent to various physicians, hospitals, therapists, and cancer support groups in and around Knoxville, Tennessee. Individuals who expressed an interest in the study were provided letters which were then sent to potential participants. These letters described the study in detail and requested persons interested in participating to notify the researcher or a contact person in the physician's office, hospital, or agency of their interest. A copy of the initial letter sent to all potential participants with cancer is presented in Appendix A-1

Non-cancer patients, who served as the comparison group were self-selected friends, family members, and co-workers recommended by patients with cancer. A summary of information describing participants with cancer is presented in Table 8; a similar summary is provided for participants with no chronic disease in Table 9.

TABLE 8

DEMOGRAPHIC CHARACTERISTICS OF WOMEN WITH CANCER

AGE	TYPE OF CANCER	MARITAL STATUS	CAREER STATUS	PARTICIPATION IN PSYCHOSOCIAL SUPPORT
21	Endometrial	Single	Careerwoman	No
28	Colon	Separated	Careerwoman	Yes
31	Breast	Married	Careerwoman	No
31	Molar Pregnancy	Married	Homemaker	No
32	Breast	Married	Careerwoman	Yes
32	Lung	Single	Careerwoman	Yes
37	Breast	Married	Careerwoman	No
39	Endometrial	Divorced	Careerwoman	No
39	Lymphoma	Married	Homemaker	Yes
40	Breast	Single	Careerwoman	No
42	Uterine	Single	Careerwoman	No
43	Colon	Married	Homemaker	No
44	Colon	Married	Careerwoman	Yes
44	Breast	Divorced	Careerwoman	Yes
46	Breast	Married	Careerwoman	Yes
51	Breast	Married	Careerwoman	Yes
52	Breast	Widowed	Careerwoman	No
53	Thyroid	Married	Homemaker	Yes
61	Melanoma	Married	Homemaker	Yes
62	Breast	Married	Homemaker	No
62	Pancreatic	Married	Homemaker	Yes
64	Liver/Breast	Widowed	Careerwoman	Yes
64	Lymphoma	Married	Homemaker	Yes
65	Endometrial	Married	Homemaker	Yes
65	Ovarian	Married	Homemaker	Yes
65	Lymphoma	Married	Careerwoman	No
69	Melanoma	Widowed	Homemaker	No

TABLE 9

DEMOGRAPHIC CHARACTERISTICS OF WOMEN WITHOUT CANCER

AGE	CANCER PATIENT'S RELATION TO PARTICIPANT	MARITAL STATUS	CAREER STATUS	PARTICIPATION IN PSYCHOSOCIAL SUPPORT
20	Father	Single	Careerwoman	No
21	Father	Single	Careerwoman	No
27	Mother	Married	Careerwoman	No
29	Father	Single	Careerwoman	No
30	Mother	Divorced	Careerwoman	No
32	Sister (2)	Single	Careerwoman	No
32	Grandmother	Single	Careerwoman	No
33	Grandmother	Widowed	Homemaker	Yes
33	Daughter	Married	Careerwoman	No
36	Grandmother	Single	Careerwoman	No
38	Co-worker	Married	Careerwoman	Yes
38	Mother & Co-worker	Married	Careerwoman	Yes
43	Co-worker	Married	Careerwoman	Yes
43	Grandmother	Divorced	Careerwoman	No
43	Mother	Widowed	Careerwoman	Yes
45	Roommate	Single	Careerwoman	No
45	Mother & Grandmother	Divorced	Homemaker	No
47	Grandmother	Divorced	Careerwoman	No
49	Mother	Separated	Homemaker	No
50	Grandmother	Divorced	Careerwoman	No
53	Father	Divorced	Homemaker	No
55	Spouse	Married	Homemaker	Yes

Forms and instruments:

Each participant completed an Informed Consent Form which was their agreement to participate in the study. A copy of the informed consent form is provided in Appendix A-2. Participants also were asked to keep a record of their crying behavior over a 30-day period. A behavioral checklist in the form of a calendar was provided by the researcher. On this calendar, participants were asked to record the frequency of four behaviors: needing to cry but can't or don't, watery eyes, crying/weeping, and sobbing. Participants rated each occurrence of these specific behaviors according the following scale for intensity: (0) none, (1) mild, (2) moderate, (3) strong, (4) severe. In addition to verbal instructions given by the researcher, a set of written instructions describing the method for completing the behavioral checklist was provided along with selected examples of behaviors. Copies of the frequency/intensity behavioral checklist and written instructions appear in Appendix A-4 and A-5. Participants were provided one additional form and were instructed to complete it at any time during the 30-day period. On this form, each participant was asked to choose one experience of any of the four behaviors tracked as it occurred during the 30-day period and to describe it in detail. A copy of the form provided for written descriptions appears in Appendix A-6.

DATA COLLECTION

Bracketing:

In addition to considerations required of any researcher interested in collecting behavioral and survey data, phenomenological research requires the researcher to make explicit any assumptions held with regard to the topic prior to the collection of data. It is at this point in the research process that the epistemological stance of the phenomenological investigator is critical. Quantitative methodology is routinely depicted as an approach to research which applies a natural science, in particular a "positivist"

approach to phenomena (Thompson, Locander & Pollio, 1989). As a method of data collection, using questionnaire items allows concepts to be operationalized. Objectivity may be maintained by both the distance that exists between observer and observed as well as by the possibility of external checks on the questionnaire. Replication can be carried out by employing the same instrument in other contexts. Research of this type is underpinned by a distinctive theory of what should pass as warrantable knowledge according to a positivist paradigm.

Giorgi (1983), Pollio (1982), Valle & King (1978), and Zaner (1970) all have pointed out basic philosophical assumptions that underlie this "Cartesian" stance. Of particular relevance to the present study is the conceptualization of the body as a machine with components which, when studied in isolation, will lead to an understanding of overall function. In a second conceptualization, the body is viewed as a container for the mind which is, in turn, viewed as a container for symbolic representations, schema, and structures (Lakoff & Johnson, 1980). Experience is thus private, internal and subjective while activity is external, observable, and therefore objective. This dualistic notion of human being gives precedence to observable behavior; data are reliable, replicable, and verifiable when they are observable and can be repeated by others.

The subject matter of phenomenology as used in qualitative research begins with a "first-person" description of some experience. A hermeneutic method allows phenomenological methods to be applied to discourse about the human life world as it is transformed into written texts from open descriptions of phenomenon. Merleau-Ponty (1962) and Spiegelberg (1960) outlined three aspects of the phenomenological method: (1) open description, (2) investigation of essences, and (3) phenomenological reduction.

Open description does not attempt explanation but, rather, stays at the level of clarification. It aims at giving as precisely and completely as possible, a description of the phenomenon without any considerations of origin or causes. An investigation of

"essences" involves searching for common themes in descriptions given by persons who have experienced the phenomenon. The phenomenological reduction takes place through a process of "bracketing." The researcher attempts to bracket or hold in abeyance common sense and scientific knowledge in order to arrive at the essence of some phenomenon. A simple example of this process would be similar to viewing a Necker cube, placing in "parenthesis" the idea that "this is a cube" and allowing other possible forms to emerge from the figure. A complete bracketing of previous knowledge is impossible (Merleau-Ponty, 1962) and also unnecessary. What is necessary is a conscious awareness of one's own preconceived notions about the phenomenon.

When expectations of the researcher are made explicit through a bracketing interview, the potential for distortion in data collection and description is reduced (Hawthorne, 1988). Bracketing is not simply an exercise performed at the beginning of the study; rather, it is an ongoing process that occurs throughout the study that helps the researcher detect and understand underlying assumptions about human experiences as they emerge. Bracketing allows the researcher to be open to new and unexpected aspects of the phenomenon under investigation (Kvale, 1983).

The process of bracketing -- looking at one's preconceived notions and expectations -- is also fundamental to hermeneutic analysis. The hermeneutic interpretation allows us to make something apparent with all its obscurities and unevenness (Scott, 1982). As we interpret, we provide order. In other words, our preconceptions guide us in the direction of some anticipated outcome although the phenomenon itself brings these preconceptions into question. We are pushed forward into the phenomena and pulled into the backward arc of evaluation of our findings. We are drawn out of the phenomena into methodological issues whose complexity and lack of clarity bring us back into the interview text again.

An effective method for identifying preconceived notions and subjective biases is through participation in a group that provides multiple perspectives (Halling, 1988; Thompson, Locander & Pollio, 1989). The Phenomenological Research Groups at the University of Tennessee's Learning Research Center and Department of Psychology provided ample opportunity for exposure to multiple and diverse perspectives during the course of this study.

When considered from an epistemological standpoint, quantitative and qualitative research methods might seem to be diametrically opposed. When considered from the standpoint of the Lebenswelt (Husserl, 1970), the world of the individual, however, we attain a different perspective. Our Western culture exposes us to attitudes and beliefs about our bodies, particularly during illness, that are predicated on a highly advanced technology derived from scientific reasoning -- the view of the body as machine or container. Even as we are being influenced by this cultural view, we also live our body; that is, we experience and identify our body both as "me" -- myself-- and as "mine" --an object I possess (Plessner, 1970). Through a process of bracketing, we will attempt to "deconstruct" the foreknowledge that derives from the objective stance and attempt to look at the experience of crying as it happens. In other words, we will attempt to view the experience of crying as it emerges out of the lived world of each individual participant recognizing that world is grounded in the tradition of Western scientific technology and methods. This stance lies between the scientific, objective, externally derived view provided by behavioral observations and questionnaire data and the more open descriptions of first-person experience provided by participants. This is neither a comfortable position nor one to be taken lightly. Although it is somewhat like standing with each foot in an entirely different world, it is a position central to everyday human existence in this culture.

Selection of Participants:

It has been suggested by Colaizzi (1978) and by deRivera and Krielkemp (1981) that minimal criteria for participants in phenomenological research are: (1) personal experience of the topic to be investigated, and (2) a willingness to talk about these experiences. Such criteria seemed applicable to both qualitative and quantitative components of the present study but, as it turned out, the first criterion was more easily filled than the second. The study was originally designed to include 30 women with cancer and 30 women without. All participants with cancer were required to be within two and a half years of first diagnosis. Initially, 150 letters were sent to potential participants. Two responses were received from this initial contact. A subsequent followup of potential participants initially contacted by their physician resulted in nine additional volunteers. Eleven potential participants from this group declined to participate. A telephone followup with sixteen potential participants yielded 1 additional participant and 15 people who declined to participate. A summary of reasons given for declining to participate on followup will be addressed in Chapter 6.

The researcher was subsequently invited to address a psychosocial support group for cancer patients about the study. Twenty-four potential subjects out of a pool of forty expressed an interest in the study following this direct contact. Cancer patients who expressed an interest in the study were then contacted individually by the researcher. Four potential participants were male and were excluded from the study on that basis. Five other potential participants declined to participate when contacted on followup. One potential participant was five years post diagnosis and was excluded from the study. The researcher was also asked to address a peer support group for cancer patients to describe the research. Three potential participants from a pool of forty-two expressed further interest in the study. On followup, one male was excluded and two women declined to participate.

Participants with cancer were asked to recommend friends, family members, and relatives who might be interested in participating in the study as a comparison group. Twenty-three potential participants for the comparison group were contacted individually by the researcher and all agreed to participate. One candidate was found to fit criteria for the cancer group and was ineligible from the comparison group.

As noted previously, the study was originally designed to include thirty participants with cancer and thirty participants in a non-cancer comparison group. Solicitation of participants began in September, 1991. On March 1, 1992, a total of 27 participants meeting criteria for the cancer group had agreed to participate as had 22 participants in the comparison group. As a result of time constraints and an integral behavioral component requiring 30-days for data collection, a decision was made to limit the study to the number of participants already volunteering.

The nature of the study and its purpose were explained to each potential participant in depth during a followup meeting. A copy of the consent form was provided to each participant. Upon completion, the signed consent form, questionnaires, and demographic and history sheets were placed into individual sealed envelopes. An identification code was assigned to each to protect participant confidentiality. All data were thereafter identified by the assigned code number. Names and phone numbers of all participants were included in one master list which was housed at the American Cancer Society for the duration of the study.

Psychological Tests:

Data were collected during a meeting between the researcher and each participant either at the agency providing support or in the researcher's campus office. The researcher met alone with each participant. Demographic and medical history questionnaires were completed first. Directions for completing each questionnaire were

provided by the researcher. These were then presented to the participant and completed one at a time. The sequence of information gathering and test completion was as follows:

Demographic and Health Questionnaire

Personal Attributes Questionnaire (PAQ)

Toronto Alexithymia Scale (TAS)

Body Cathexis Scale (BCS)

When testing was complete, forms were placed in an envelope which was then sealed and remained so until collected for full analysis. All identifying information was removed with the exception of the participant code. Each testing and information gathering session required approximately 30-minutes.

Following this phase of the research, the Behavioral Checklist was given to each participant and oral instructions for completing the form were provided. The researcher instructed each participant to record a measure of frequency and intensity for each behavior, each and every time it occurred during each day of the 30-day period. A set of written instructions also was provided.

Phenomenological Descriptions and Interviews:

Each participant was asked to provide on a form designed for that purpose, a written description of one of the experiences recorded on the behavioral checklist during the 30-day period . Forty four participants provided written descriptions of at least one experience. Of these, 24 were provided by women in the cancer group and 20 by women in the comparison group. Five women who did not complete the written description and a summary of their comments is provided in the Results section.

The number of participants included in phenomenological research is guided by a commitment to an exhaustive and rigorous description of the phenomenon (Goodrich, 1988). Descriptive data analysis and qualitative research interviews do not require the participant to have any expertise beyond that of having had the experience under consideration. Participants were not asked to observe their own "consciousness," but simply to recall or reconstruct their experience -- a method of retrospection rather than introspection. Interviews were conducted with participants until no new themes emerged from descriptions of the experience. In-depth phenomenological interviews were obtained from 16 participants, eleven interviews were provided by volunteers with cancer and five were provided by volunteers in the comparison group. At this point, the criteria for an exhaustive and rigorous descriptive structure had been fulfilled and no additional interviews were scheduled. A letter was sent to each of the remaining participants thanking them for their participation in phases one and two of the study and notifying them that their participation in phase three was unnecessary. A copy of this letter appears in Appendix B-1.

Each participant who provided an in-depth interview met with the researcher individually at the agency, physician or researcher's office. All interviews were conducted by the researcher. Questions regarding phases one and two were solicited from participants and answered. The participants' position as expert in the study was reiterated. Each person was then invited to share any information she might choose regarding her crying experiences. Each participant was asked to describe as fully as possible her experience of crying. The question was not confined to any single period in the participant's life. Several participants noted that they had been thinking about the question during the 30-day period of behavioral data collection. Participants were simply asked: "Could you describe your experience of crying for me?"

Structured interviews are impregnated with subjectivity in the form of working assumptions made by the researcher and are, therefore, likely to yield little understanding of the world as experienced from the point of view of the participant (Markson & Gognalons-Caillard, 1971). Open-ended interviews are conducted in an informal, non-directive manner with the interviewer attempting to influence participant description as little as possible. The meaning of the experience is generated in the dialogue that ensues between the interviewer and participant who is considered the expert about her own experience. The interviewer attempts only to understand. If the researcher fails to understand a particular point made by the participant, clarification may be asked for. The research interviewer must however, avoid asking questions that might be considered as "leading" the subject (Kruger, 1971). Followup questions are restricted to aspects of the experience introduced by the participant. The language and terms used by the participant to describe the experience are used in queries. The researcher "brackets" by avoiding the imposition of personal ways of talking about the topic thereby building rigor into the interview process (Hawthorne, 1988). Fidelity to the phenomenon requires allowing participants to identify and express what is important in their experience in their own words. The flow of the dialogue is neither constrained nor influenced by asking standardized questions the researcher might think are important.

Interviews varied in length depending on the number of experiences described by a participant, and averaged between one to one and a half hours each. All interviews were recorded on audiotape placed in full view on a table adjacent to the researcher and participant. As each experience was related by the participant, the researcher was reminded of Kvale's (1983) assertion that participants in phenomenological interviews often discover new relations, see new meanings in what is experienced, or may spontaneously see new connections within the life-world. This occurs on the basis of descriptions given without any direct influence or interpretation from the interviewer. It is

an experience, from the point of view of this researcher, of being engaged in a dialogue with the participant even as the participant engaged in meaningful personal dialogue. When each vignette had been explored by the participant, the researcher asked if any other experiences or aspects of the topic were in need of exploration. When participant and researcher both felt a sense of completion to the dialogue, and the participant offered no further instances of their experience for discussion, the discussion ended. Each participant was thanked for sharing personal experiences and for participating in the study. A tentative date for followup summary of the interview was set.

Each audiotape was marked with the code number assigned to the particular participant. Participants' names were not recorded on the audiotapes or on transcripts produced from tapes. One interview was inaudible due to malfunctioning audiotape equipment and was unusable. All other interviews were subsequently transcribed verbatim. A copy of a verbatim transcript obtained from an interview with one participant with cancer is included in Appendix B-2 and provides an example of the richness of the data gleaned from participants as well as the interview technique utilized.

DATA ANALYSIS

Psychological Tests and Behavioral Data:

The aim in this portion of the study was to describe personality characteristics of participants as measured by the Personal Attributes Questionnaire (PAQ), the Toronto Alexithymia Scale (TAS) and the Body Cathexis Scale (BCS). A concommitant goal was to gather a quantitative measure of crying frequency based on a scale of intensity for comparison. No attempt was made to differentiate psychopathology. In addition, medical, social and demographic data were also collected to describe and compare with behavioral data and personality characteristics.

General Description of the sample:

Personality characteristics: Mean, mode and median scores on the PAQ, TAS, and BCS were described for the sample as a whole as well as for individual groups of participants.

Behavioral Data: Scores of mean frequency and intensity of crying taken during a 30-day period in each participants life were described for individual participants in each group as a whole as well as for each group as a whole.

Medical and Demographic Data: Participants were described in terms of medical information e.g. cancer diagnosis, and/or family history of cancer, along with marital and career status.

Analysis of Individuals and Individual Tests:

Each test was analyzed using well established, current guidelines.

Personal Attributes Questionnaire (PAQ): Scores were obtained for each of two subscales of the Personality Attributes Questionnaire (PAQ) (Spence & Helmreich, 1978) for each participant. The PAQ was selected because of its demonstrated psychometric superiority (Pedhazur & Tetenbaum, 1979; Ruch, 1984) as a measure of gender-role orientation. The masculine scale has been defined conceptually as "instrumentality," i.e., as defining attributes linked to a general goal orientation and the ability to maintain the self in the outside world (Cook, 1985) or as a sense of "agency" (Bakan, 1966). PAQ masculinity scale items cluster around dimensions of self confidence, autonomy, persistence/fortitude, and active/competitive (Holmbeck & Bale, 1988). The feminine scale has been defined conceptually as "expressivity," i.e., as defining attributes linked to other-centeredness and a concern with interpersonal relationships (Cook, 1985), or communion (Bakan, 1966). The PAQ feminine scale items cluster around dimensions of emotionality, helpfulness, and capacity for

empathy/warmth (Holmbeck & Bale). M-F scales contain both agentic and communal characteristics and seem to refer to emotional vulnerability, i.e. higher scores indicate less emotional vulnerability. The PAQ illustrates a bidimensional gender role concept in which items are considered socially desirable for both an ideal male and female to possess but which are perceived as stereotypic of either a typical male or female (McCreary, 1990), the expressivity scale contains items ideally desirable for both males and females but which are expected to be found in females. The desirability of developing traits in both domains is inherent although the difference between social ideals and real world expectations is stressed. Self-reported adherence to traits targeted by the PAQ has been found to relate significantly to self-reported behaviors that tap similar dimensions (Holmbeck & Bale, 1988).

Toronto Alexithymia Scale (TAS): The TAS is a reliable and valid measure of the alexithymia construct (Bagby, Taylor, James, & Parker, 1990) which has been used both with clinical and non-clinical populations to differentiate the ability to identify and distinguish between feelings and the bodily sensations of emotional arousal. It also assesses the ability to describe feelings, restricted imaginative processes (e.g., daydreaming), and externally oriented thinking as evidenced by a concrete, reality-based cognitive style.

Body Cathexis Scale (BCS): The BCS is commonly used as a measure of body image (Wylie, 1974; Fisher, 1970) to assess satisfaction or dissatisfaction with various parts or processes of the body. The higher the score, the greater the satisfaction and confidence in body parts and physical appearance (Secord & Jourard, 1953). The reliability coefficient for the BCS has been assessed at approximately .87 (Tucker, 1981) to .89 (Balogun, 1986) indicating that body image is consistent and not a transitory social conception. People with positive body images tend to be more socially confident and rate themselves more highly within their family than individuals with a negative body

image. As body image improves, a person's sense of adequacy and worth in social interactions increases. The body is the most tangible and visible component of the self (Tucker, 1983) with physical, personal, and social traits inextricably interdependent.

Group Comparisons And Sample Correlations:

Personality Characteristics: Participants were divided into one of three groups: one group consisted of women with no diagnosis of chronic disease; a second group consisted of women with cancer who regularly participate in on-going, psychosocial support groups for cancer patients facilitated by licensed therapists, and a third group was comprised of women with cancer who are not involved in a therapeutically based on-going support group. The groups were compared on different variables of the PAQ, scores from the TAS and BCS. A one-way analysis of variance (ANOVA) was performed across each of these variables.

Behavioral Data: Participants were divided into groups according to the same criteria used for analysis of personality characteristics. Mean frequency and intensity of crying across a 30-day period were then compared with personality characteristics differentiated on the PAQ, TAS, and BCS. Multiple analysis of variance technique (MANOVA) and Pearson Product Moment correlations were performed to ascertain relationships among variables and to evaluate the significance of differences between groups.

Phenomenological Data:

Procedures selected for use in the analysis of interview transcripts and written descriptions of crying episodes were guided by four goals. These goals were set as an attempt on the part of the researcher to develop a set of structural invariants, or basic categories, which would describe the experience of crying as a whole and in relation to

each separate group of participants. This preliminary set of goals included:

(1) An attempt to understand the experience from the participant's point of view.

(2 An attempt to use data derived from descriptions of actual events in the participant's lives.

(3) An attempt to further explicate experiences reported by participants by asking "when," "what," and "how" questions rather than "why."

(4) An attempt to seek rigorous and exhaustive descriptions of the phenomenon while remaining respectful to the participant as expert.

Interview techniques and suggestions for posing questions outlined in Thompson, Locander and Pollio (1989) were useful in developing the style incorporated into this study.

No "standard procedure" for analyzing data along these lines exists. The rigor of phenomenological research and dedication to maintaining fidelity to the phenomenon as described in the experiences of participants requires that the analysis be custom made to fit the phenomenon being investigated. It is important only that the method dialogue with the content (Giorgi, 1970, 1974; Kruger, 1979; Van, Kaam, 1969). As Giorgi (1970) pointed out, "it is phenomenologically unsound to establish a method that must be used that is prior to and independent of the phenomenon to be investigated." The unique aspect of phenomenological method for this researcher is that it is reflective and is itself phenomenologically derived. A number of guidelines set by previous investigators, however, proved particularly useful for the present project. Adaptations of guidelines recommended by Colaizzi (1978), deRivera and Krielkemp (1981), Kruger (1979), and Aanstoos (1986) were most helpful. Analytical methods introduced and further developed in phenomenological research labs at the University of Tennessee also proved invaluable in developing the present method.

The analysis of data obtained from interviews with participants proceeded in stages. Stage one which constituted the "first data reduction" focused on individual transcripts and was conducted along these lines:

(1) Create a verbatim transcript of the interview.

(2) Become familiar with each transcript as a whole.

(3) Create a summary of each transcript.

(4) Review individual summaries with respective participants.

Again, there is no set procedure for analysis and each method must emerge from requirements inherent in the particular aspects of human experience under investigation.

In some previous studies using phenomenological methods, audiotapes of interviews with participants were not transcribed (Dapkus, 1983; Koelin, 1987). As has been pointed out, however, written transcripts not only facilitate the publication of tape recorded interviews but also afford an easily accessible additional medium for viewing the phenomenon (Hawthorne, 1988). Written transcripts are also more amenable to group analysis as well.

Creating a verbatim transcript of the interview: Transcription of interview data was performed in part by a skilled legal secretary and in part by a certified medical transcriptionist. Each draft was typed directly into a computerized word processing program. A copy of each interview transcript was provided to the researcher as soon as the transcription was completed. The researcher then listened to each original audiotaped interview while following along with the transcribed copy. Errors in transcription do occur. In this particular study, most errors turned out to be simply a result of changes in voice inflection or unfamiliar colloquialisms that tend to pop up in everyday language and may be unfamiliar to persons of different cultural or ethnic background.

When discrepancies were found between the audiotaped and transcribed versions of the interviews, both audiotape and transcript were reviewed together until the discrepancy was clearly understood. When transcription errors were detected, the transcript was marked by the researcher who then edited the text on the word processor. No aberrations of language, voice inflection or colloquial expressions were sufficient in this study to warrant a return to any individual participant for clarification but remained an option had some extreme difficulty in transcription or understanding necessitated such an event.

It is difficult if not impossible adequately to capture the timbre, tone, and tempo of someone's voice on paper even though these aspects of speaking can and do change the meaning of words depending on the context in which they are spoken (Pollio, 1982). In an effort to capture to some extent the quality of voice inflection used by participants, an emphasis on particular words or phrases as they appeared in the interview are reflected in the text either by underlining or by inflection descriptors that appear in parenthesis, e.g., (whispering), (laughing), (teary), etc.

Names of people discussed by participants were changed to protect confidentiality. No names of people were deleted. Proper names of businesses, agencies, churches, organizations, cities, states, etc. were deleted during transcription and are designated in the text by a descriptor in parenthesis e.g. (street), (religious organization), (fraternity). A series of periods mark instances in the dialogue when the participant began a sentence or thought and then began another without completing the first e.g. "most of the tears of what happened ended until...all along I was, I knew I was going to have another mastectomy." Ellipses (...) and/or (pause) were used to indicate where a prolonged break, pause, or period of silence occurred amidst the flow of the dialogue of either the participant or interviewer. No dialogue was deleted from the text of the interviews. Final responsibility for the accuracy of all transcripts remained with the

researcher. The length of finished transcripts ranged from eight to twenty-four single spaced pages with an average length of twelve pages. A copy of one transcribed interview is provided in Appendix B-2.

Becoming familiar with the transcript as a whole: Checking and rechecking the transcripts against the audiotapes of interviews affords the researcher an opportunity to become well acquainted with each interview. The goal of this step is to retain the integrity of the interview and the person interviewed throughout subsequent steps. It is essential to maintain this integrity whether specific aspects of experiences shared by participants are separated from the entire corpus of data as well as when experiences across a range of participants are intermingled.

The bracketing process became particularly focal for the researcher during this aspect of analysis. As a member of a society which tends to stigmatize people with chronic diseases, particularly people with cancer, it was my expectation that women with cancer would tend to report experiences of crying about the diagnosis and the negative effect of that diagnosis on their lives; many cancer participants did address these aspects of the experience. Others, however, were most aware of crying in situations not associated with the diagnosis. Some related positive experiences including feelings of closeness to other patients with cancer, or to friends, or family members. Some experienced an increased appreciation for life that was neither anticipated nor expected to result from the diagnosis of a life-threatening illness. As participants related these experiences and as transcripts of the interviews were reviewed, preconceived notions about the impact of the disease and its effect on participants' lives had to be suspended and efforts to bracket those presuppositions facilitated a fuller appreciation of experiences as they were related by all participants.

Creating a summary of each transcript: The method used for creating summaries of individual transcripts was adapted from a technique of report writing

devised by Fischer (1985). The summary is intended to focus on the participant as a particular experiencing person. Although helpful, quantification and categorization are adjunctive rather than basic. The language and style of writing attempt to evoke a sense of the *person*. Summaries include descriptions of demographic and health related data provided on initial contact. Specific experiences related in the interviews and written descriptions of crying were summarized, with themes related to the particular individual's experience of crying made focal first by marking the topic as it occurred in the transcript and then by gathering all statements relevant to a particular topic together for an overall example. Some examples consisted of a single "vignette" in which the participant described one episode of crying. Other examples consisted of several episodes bound together by a common thread such as "times when I have been angry and cried," etc. An example of one such interview summary appears in Appendix B-3.

Reviewing individual transcripts with participants: Copies of the entire transcript along with a copy of the summary were then returned to respective participants with a letter asking them to review the materials, make any additions, deletions, or comments they felt necessary to completely and clearly describe their experience. They further were asked to make comments about the interviews as well as of their impressions, agreements and/or disagreements with summary statements of interviews provided by the researcher. Participants were invited to phone the researcher to discuss comments and to make an appointment for a brief followup meeting if desired. A return envelope addressed to the researcher was also provided in the event participants might chose to send a written reply. A copy of this letter is also included in Appendix B-4.

Stage Two of the hermeneutical analysis involved an attempt to identify tentative categories and patterns within a nexus of themes derived from the complete corpus of interview data. The steps involved in this stage included:

(5) Engage in group analysis of individual transcripts.

(6) Look for common structural components across interviews.

(7) Arrange emergent categories into an overall, interrelated structure.

(8) Reference categories to original participant transcripts.

Engaging in group analysis of individual transcripts: In an effort to capture the dialogic nature of the interview process, verbatim transcripts of interviews obtained from participants are read aloud in research group meetings. Two research group at the University of Tennessee were involved in this stage of data analysis. These groups consist of participants from diverse fields including Psychology, Religious Studies, Music, Dance, Sports Medicine, Nursing, English, Business, Marketing, and Human Services. Research groups treat each interview transcript in its own uniqueness as an accurate description of the experience under investigation. No attempt is made to verify descriptions of phenomena with data derived from external sources regardless of theoretical orientation or individual attitudes of group members. The goal is to understand the importance of crying in the situation described by the participant. In other words, if the participant said, "this was a devastating experience for me and I turned to my husband and cried," the group would attempt in reading the participant's discourse, to understand what "devastating" meant to the participant and how the presence of the husband figured into the participant's experience of crying.

Descriptions presented in the interviews are considered as reflections on events as these are reconstructed in the interview rather than as "schema" or "representations" of previously experienced events. Hypotheses regarding causes and/or effects of events described in the interviews are also unnecessary when analyzing interview data. Participants may cast descriptions of the phenomena in terms familiar to the group as theoretical formulations. For instance, a participant might say, "I was feeling very frustrated in that situation and thought it might have been the result of years and years

of repressed hostility against my family." Instead of attempting to explain the participant's experience in terms of theoretical mechanisms, the comments are simply seen as descriptions of lived experience. Thus, the experience of the participant remains primary over the theoretical stance or personal experience and meaning of specific words to members of the group.

This process of "bracketing" does not mean that researchers pretend these preconceptions do not exist. Rather a diversity of perspectives on the phenomenon facilitates the process of analysis by standing as a constant reminder of each discipline's particular biases. Thompson, Locander, and Pollio (1989) provided an excellent description of the structure and function of an interpretive group. In addition to providing multiple perspectives on crying as described by participants in this study, the research group involved in this study provided the following:

(1) Support for all interpretations made of the data taken from actual words of participants' derived from individual descriptions.

(2) An accumulative process of data interpretation. This process involved an evaluation of each description given in the text. Each new description was then compared with previous descriptions. An accumulation of descriptions eventually encompassed all elements of data in interview transcripts and was considered complete when each element could be accounted for by verification in the participant's words.

(3) A feedback network or "sounding board" for ideas generated in data analysis. This dynamic network prevented the possibility of a lone researcher becoming bored with the task or coming to doubt the validity of the analysis simply as a result of the type of tunnel vision that often derives from attempts to "make sense" of large blocks of data containing myriad components.

(4) Enhanced accuracy of interpretive analysis. The presence of researchers with multiple perspectives resulted in a more comprehensive understanding of "patterns"

as they emerged from data analysis since such patterns often present themselves from multiple perspectives as well (Giorgi, 1983).

Look for common structural components across interviews: An underlying premise of phenomenological research is that human experience is meaningfully organized although not necessarily sequentially arranged. Each individual experience therefore becomes figural out of a larger network, or ground, of experiences that make up human existence as a whole. The hermeneutic process explicates the essential structure of each individual experience. Any existing inter-relationships between the phenomenon and surrounding life experiences are also explicated as these arise out of the ground(s) selected by each participant. For example, crying may occur for one person during experiences of frustration or anger and for another during experiences of sadness or loss. What is different for each is the type of emotion associated with crying. What is similar about them is that each involves some emotional component that arises out of a relationship to another person or to one's self. The structural essence would therefore be the emotional component, with the relationship forming the ground of each experience.

Throughout step one, and in the course of engaging in group analysis of individual transcripts, certain types of experience or themes were mentioned often enough or in such a compelling way that possible fundamental categories of the experience of crying began to emerge. As each phase of the process was undertaken, a list of tentative categories was complied. All copies of individual interview transcripts used in group analysis were collected at the end of each group session and a summary list of tentative categories complied from the pooled analysis. Patterns of occurrence of tentative categories began to emerge over the course of several sessions as did possible interactions of tentative categories.

Arrange emergent categories into an overall, interrelated structure: A comparison of all items listed in tentative categories derived from summaries of individual interviews was undertaken as these emerged from group analysis. All tentative categories were considered of equal importance to the experience of crying, and no attempts were made to quantify or hierarchically arrange various organizational components. Potential groupings of similar categories were then attempted across all transcripts. A method of organizing data into an overall, interrelated structure was developed which allowed for referencing categories to original participant transcripts at each stage of the process.

Refer categories back to original participant transcripts: When a tentative arrangement of emergent categories was complete, a total pool of 329 statements had been extracted from six transcripts of participants involved in psychosocial support groups for women with cancer. A sample of statements extracted for one participant are given in Appendix B-5. The method used for this phase of the analysis was adapted from Dapkus' (1985) method of reducing a transcript to Significant Statements. Each statement was what appeared to be the spoken equivalent of one paragraph and the beginning of an item was often the answer to a new question, a change of subject, a long pause, or a marked change in voice quality.

This process of extracting significant statements involved simply paging through the transcript and extracting each statement or phrase relevant to any narrative topic, one at a time, as these occurred in the text. Contrary to Dapkus, however, the participants' language appears in the statement as given in the interview; statements were not modified in any way. When participants tended to run-on sentences, the beginning of a new thought without the beginning of a new sentence was noted by an ellipse (...) indicating that previous dialogue occurred in the original transcript. Each individual statement was numbered according to the assigned participant code number.

This code number was then combined with a number designating the sequence in which the statement was taken from the transcript. The two numbers appear separated by a colon, e.g., 201:14 indicates this statement as the fourteenth taken from the transcript of participant number 201.

At this point, the method chosen for this study departed from methods used in previous studies (Dapkus, 1985; Goodrich, 1988; Hawthorne, 1988; Fernandez, 1990). No attempt was made to reduce "themes" derived from original protocols and group analysis into overarching "categories." In fact, this "top down" approach seemed to the researcher to be contrary to the intent of hermeneutic analysis which is allow themes to emerge from the dialogue itself. Polkinghorne (1989) described a method of phenomenological analysis wherein the researcher "moves back and forth between meaningful statements and successive revisions of tentative lists of categories until all experiences are accurately reflected in the categorical clusters." The final result is the essence of the research, "the essential structural definition" of the phenomenon. Colaizzi's (1978) criteria for validating categories also proved invaluable here.

In an attempt to maintain fidelity to the phenomenon as well as to maintain fidelity to the participant's experience, a tentative list of categories pertinent to the experience of women with cancer from the psychosocial support group was complied. Specific categories were defined as clearly as possible from tentative lists derived earlier from individual and group analysis of protocols. Categories were numbered from one (1) to eight (8). A broad range of examples for each category was compiled from participant statements. A list of categories, appropriate examples, and the total pool of items taken from the interview transcripts was then compiled.

Using this list and selected examples as a guide, each individual item in the total corpus was compared to the composite list. Each category represented in the item was scored using the numbering sequence 1-8. As much time was devoted to the task as

was deemed necessary to categorize each statement completely using as many of the eight categories as necessary to portray the experience described.

This process led to a Master Category List which provided a clear understanding of each aspect of the experience of crying as described by women in this group. Categories were accepted as final and were integrated into the Master Category List only when every Significant Statement from every protocol could be scored according to these categories.

A similar analysis of interview data derived from participants with cancer who were not engaged in a psychosocial support group and participants with no chronic disease was subsequently undertaken. The Master Category Lists for Women in Psychosocial Support Groups for cancer patients proved applicable to protocols of women with cancer not engaged in support groups. Although specific words or terms used to describe aspects of the experience were slightly different, e.g., "touching" in the first group became "connecting" in the second group, the meaning of terms as given in the context were quite similar. Again, every Significant Statement from every protocol could be scored according to the eight categories defined from analysis of data taken from the first group. Initially, an attempt was made to score all protocols taken from women without any chronic disease although the category system proved inappropriate. A subsequent analysis of protocols from this third group yielded a unique set of descriptive categories which were then numbered from one through nine (9). When every Significant Statement from every protocol in this group had been coded according to the Master List, analysis was considered complete.

Stage three involved "putting it all together," formulating an overarching thematic essence of the phenomenon derived from a holistic grasp of the basic categorical structure. A description of the essential experience of crying for women with cancer and women with no chronic disease emerged. Three steps were involved in this final phase:

(9) Combine category structures for all three participant groups.

(10) Allow overarching themes to emerge from the category structure.

(11) Form an exhaustive description of the fundamental structure of the experience of crying for all women.

Combine category structures for all three participant groups: When a Master Category List had been complied for each group of participants and every statement taken from the individual protocols in each group had been scored according to the categories therein, the list was accepted as "final." Subsequently, all categories were organized into a systematic, categorical "structure."

Allow overarching themes to emerge from the category structure: Themes may also be described as meanings for the topic of discussion. Unlike categories, they are not necessarily explicitly stated in the data; rather, they become obvious when viewing the data as a whole. Following categorical analysis, each interview was examined in a global way. Categories specific to each of the three groups were considered as were examples of the total experience of crying expressed in that theme for participants in all groups. Two essential criteria helped to identify overall themes: (1) the experience was introduced by the participant, not elicited by the researcher, (2) the participant reiterated the theme several times over the course of the interview, e.g.,discussed several experiences of crying in which connection or a break in a relationship was figural. A total of four themes emerged from this phase of the analysis. A summary description of these four themes along with the specific categories related to each theme across the three groups is included in Appendix B-6.

Form an exhaustive description of the fundamental structure of the experience of crying for all women: Each significant statement was checked and double checked to ensure that it could be assigned to one of the categories emerging from steps 7 and 8. Then, every example in the Master lists of each group was checked to ensure that it

could be categorized into one of the four overarching themes which emerged in Step 10. An exhaustive description of the experience of crying as given by women with cancer and women with no chronic disease was subsequently written. This description appears in the Results section.

CHAPTER 5

RESULTS

GENERAL CHARACTERISTICS OF PARTICIPANTS

A total of 49 women participated in the study. Twenty-seven were women with cancer who ranged in age from 21 to 69 years. Twenty-two were women with no chronic disease who ranged in age from 20 to 55 years. A majority of participants were white (92%) careerwomen (67%). A majority of women with cancer were married (63%) although only forty-seven percent of all participants were married. A summary description of participants' marital and career status is presented in Table 10.

TABLE 10

MARITAL AND CAREER STATUS OF ALL PARTICIPANTS BY GROUP

MARITAL STATUS	ALL	NC	CN/S	CS	CNS
Single	23%	32%	15%	7%	25%
Married	47%	27%	63%	73%	50%
Widowed	10%	9%	11%	7%	17%
Divorced/ Separated	20%	32%	11%	13%	8%
CAREER STATUS	**ALL**	**NC**	**CN/S**	**CS**	**CNS**
Careerwoman	67%	77%	59%	53%	67%
Homemaker	33%	23%	41%	41%	47%

NC = Women with no chronic disease
CN/S = All participants with cancer
CS = Women with cancer who participate in psychosocial support groups
CNS = Women with cancer not in psychosocial support groups

BEHAVIORAL AND PSYCHOLOGICAL TEST DATA

Means and standard deviations of various measures for each of the three groups are presented in Table 11. In the Table, Intensity refers to the average rating of crying intensity for all episodes of crying which occurred within the 30-day period for each group of participants. Episodes refers to the average number of episodes of crying for subjects within each group for the entire 30-day period of data collection. The PAQ scores are averages for each group which were obtained from responses to the Personality Attributes Questionnaire. M-scores cluster around dimensions of self-confidence, autonomy, persistence/fortitude, and active/competitive or "instrumentality" of emotional expression. F-scores cluster around dimensions of emotionality, helpfulness, and capacity for empathy/warmth or "expressivity" of emotions. M-F scores reflect emotional vulnerability. TAS scores reflect average response for each group on the Toronto Alexithymia Scale, a measure of the alexithymia construct and BCS scores reflect the average response of each group on the Body Cathexis Scale, a measure of body image. The last column presents the mean age in each of the various groups. A one way analysis of variance (ANOVA) was performed for each of the variables across the three groups of participants to determine whether differences among the means of the various measures were significant. An examination of relevant F ratios indicates no significant differences on any of the eight variables.

Relationships between specific variables were then evaluated using Pearson product-moment correlations for all variables across all groups. These results are presented in Table 12. In this table, correlations above $r = .28$ are statistically significant at $p < .05$. An examination of Table 12 indicates that when age is considered across all participants, there is little correlation between the intensity of the crying ($r = -.12$) or the number of times one cried ($r = -.14$). A low positive correlation was found between age and scores on the Toronto Alexithymia Scale (TAS) ($r = .28$) indicating a trend among

TABLE 11

MEANS AND STANDARD DEVIATIONS OF

THE VARIOUS MEASURES FOR

EACH OF THE THREE GROUPS

GROUP		INTENSITY	EPISODES	PAQ M	PAQ F	PAQ MF	TAS	BCS	AGE
NC	MEAN	1.38	28.27	19.4	23.5	18.5	57.96	159.3	38.1
N = 22	SD	1.54	32.4	3.26	3.57	3.80	12.04	19.18	9.5
CS	MEAN	.72	13.53	22.0	25.5	20.5	66.5	164.4	49.3
N = 15	SD	.53	8.86	4.26	4.24	2.33	1.1	30.3	13.75
CNS	MEAN	1.18	21.58	20.0	24.3	19.3	62.9	154.0	44.3
N = 12	SD	.89	16.23	4.09	4.42	3.6	8.2	21.14	14.8
F ratios*		1.42	1.72	2.22	1.13	1.63	2.23	0.65	3.81

* for 2/46 df $F < 4.07$; $p < .05$

older women to be less verbal in expressing emotions when compared to younger women. A significant negative correlation (r= -.51) was found between scores on the Body Cathexis Scale (BCS) and the Toronto Alexithymia scale among women in this group. These findings indicate that women with poorer body images have more difficulty identifying and distinguishing between feelings and the bodily sensations of emotional arousal in addition to having difficulty describing feelings. As might be expected, a strong positive correlation (r=.96) was found between intensity of crying and the number of episodes of crying reported by participants.

TABLE 12

CORRELATIONS AMONG ALL FACTORS ACROSS ALL GROUPS

VARIABLE	AGE	INTENSITY	EPISODES	PAQ M	PAQ F	PAQ MF	TAS	BCS
AGE	1.0							
INTENSITY	-.12	1.0						
EPISODES	-.14	+.96***	1.0					
PAQ M	+.15	-.05	-.10	1.0				
PAQ F	+.05	-.17	-.20	+.08	1.0			
PAQ MF	+ .07	+.26	+.20	+.21	+.10	1.0		
TAS	+.28*	-.10	-.09	-.17	-.23	-.09	1.0	
BCS	-.14	+.17	+.10	+.14	+.10	+.21	-.51**	1.0

* p < .05
** p < .001
*** p < .0001

When correlations among various factors were examined only for women without cancer, a somewhat different pattern of relationships presented itself as noted in Table 13. Again, a strong positive correlation was found between intensity of crying and number of episodes (r=.96).

TABLE 13

CORRELATIONS AMONG ALL FACTORS FOR WOMEN WITHOUT CANCER

VARIABLE	AGE	INTENSITY	EPISODES	PAQ M	PAQ F	PAQ MF	TAS	BCS
AGE	1.0							
INTENSITY	+.23	1.0						
EPISODES	+.21	+.96**	1.0					
PAQ M	-.03	-.23	-.26	1.0				
PAQ F	-.44*	-.19	-.23	+.46*	1.0			
PAQ MF	+.04	+.33	+.29	-.07	+.21	1.0		
TAS	+.21	+.09	+.10	-.29	-.23	-.26	1.0	
BCS	-.003	+.23	+.12	-.23	-.11	+.26	-.37	1.0

* $p < .05$
** $p < .0001$

Another significant correlation is a moderate negative one ($r = -.44$) between age and the F scale on the Personality Attributes Questionnaire (PAQ) indicating younger women without cancer tend to be significantly more expressive of their emotions and tend to be more helpful and concerned with interpersonal relationships than older women having a similar health status. A moderate positive correlation ($r = +.46$) between scores on the PAQ M and F scales suggests a tendency among these women to possess positive characteristics of both agency and communion. When these women are empathic, helpful, concerned with interpersonal relationships and "other-centered", they also are more active, competitive, self-confident, and autonomous and goal-oriented.

In Table 14, relationships among all factors were examined for women with cancer regardless of level of psychosocial support.

TABLE 14

CORRELATIONS AMONG ALL FACTORS FOR WOMEN

WITH CANCER REGARDLESS OF LEVEL OF PSYCHOSOCIAL SUPPORT

VARIABLE	AGE	INTENSITY	EPISODES	PAQ M	PAQ F	PAQ MF	TAS	BCS
AGE	1.0							
INTENSITY	-.42*	1.0						
EPISODES	-.48**	+.97****	1.0					
PAQ M	+.12	+.27	+.24	1.0				
PAQ F	+.18	-.09	-.10	-.17	1.0			
PAQ MF	-.02	+.30	+.25	+.37	-.06	1.0		
TAS	+.19	-.30	-.27	-.22	-.35	-.07	1.0	
BCS	-.21	+.16	+.14	+.31	+.21	+.19	-.65***	1.0

* p < .05
** p < .01
*** p < .001
**** p < .0001

Moderate negative correlations were found between age and both number of episodes (r= -.48) and the intensity of the crying (r= -.42), e.g., older women cry less frequently and with less intensity than younger women regardless of health status. Scores on the Toronto Alexithymia Scale (TAS) and Body Cathexis Scale (BCS) were also negatively correlated (r= -.65) again indicating that women who report dissatisfaction with various parts or processes of the body (low BCS scores) also are significantly less in touch with feelings and bodily sensations and demonstrate a more concrete, reality-based cognitive style (high TAS scores).

Relationships among all factors for women with cancer who participate in psychosocial support groups is presented in Table 15.

TABLE 15

CORRELATIONS AMONG ALL FACTORS

FOR WOMEN WITH CANCER IN PSYCHOSOCIAL SUPPORT GROUPS

VARIABLE	AGE	INTENSITY	EPISODES	PAQ M	PAQ F	PAQ MF	TAS	BCS
AGE	1.0							
INTENSITY	-.04	1.0						
EPISODES	-.08	+.98***	1.0					
PAQ M	+.32	+.26	+.32	1.0	-.10			
PAQ F	-.09	+.45	+.35	-.10	1.0			
PAQ MF	+.55*	+.38	+.31	+.32	+.07	1.0		
TAS	+.21	+.17	-.18	-.35	-.37	-.06	1.0	
BCS	-.24	+.04	+.03	+.13	+.24	+.09	-.79**	1.0

* $p < .05$
** $p < .001$
*** $p < .0001$

In this group, little or no correlation was found between age and either intensity ($r = -.04$) or number of crying episodes ($r = -.08$), although a strong positive correlation is again demonstrated between crying intensity and total number of crying episodes ($r = .98$). A moderate positive correlation was also found between age and scores on the Personal Attributes Questionnaire (PAQ) M-F scales. Since this scale reportedly measures emotional vulnerability, high scores on this scale among older women would seem to indicate that older women in this group were less emotionally vulnerable than younger women. In this group of women with cancer, those who have poor body image not only report feeling less socially confident, they also show a significant tendency to restrict identifying and describing emotions and associated bodily sensations as the negative correlation between scores on the TAS and BCS demonstrates ($r = -.79$).

For women with cancer who are not in psychosocial support groups, age correlates negatively with both the number ($r = -.72$) and intensity ($r = -.66$) of crying episodes. (See Table 16.)

TABLE 16

CORRELATIONS AMONG ALL FACTORS

FOR WOMEN WITH CANCER NOT IN PSYCHOSOCIAL SUPPORT GROUPS

VARIABLE	AGE	INTENSITY	EPISODES	PAQ M	PAQ F	PAQ MF	TAS	BCS
AGE	1.0							
INTENSITY	-.66*	1.0						
EPISODES	-.72**	+.96***	1.0					
PAQ M	-.22	+.52	+.39	1.0				
PAQ F	+.45	-.41	-.33	-.35	1.0			
PAQ MF	-.53	+.40	+.35	+.36	-.23	1.0		
TAS	+.13	-.48	-.39	-.11	-.43	-.22	1.0	
BCS	-.28	+.51	+.45	+.57*	+.10	+.25	-.44	1.0

* $p < .05$
** $p < .01$
*** $p < .0001$

In other words, older women in this group cry less frequently and when they cry, their crying is of less intensity than comparable women of younger age. The only other significant relationship concerns the relationship between scores on the Body Cathexis Scale (BCS) and the PAQ M-scale ($r = .57$) suggesting that women who do not participate in psychosocial support groups have greater satisfaction with and confidence in their bodies when they are goal oriented and feel a sense of "agency" or autonomy with regard to the outside world.

A stepwise regression analysis (PROC REG: Selection/STEPWISE) was implemented in an effort to determine which variables among those selected for examination in the present study best predict the number and intensity of crying episodes among women with and without cancer. No single variable nor any combination of variables from those selected for the study was found to predict either number of occurrences or intensity of crying episodes when all women in the study were considered together. Nor was any single variable or combination found to be a

predictor for women without cancer or for women with cancer who participate in psychosocial support groups. Among women with cancer who do not participate in psychosocial support groups, however, 51% (R=.71) of the difference in number of crying episodes is predictable on the basis of age. With regard to intensity of crying among these women, 76% (R =.87) of the variance is attributable to an interaction between age, F-scores on the Personal Attributes Questionnaire (PAQ) and scores on the Toronto Alexithymia Scale (TAS). When age was removed from the regression equation, 69% (R =.83) of differences in intensity of crying among these women is accounted for by the PAQ F-scores and TAS scores alone. These results indicate that among women with cancer who do not participate in psychosocial support groups, fewer episodes of crying are predictable with increasing age. The intensity of such episodes also decreases among these women as they age, especially those who tend to be "other centered," helpful, empathetic and concerned about interpersonal relationships. Such women are apt to exhibit a reality-based cognitive style characterized by externally oriented thinking, restricted imaginative processes and to have difficulty verbalizing their feelings regardless of their age.

PHENOMENOLOGICAL DATA

Overview:

Interviews were obtained from sixteen participants in the study; eleven from women with cancer and five from women with no chronic disease. Of those provided by women with cancer, six were interviews with women who regularly participated in a psychosocial support program for cancer patients and five were with women who do not participate in such groups. The average length of each interview was 12 single-spaced typewritten pages. A written description of one episode of crying that occurred within that 30-day period during which frequency and intensity of crying behavior was

monitored also was obtained from each participant. These descriptions averaged three-fourths of a page in length.

The goal of this investigation was to render a comprehensive description of the universal human experience of crying among women with and without cancer. An analysis of the interviews provided by participants in the study revealed that crying occurs as an event situated or "grounded" in a woman's view of "The Way Things are Supposed To Be." This Way affects a woman's way of viewing the world e.g. her beliefs, expectations, or anticipations about how the world is, should be, or must be, and the immediate context of the crying event which involves relationships that impinge most closely on the crier in the immediate situation. An analysis of descriptions provided by these women suggest that crying may best be understood as it becomes figural in an immediate context against some relational ground unique to each particular experience. As a result, women who cry frame most of their experiences in terms of The Way or context of relations which play a significant, though not necessarily direct, part in the event.

In addition to The Way or ground against which the crying episode becomes figural, three overarching themes emerged from an analysis of experiences of crying provided by women in this study. These themes are: Being Separate From, Barrier, and In Unity With. A description of these themes along with specific situational contexts and relationships that exist between the contextual ground and crying will be presented. A description of figural aspects of the event and a detailed discussion of specific categories in the experience also will be presented. The process whereby these aspects of the experience become figural will be described and the structure of crying as it emerged from The Way Things are Supposed to Be or ground of the experience will be elucidated.

A useful image or metaphor for understanding the experience of crying is that of a sluice or a stream flowing through a floodgate. The streambed is the Way Things are Supposed to Be or the "normal course of events;" those things a woman expects or anticipates happening in life, e.g., "old people die, young people live to be old," or "people who follow the rules, receive the reward." The Way is a conglomeration of many things she has heard, learned, or been taught by her family, society, or world. The stream forms a connected sequence of events, the particular way in which specific events in her life are constructed. Although the way or ground is primarily experienced as somewhat fixed, it moves and shapes to some extent who a woman is and what she may become -- the flow of events as they occur in her life. The sluice or gate is meant to capture her ability to monitor events, to invite and/or exclude unwanted thoughts, feelings, emotions, or as a way of maintaining some control over the flow of life events, recognizing that her choices are greatly influenced and affected by the "streambed" itself. Whether the sluice gates remain open, are closed in certain situations, or become permanently closed is usually determined by the volume and intensity in the "flow" of the stream of events as they follow their course. A woman may simply choose to impose limits regardless of capacity or the intensity of related events. A "dam in the river of her emotional life" may result when the gates are experienced as temporarily "stuck" or even as permanently locked. Although an artistic rendering would be necessary to capture the dynamic elegance of crying as metaphorically embodied in the image of a sluice gate, a somewhat simplistic attempt is presented in Figure 2.

Although the figure is presented inside box-like borders, women who described their experiences of crying usually provided no such clearly defined boundaries. "The Way Things Are Supposed to Be" and "Things Are Different Now" appear to represent two different aspects of the figure when in fact, they are aspects of the total ground of the experience. The Way Things are Supposed to Be is a woman's view prior to the

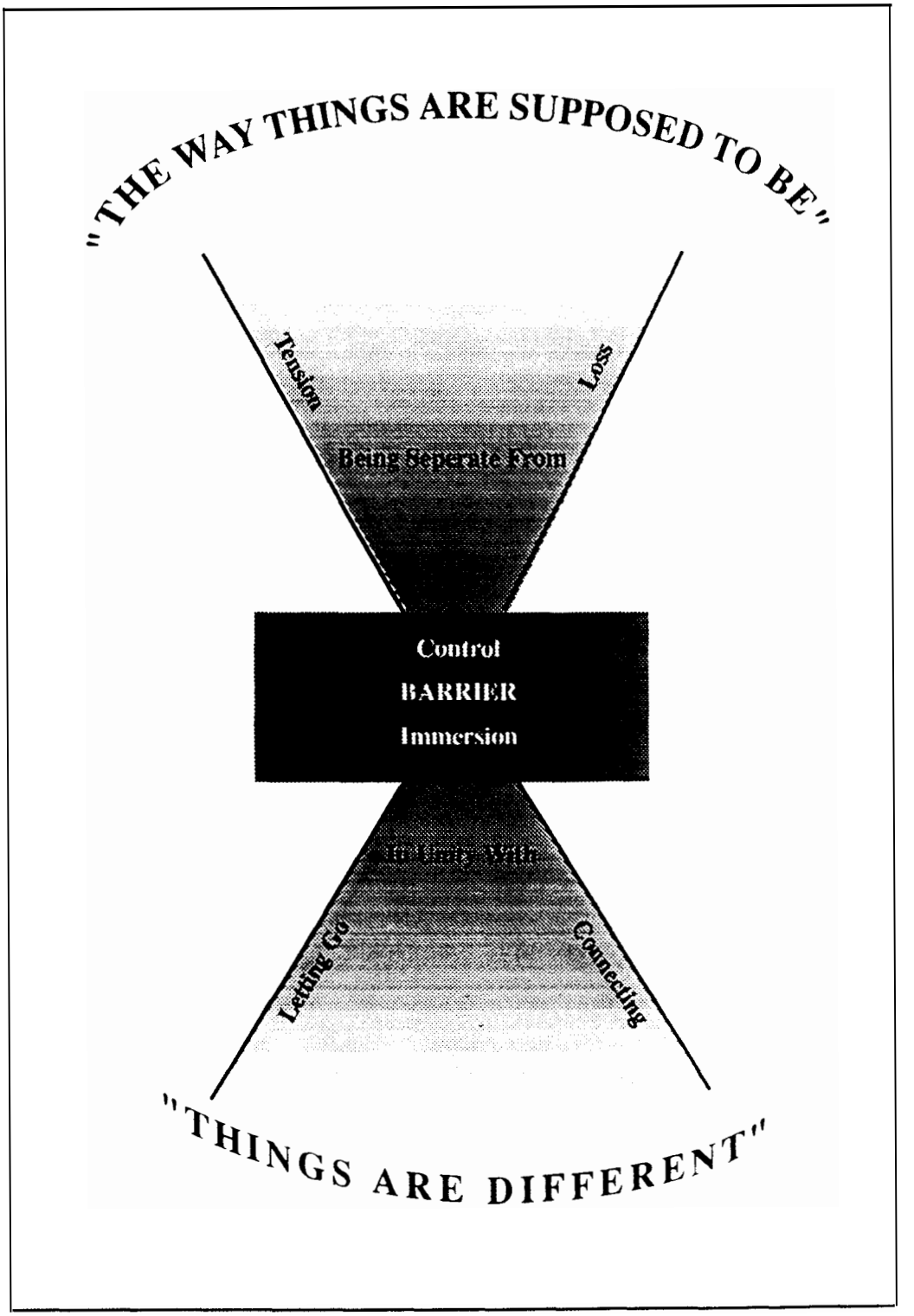


Figure 2

MAJOR THEMES AND CATEGORIES IN THE EXPERIENCE OF CRYING

crying experience while Things Are Different in her point of view following the episode. Even though things may be different following an episode of crying, a woman still has expectations about The Way Things are Supposed to Be. Her expectations may or may not be changed by events that occur during an episode of crying. The design of the figure may make it appear that experiences move in sequence from "The Way Things are Supposed to Be" into "Being Separate From" through the "Barrier" and into being "In Unity With" to end with "Things are Different Now." Based on experiences described by participants in this study, however, such is not always the case. Events may indeed flow smoothly in this sequence; it is also possible for a woman to get stuck in her experience of The Way Things are Supposed to Be, to be unable to break through the barrier that blocks her way as tensions building up and losses threaten to overcome her. Breaking through these blocks may take time, may occur suddenly, or not at all. When she is able to let go of the tensions or to work through her need to control them, the barrier may be overcome and she will report experiencing a sense of unity, an at-one-ness, with her surrounding world. Experiences of Connecting are entirely different than those of Tension, Loss, or Control and yet, they also may precipitate crying episodes. During such times, Being Separate From or the need to control and build Barriers may not become figural at all. Often she experiences only a sense of meaningful connection with others.

Figure 2 is meant to provide the reader some sense of a relationship among events in which a woman feels Separate From others, from herself, or may choose to be separate either from others, perhaps even from her own feelings, thoughts, and desires in order to maintain control over herself in specific situations. These experiences develop from a buildup of Tension or losses that threaten to overcome her. She may hold back her emotions to avoid confronting fears. The central location of the Barrier in Figure 2 demonstrates those obstacles that prevent her from experiencing the

connection available in Being in Unity With others. She may even get caught in a negative loop of Tension, Loss, and Control unable to work through the emotional barrier and get free. During such experiences, she is most likely to describe herself as feeling "trapped," "stifled," or "frozen." While the reader need not view Figure 2 as presenting a full and immediate experience of crying, it does provide a reasonable facsimile.

The Way Things Are Supposed To Be:

The Way Things are Supposed To Be constitutes a context for episodes during a participant's life when she cried. Family scripts help determine a woman's expectations, anticipations, and the "facts" as she views them. Her situation is simply part of a world view directly influenced by the way relations form a matrix or "set" a background for present experiences. Women who talk about crying usually contextualize the event, ostensibly "setting the stage," by describing events leading up to an episode of crying. Such an account consists of past, present, and/or future events that may be expected or anticipated; things a woman feels are "supposed to happen," or ways she is "supposed to be." This pattern of relations or relationships sets up and helps determine to some extent what she will choose to do, prefer not to do, or even what she "wants to do." The Way Things are Supposed to Be provides a background, influences how she perceives things, helps determine what becomes focal in awareness and provides a setting where the "gist" of things becomes focal from her unique point of view.

The influence of previous events on current events in a woman's life may be seen in the following excerpts from interview protocols:

> The family script also is, "We don't show emotion." Now, my poor mother, since my dad died, has shown more emotion than I think she has ever known she had in her body. Its scary to her. It was scary to me to all of a sudden be at a place and be with people that I thought I could kind of show what I'm feeling inside. So, with her, at age eighty, its real difficult for her.

> it was not embarrassing to cry in my household at all. I'm sure I cried a good bit as a child. But, I don't know why I don't find it the way I seem to get relief, or it kind of gets in my way. In other words, I need to stop all this crying and get on with what we need to get done.

The Way Things are Supposed to Be provides a woman methods for setting a temporal context for events she chooses to discuss. The context allows her to relate some sequence of events that led up to an episode of crying.

> So, the game plan was to get through chemotherapy, get over the chemotherapy and let my body recuperate. Then, I would be ready to have the second mastectomy and have my reconstruction. That put me right up with the holidays again.
>
> When I was in my thirties, it was a taboo subject. I suppose some psychiatrists talked about it maybe with their clients, but in general, it was not something that was on a talk show or on TV or in magazine articles or something like that. It was something you did not talk about. That was another thing that contributed to my feeling bad or evil or something, because it was not discussed.

The timing of events may also become figural as part of The Way Things are Supposed to Be.

> I have forgotten dates but I think I went to see him around the first or second of December. I've forgotten when I got the "suspicious" diagnosis but then on the ninth of December, I had the biopsy that was definitely malignant, and then I had, on the fifteenth of December, I had the mastectomy. So, I think she died just a few days after Thanksgiving.
>
> I teach Special Ed. I didn't know half the kids in there. Usually my children carry over from year to year, but they had referred new ones. The class was new. They didn't know me. I didn't know them.

Although crying does not necessarily occur when a woman talks about events that configure The Way Things are Supposed to Be, elements of this theme are interwoven within descriptions of direct experiences of weeping. Statements tend to move along a relational continuum following from things she hopes for or anticipates to things she "dreads."

> I guess you kind of expect your parents to die sometime or another, mine died soon for me but they were both in their eighties. So, it wasn't a real shockeroo.
>
> I was anticipating the time when I wouldn't be able to do this. That entered my mind.
>
> I'd get real emotional and upset. I dreaded their phone calls, or I dreaded calling them because of how it was going to make me feel.

The Way Things are Supposed to Be also reflects a woman's unique way of being situated in her world; "her way" of doing things, her self identity, body image, those things she expects of herself or that significant others expect of her. Her manner of "fit" into this pattern of relations often affects her relationships with others as well as her self view.

> I guess that's because I'm kind of a mover and shaker, you know.
>
> I never expected to outlive my Aunt who is 82, 'cause you can't keep up with her anyway. It would never surprise me if I checked out at 106 and she's 30 years older than that! But, I always expected I would outlive the fourteen year old dog!
>
> I was just a pretty, almost regimented person, I think. "Good Girl Syndrome." Very definitely Good Girl Syndrome. Always, couldn't admit...I think that, you know, I was bound and determined to be the good wife, the good mother, the good churchgoer...

The Way Things are Supposed to Be affects a woman's life in many different ways: it by affecting her in some situation, influencing her awareness of others, or even contributing to interactions that occur between her and other people. When women talk about crying, the situational context of The Way Things are Supposed to Be forms a ground from which crying emerges and may affect when or even whether or not she cries at all.

Major Themes in the Experience of Crying:

Being Separate From: Experiences of Being Separate From accounted for 46% of all descriptive statements derived from the various protocols provided by women in

this study. Two major subthemes comprise the major theme of Being Separate From: Tension and Loss. Women are aware of tension building up in relationships between people, in certain situations, or in themselves; for example, when a woman experiences conflicts between her thoughts, feelings, and actions. Sometimes tensions arise in relationships between other people, e.g., her husband and child, boss and a coworker, etc., and she feels the effects. Tensions create limitations and barriers that block relationships, communication, activities, and feelings. These tensions build up slowly, putting pressure on a woman, on her relationships, and/or on situations in which she becomes involved. She experiences herself in conflict; often feeling she has exceeded her own limits and eventually reaching a crisis point. The physical aspects of this tension may be most focal for her.

> There's trying not to cry like when I was watching Terms of Endearment and the death and graveyard scene. Here I am in a public theater and I wanted to just wail, I mean wail and my throat was hurting from holding back. I wanted to break down and loud boo-hoo-hoos and I held it in. My throat just ached from it.
>
> It was a real tightness. I don't know if it was resistance. It was just this feeling of the muscles being really tight and like a big knot in my throat...Like something blocking it.

The theme of Tension also may emerge when opposing or even conflicting views of herself emerge, during conflicts involving opposing thoughts and actions, or even dissimilar personal characteristics.

> I was NOT going to show my emotions, but here I was on the outside being looked at and criticized by people who didn't even know me. Making judgments about me, you know. And it was the weirdest feeling. Really weird, because inside I was just terrified about what was happening you know.
>
> It doesn't make any sense to me to be feeling this awful when I'm thinking about something so wonderful. Its a clash. Rationally, it doesn't make any sense.

Tension may be experienced in relationships between her and some other person. When she is unable to focus directly on herself she may deflect the tension onto her experience of others.

> The only time I can clearly remember was when I was at work and, I can't remember the exact remark that was made but this man that used to work there made some rude remark and it really hurt my feelings. I was trying not to cry, choking it in and finally, I couldn't keep it in and when the tears started rolling down my face, I just picked up my pocketbook and left. I guess I didn't, I didn't want him to know that he had hurt my feelings and I wasn't comfortable - I'm not comfortable - confronting people. I will let people walk over me to an extent because I don't like confrontations.
>
> ...and I don't know how much tears played a part in that, I know I cried. there was still anger in me at other people. It was really my own anger at myself, I guess, but I couldn't focus it on me.

Feeling responsible for other people's relationships to each other may also create tension in her.

> I was so much what he wanted and we both liked each other. I mean, you know, we both got a lot of comfort out of each other's hugs and I just felt like maybe it helped split them farther apart. You think if he'd grown up without that, she would have loved him more...I don't think she wanted me to love him that much. She was jealous. And, if she was jealous, then she'd take that out on him when I didn't see it.

Sometimes, tension may arise simply as a result of some situation in which she is involved.

> All I knew is that I sensed without anybody ever saying it to me, I sensed the fact that they thought I was being very emotional about my cancer, that I was being very emotional, and the only reason I was having reconstruction, was because I was emotional about it. You know, why can't you not be that way?
>
> Actually my doctor told me over the telephone because I had been pressing for an answer from him for a couple of days and the receptionist kept putting me off and saying he was with a patient and blah, blah, and then I just got tired of getting worried over it, so I called up and said, "Well I want to talk to him. I'll wait on the line until I can talk to him." So then he told me that he hadn't called me because he didn't have ALL the results back, but that I DID have cancer and I was going to have surgery immediately and so on. Of course I had been worrying about it for several days so the build-up was pretty strong.

A woman also may be affected by tensions that exist in others.

> Kind of the curse of my mom because she's always like that and she's miserable. You wouldn't know it to look at her but she's not a happy lady, I don't think. You know, when you get talking to her, she's unhappy because she doesn't have any friends. She doesn't want to open herself up to have friends because then she's afraid she'll get hurt.
>
> Well part of it is that I'm imagining them in their pain, that they're relating, if its from the past or something like that, or someplace else and they're telling me about it. I'm imagining what their experience may be like and that reminds me of the human plight and it also reminds me of my own experiences of pain. Its just the whole poignancy of human suffering comes forward. How difficult life is the things people survive, the things people inflict on one another, the senselessness of it, the apparent senselessness at any rate, the meanness of it. And, that people prevail.

As a woman attempts to maintain her balance in the midst of increasing tensions, she may experience pulling back from the world more and more. As the pressure builds, events press in on her and she experiences a limit or feels the need to impose one.

> That was more like a marathon runner. You know, you run and run and run so hard and so fast and you're not there yet and you can't run any more so you just collapse.
>
> I decided that was going to be my cut-off point. I was going to say "no more" (laughs). This is it. I think you can make yourself sick just by being too involved in all this stuff, you know.

She may begin to feel stuck, stifled, or even trapped in the situation but unable to get free.

> Um, its like my life has been such a negative mind set that when the opportunity for a positive mind set comes along I'm having some resistance to accepting the fact that it can be mine, that life can be happy for me. Its like I'm addicted to all that negative shit.
>
> Well, this is not really something I've really ever talked about before. I guess I have talked about it in different ways. I guess its something I'm not totally happy with. Right now, I'm feeling kind of stifled inside.

Connections between herself and others are burdensome, weigh heavily on her. She experiences herself "blocked" from participating in the world as actively as she might. Barriers to communication and relationships may result from years and years of blocked emotions that refuse to budge even in the midst of traumatic life events.

> its an approach-avoidance sort of thing. Its a block to being intimate with the Divine the same way that I do with humans.

> I think my husband understands it, but he doesn't delve into it, because I think he's always sort of blocked out emotions all his life. So, I think he's doing all....I'm not letting him off the hook...because there are too many situations that are now arising that touch on male-female, they're supposed to have the same feelings is what I've been told. The same emotions are there and the same feelings are there. If they've been blocked out for so many years, you can't just bring everything up to a level in a period of time just because of cancer or an illness or because of a trauma or tragedy.

The second subtheme of Being Separate From is Loss which includes experiences of loss of control, loss of connection, and loss of awareness. Despite all her efforts at control, in some situations a woman is overcome either by her emotions or by the physical constraints placed on her by her responsibilities in the world and she loses control. When loved ones die or she herself faces the threat of nonbeing, she experiences a loss of connection. Loss of awareness involves a disconnection from self. A woman may experience distancing, a sense of uninvolvement in her life. This may be expressed in terms of loss of awareness of her emotions, or distancing in her relationships to others, or even to herself. She may lose touch with the meaning of her actions, feelings, or experiences. Losses constrain a woman, pull her back from being connected in a world of relations to others; they may even alienate her from herself. She may experience a loss of awareness, control and/or connection to some other person or to herself. Loss of awareness involves more than simply being ignorant of some fact; it is the difference between being unaware when something happens and making some attribution about "why" it happens. Being unaware of something significant about herself or her emotional expression is a part of this experience:

> You know, my dad's always wondered why I get so emotional and I don't really know. I think just...I don't know. I mean I've never really been able to explain why I'm emotional and the other people in my family aren't.
>
> How do I know when I need to cry? I just feel it...I don't know, its like, how do you know when you need to turn over in bed? You just feel it. You feel like, "I need to be on my right side." I just...I don't know. (laughs) Of course, I had trouble sleeping, too. Well, I didn't have trouble getting to sleep, but then I'd go to sleep and I'd wake up. And then there you are laying there, and you've got all these thoughts running through your head and that's usually when I would do it. I would just feel like it. I don't know....There's just something in your body that says, "turn over." I mean, how else would you describe that?

Loss of control may become figural for a women when she is overcome by her feelings or emotions during an episode of crying.

> I couldn't make the tears stop. I went in the bathroom. I thought, "Okay, I'll just go in the bathroom and give it a good wail, and then I'll get out, and then I'll be able to walk out of here and not cry any more until I get home." I couldn't do it. I went in there and cried and cried and cried and cried, got myself together and went back out there and cried and cried and cried. I couldn't not stop. It was very weird
>
> I guess the first thing that comes to mind is my nephew's death and when he was in the hospital, I couldn't stop. I cried and cried and cried. It was like...I'd get control of it and then, all of a sudden, I would just be sobbing and it was hard for me 'cause I don't like to cry. I like to laugh!

The situational context itself may precipitate an episode of crying and a woman's inability to change an event may result in her feeling out of control either of the situation itself or of her response to it.

> It was like I had lost my mind for a few minutes and I was screaming at him saying all these things and then, all of a sudden, I just sat down and shut up and was thinking, "I can't believe I said all those things." Some men would have kicked 'em out right then and you know, I'm thinking, "I can't leave, I don't want to leave, I love him. I can't believe I told him I was going to leave him." When I started crying, I just felt helpless. I knew there was probably nothing I could do to fix the situation so I just sat there and cried.
>
> Well, that you want to change the way things are. You really don't have any control. A feeling that you can't change a situation or someone is doing something <u>again</u>! That's basically it. AGAIN!

Physical aspects of losing control, e.g., actual bodily states, also may become focal during these episodes.

> Just something that had consumed me, just taken over my body. Just wells up from the depths of my heart I guess and comes upward and engulfs my mind and my brain. Just a total, not just tears that come from the throat, not just watery eyes, just a total body involvement I guess is the best way to put it.
>
> When I came to the point where I was trying to maintain all that and there wasn't time to come home every evening to do it all. I really think the crying I did was just from being so tired. I would just collapse. I would come to the point where I would actually physically collapse.

A woman with cancer may feel she is being controlled by her disease, her treatment, or even by complications surrounding these events.

> Well, every time I'd drink something, I would throw up, so it was again this feeling as if "it's controlling my body" and I think that I am pretty much a person as if, "I want to be the one in control!" And, it was beyond my control. So, it was a helpless feeling. And I guess that's the way it is each time I'd go into the bathroom and I throw up and then I just sit on the floor because I'd just be so exhausted. What am I going to do? So, the helplessness.
>
> Yes, it was a loss of control. All of a sudden, its controlling me. I guess it was more the treatment that was controlling me but of course cancer was the reason for the treatment so I blame it on the cancer.

Loss of connection is a third subcategory of the theme of Loss and includes loss of connection to loved ones and/or to self, experiences of detachment from some person or situation, and being alone. A woman may experience being alone either positively or negatively. When she longs for connection yet feels cut off or isolated, even in the presence of others, her experience is of Loss.

> I had this feeling as if, "Well, you really weren't there for me the night and the morning of the surgery because you were in such dire pain and

> here I am struggling because I am going to have this chemotherapy tomorrow and you can't even talk to me, because you're so sick! So I really felt real, real low and so I'm sure I had some tears in my fear. I don't remember, specifically, an episode of it, but yet I think that I just had that awful feeling as if "I am so alone..."
>
> I walked through the house and started sobbing. I just felt so despairing. She said, "Do you want me to hold you?" and I said, "I don't know." And, she did come over and sat by me on the couch and she put her arms around my shoulders and that felt pretty good and I was sitting there thinking, "Who in the world can I call," and "Maybe my therapist has got someone on backup and maybe I can call." I did make a phone call to a couple of people and got their answering machines.

The death of a loved other may result in tears, whether the death concerns a beloved pet or a spouse.

> That's just spontaneous kind of stuff. When my family dog had been run over, I got down on the ground, prostrate over the dog and sobbed.
>
> I knew he'd be gone that there wasn't any hope (crying) and I just kept remembering how much I would miss him and all the things we had done together. I've had several deaths in my life but that was the absolute worst thing that I can imagine 'cause just suddenly, one minute he was gone. He was in ICU for 13 hours and I cried for the entire time. If you'll look at the chart and see how often I usually cry...this is after the death. Before that, I didn't cry for years. It's just unbelievable that I could cry that much and still do.

When a woman is devastated by the loss of a loved one, her experience may be described as a profound emptiness, a void.

> The void was just that I was there. It was sort of like I had been beamed up to a planet closer to the sun that had no life on it.
>
> Yes, the void. There's just part of your heart that just leaves. It's just part of you that's missing.

Losses are described as pulling the woman back from engagement in the world; she may be thrown back on herself, feel alone and/or lonely. Being faced with a threat of self loss confronts the woman with cancer, and she may respond with feelings of

profound loneliness or despair. She may feel cut off from her surrounding world either physically, emotionally, or both.

> I couldn't (remove myself) physically, but I would emotionally I think. I would sort of cut off all feelings, or try to. Yeah, in fact, I had a period of depression where I did take to my room. It was the biggest and only...it was the end of it. I never did that again. It was almost like I really wanted to die at that moment.
>
> Yes, and some of the tears were of despair. Not only of being alone and lonely but feeling despair and maybe feeling the despair because of feeling so alone.

At times, crying may be experienced positively only when she is alone or in private.

> I'm alone, always.
>
> it was something that would come over me at odd times or, and I would really cry. Usually I would be alone.
>
> I've always been a very private person. I've always been one to cry alone. I don't know why but ever since I can remember most of the times that I've cried, I've been alone. Its like I'm just not comfortable with other people seeing me cry. Its like, "You've let down your guard. You have to tell them <u>why</u> you're crying."

Being alone may bring the woman a sense of freedom, lessen feelings of vulnerability, or offer a time free of the constraints, questions and expectations others place on her.

> And sometimes I would just disappear for ages and I'd say, "Well, at least you knew I had to be within the confines, I wasn't going overboard." And I had a great wonderful feeling of freedom because if they didn't know where I was, at least they knew I was on board. But he laughed and says, "Trying to keep up with where you were is hard." Of course, they don't even try,
>
> Well, I don't feel so vulnerable when I'm alone. I can just cry and get it out and don't have to explain to anyone why I'm crying. I don't really know, I just know that most of my crying has been alone. If I cry and its in front of someone, its usually out of anger or I've had my feelings hurt and I would usually leave as soon as I start crying.

Although a women may cry, sometimes she cannot cry for herself.

> But we went to see Audrey Hepburn in Roman Holiday, which is just a schmaltzy romance. Do you know the movie? (very teary) The guy, Gregory Peck asked her which city was the best, and she said, "Rome!" And I thought, that sort of thing gets me, but something really pertaining to me. no.

A woman may also cry and yet experience herself remaining detached. Tears may flow without experiencing an emotional engagement.

> Oh, just compassion that she was hurt. I wasn't worried or anything. I mean I felt for her, but I could detach. I was definitely going to do everything I could to get her better. And part of doing that is, I think, maybe is being detached enough where you don't get involved in it.

Self-doubts may plague a woman diagnosed with cancer, especially when confronted with differences between her views and the view of others significant to her.

> She just sat there and it was like she had a little clipboard with things that she was checking off. She'd ask me questions, I'd answer them, and sometimes she wouldn't write anything, and other times I'd say something and she'd start furiously writing, and I'd say, "Uh-Oh! Goofed up that time!" (Laughing) So that took about an hour and at the end she said, "Well, I think you are depressed and try some Prozac." And I said, "Well, oky-doke!" But I still, no one...and I talked to my gynecologist who I just love about it and he didn't think I was depressed, in that I guess "clinically depressed." He said, "Well do you go to work?" I said, "Yep." He said, "Do you still groom yourself?" "Yep." And, "Do you still have social contacts?" "Yep." Anyway, none of the questions he asked me, my symptoms didn't fit that and I did have sleeping problems. He said that was due to the surgical menopause again, so he was more thinking it was menopause. So I don't really know and then...No one that I know, no one, said, "Yeah, you need to go to the psychiatrist," or "yeah, we think you're depressed." But then you think, "Well gee, maybe I am and I've just fooled everybody else and me too!" So, it makes you wonder, "Am I depressed?"

Self-doubts not only involve a loss of self awareness, they also are closely associated with the subtheme of Control. A woman may not be able to control the situation, others in the situation or even what happens to her body. In such cases, self-doubts offer a way for her to feel in control even though she loses or gives up awareness of herself.

Experiences of Tension and Loss separate a woman from her world, from herself, and sometimes even from the relations which situate and ground her in her world. At such times, she may feels sadness, grief, a lack of autonomy and self-efficacy especially if her experience is of a hostile world in which she is vulnerable and from which she must retreat. When the intensity of her own emotions threaten to overwhelm her, she may seek escape. At these times she may experience separating herself from the natural flow of events in her life; no longer a flowing stream, she becomes encapsulated, separate from both herself and others, an empty container.

Barrier: Fifteen percent the statements describing experiences of crying concerned the theme of Barrier. Two categories of experience comprise this theme: Control and Immersion. Control concerns the methods by which a woman describes attempts to deal with events as they occur in her life. She may attempt to control her emotions by blocking them, turning them around, or by changing the situation in her mind. Control allows her an opportunity to deal with events without being overcome and becomes figural for a woman who cries when relationships with others or to certain situations place demands on her she finds difficult to meet. Situational demands impinge on her when crying seems inappropriate, during circumstances she finds embarrassing, or when she experiences conflict about expectations others may have of her. In this study, women without cancer described being aware of the demands of specific others whereas women with cancer seemed more often to focus on situational demands.

> I can remember suppressing it a few times and I was trying to remember what that was about. I think it was mostly the situation that prevented me from really crying.
>
> It was really like punishment. I didn't say anything, if I didn't cry, if I didn't show any emotion, then she would get angry about the expression on my face, that I was - she would say things like "I see the

> evil in your eyes." And, it was like there wasn't anything I could be or do that was okay and I couldn't leave and I couldn't stay and so I cried.

A women may deal with such situations by not crying. She may become angry, rebel against the situation, or control her actions and/or emotions. The methods she uses to control herself (and her emotions) include becoming actively "responsible," protecting others, learning to "take care" of others as well as assuming the role of "server" to others.

> I also felt like it was my fault for being that overweight because that's a risk factor with uterine cancer is being that overweight. So I thought, "Well, if you hadn't been such a big, fat slob, you know, you might not be in this situation. Or you might not be in this situation as young."
>
> I would much rather we all died together than for them to have to suffer on their own without me there to protect them I guess.

A women may contain herself in difficult situations either by "holding her emotions in" or by "stopping them all together." Self-containment may also involve ending an encounter or curtailing some activity.

> If I'm in a real situation, and I am actively involved, and I don't want the other person to know that I'm upset, then I'll still hold it back, you know. If they've hurt my feelings.
>
> It was like I would gulp air to keep the tears from coming, to force them not to come, to hold them back and I would be gulping air and that, somehow, would lead me to hyperventilate.
>
> I mean it was like when I was talking to him on the phone, I didn't want him to know I was crying, so I kind of squelched it. I pulled back.

When "holding in," or not allowing emotions to emerge fails a woman may attempt to maintain control by changing the situation in her mind, turning things around, or by acting in a manner opposite to her feelings.

> There are times I think about it and I'm angry and I don't cry but I have to divert my thoughts to something else, tell myself, "think about something pleasant." I have lots of days when I don't even think about it.
>
> I don't allow myself to think or talk about things I think aren't proper so maybe I really never let myself find out what I want.
>
> Then, I stop myself and try to think rationally, "You know, tomorrow you may not be here. You may get wiped out in a car wreck."

One of the most unique experiences to emerge in this research was that of listening to women talk about this way of "turning things around" with laughter in the midst of describing tragic events in life. It was difficult and sometimes impossible during descriptions of those experiences to differentiate laughter from tears.

Control emerges from a build up of Tension and the threat of overwhelming Losses experienced in Being Separate From and gives rise to the Barrier theme. Accessory to Control is an experience of Immersion; another subtheme secondary to the more general theme of Barrier. Almost all experiences of Immersion were described by women without cancer in this study; only one significant statement describing an experience of Immersion was provided by a woman with cancer. A woman's description of this experience essentially involves a dissolving of self boundaries and becoming totally immersed in some intense emotion. Women describe being fully engaged in the experience yet at the same time observing it.

> I was in bed, laying there, I allowed myself to feel it, just dwell in the sadness, like immersing myself in the sadness. Like you would a bathtub full of hot water, you just sink all the way into it. Like there's no other reality but the sadness. So you experience only the sadness and you experience it fully. And not try to rationalize, "Well everything will be okay, it will work out.." you know, not running one of those numbers on myself...I think I was fully engaged but I was observing it and I knew it was a part of the process. I knew I wouldn't be there forever. But I knew I wouldn't be there forever because I knew I was letting myself experience it fully. Does that make sense?
>
> I had that experience of my life going before me. I was crying during the whole experience. My eyes were closed. The room wasn't dark but I

> was inside this darkness. My eyes were closed and I was crying, just in this darkness, this tunnel. I could look down the tunnel and see my whole life, everything in it, the patterns of it, the themes going through... the pervasiveness of the edge, how it touched so many parts of my life and influenced so many decisions I'd made.

The process of immersion was expressed as leading to a new feeling, as though the person has gotten rid of something that had been around a long time. Some participants reported feeling "clean and clear" and that "something" emerged in the midst of the experience.

> The next day I woke up and it was like the whole thing was lifted. My theory is because I gave in to it completely, that allowed me to release it. The crying was a release and because I really did it wholeheartedly I didn't have to feel sad forever, you know. Sometimes I think if you try to squelch it then you just feel sad for a long time -- weeks, months. But my theory is if you really allow yourself to feel the pain and get into and sob and, you know...it leaves you. So the whole next day it was like....nothing. I didn't feel anything. I mean, it wasn't that I didn't feel anything, I felt real clean and clear of it, of the sadness.
>
> I'm overcome with the sadness of all this. It seems like my tears are my friend in that they let me let go of the sadness.

When a woman experiences Tension beginning to build up, the pressure of losses or threats of Loss increasingly press in on her and she attempts to restrain or block the threat to her emotional stability that become figural during experiences of Being Separate From herself, others, and/or her world. She experiences more and more difficulty as attempts to balance her relationships with others fail and she is unable to meet her own needs. A need for Control may also arise when relationships and events are experienced as not corresponding to her expectations. At this point, she feels trapped, stuck or stifled by the experience. As she reaches the limits of her endurance, anger, frustration, or sadness threaten to overcome her and she is blocked by a Barrier to the emotional flow that would allow her to let go. Sometimes a woman <u>is</u> overcome and experiences a physical or emotional collapse. Although only one women

with cancer described such experiences, women without cancer reported immersing themselves in emotions, becoming fully engaged and intently aware of the experience itself yet unaware of the surrounding world. Engagement in such experiences allows old wounds to be opened and healed, things long hidden to emerge and the woman may feel "clean and light" as the Barrier is broken through.

In Unity With: The final theme to emerge from descriptions of crying is Being in Unity With, which is composed of two subthemes: Letting Go and Connecting. A woman may overcome her experiences of the Barrier whether or not she engages in Immersion. This process forms one aspect of the experience of Being In Unity With, which is best described as Letting Go. Letting Go involves experiences that are sometimes referred to as gaining Insight, Working Through, Releasing, and Changing; in each of these, a woman discovers a "new perspective." Experiences of insight, are of "facing facts," and involve a recognition of things she never felt or noticed before. She may realize losses, connections, tensions, and/or differences between herself and others.

> I came face to face at that point that there could be other times in my life when that would happen.
>
> All of those emotions sort of crowded in and I got real teary, not just teary eyed, I didn't sob, but I cried and it was most unexpected. It just sort of came over me and we both...it was a good feeling after we finished, you know, after I cried and we talked about it. But, like I said, it was just most unexpected, I hadn't anticipated or, it just came over me and I guess you'd say, I went with it.

Her process of recognition may include becoming aware of the needs of others.

> I think Linda needs something right now, maybe more than me. Bob's wife told me that the reason she thought Linda was doing that was because to be with me was the closest thing she could be to her daddy. I thought that was a really nice thing to say.
>
> I wanted to be supportive to her and I don't think I had a need to fix it, but I just wanted her to know that I was there for her and I could understand why she made the choice she had.

Threats to her being alive or the loss of some significant other may also precipitate experiences of Insight.

> I failed to think about that until afterwards, to really sit down and think about what he had gone through. To think, I'm afraid of dying, I don't like to think about that but I really had not stopped to think how my husband and children felt. You know, they probably had some of those same fears.
>
> I just suddenly realized there were no were pennies...I even have a little trouble talking about it, there are no more pennies from daddy!

As she becomes aware of differences between herself and her surrounding world, opportunities present themselves in which she may experience new levels of awareness:

> I was very disillusioned with this person. He was not the pillar of strength I thought he was. It felt like I was much stronger than he was and I thought, "This is not the way its supposed to be." You know, the man is supposed to be as strong if not stronger than the woman.
>
> I am a person that's very aware and my husband is...at that time, totally unaware. I could see it coming, trying to communicate and say something about it. Not being heard I think was the biggest shocker.

Out of her experiences of insight may emerge a new self awareness.

> I realize that everything I was trying to do was just not doing it. I was just responding oppositely to everything.
>
> It did serve to clarify things a little bit, but it was only much later that I realized that my feelings of...it wasn't just that my father had molested me, and that I hadn't been able to tell anybody, but that I had turned it on myself a long time back and that I had a lot of guilt that I had blamed myself.
>
> It came to me while I was willing to die that I had never lived. I had never said, "I'm going to do what I want to, regardless." And I thought, "That is stupid." To be willing to end your life when you've never taken responsibility and said, "No matter what anybody in my family says, or what anybody says, I'm going to determine what I'm going to do." I think that was the turning point for me, was to realize that I was willing to give it up without a fight, when I'd never really said, "I'm going to do what I want to do."

New meanings also emerge as she connects to herself and/or to others during the experience of Letting Go.

> "You're the only one I can lash out at and know that you'll still love me." But, at the end of this one, I thought, 'You've probably gone too far this time." In the things I had said, to say he probably hoped I would die and stuff like that, that's a pretty cruel thing to say. The more I thought about it, I realized I was mad at him, we had kind of been at each other's throats for a week or so and I think the biggest thing was that I was mad or jealous or what have you that he didn't have cancer and I did. So, I wanted to hurt him.

> ...follow my instincts because they're usually pretty good. I haven't always done it, but the times I have done it, I've felt good about it. The times I haven't, I have realized that I need to trust that. I've come to realize that any time that I do something that my head tells me to do and my gut doesn't tell me to do, I regret it. They're not big things all the time, but I mean, I always feel better if I either put off the decision if there's something here telling me that I don't feel right about it. I really trust that part of me.

With insight, letting go becomes easier. She may experience an opening, a form of catharsis. Releasing becomes simply a matter of her allowing, letting something happen, going with it.

> like I said, it was just most unexpected, I hadn't anticipated or, it just came over me and I guess you'd say, I went with it.

The importance of communicating and sharing with others is experienced as taking on new meaning and she relaxes and lets go of tension as Barriers are released.

> Well, when you mourn somebody, and you can cry it out, or you can kind of resolve it. But, when it stays inside you, its hard. (crying) and, I think, talking to people, as I told my brother when he died, I had to call people and tell them about it and my brother couldn't talk about it so he sat and cried beside me. Then, I'd call and tell one of our relatives or something and finally I turned around and put my arm around him and said, "The reason you have to call people and tell them, I guess is so that when you hear yourself say it, then you believe it. So, that's why its kind of important that somebody knows how much somebody meant to you for you to be able to turn it loose.

> I'm a nurse. Why am I a nurse, I don't really know! (laughs) The part I like the most about it, is the teaching part. You know, communicating. I feel I am able to communicate something to somebody in ways they

> can understand. I can hear what the question is they're really asking. At least, when I'm dealing with patients. You know, when someone says, "I don't want this test." Then, I'm able to talk to them until I get to the point where I know why. Its either "I'm afraid or I don't understand or I'm scared if I have this test my toes will fall off." You're able to find out what it is. You know, in talking about this, I'm starting to relax.

Sometimes, however, letting go isn't easy. A woman may have to let things go slowly. If the problem is complex, or the block complete, this experience may take time; she must "work through" before resolution is possible. Although descriptions of Working Through are similar to descriptions of Immersion, Working Through is experienced as a slower, more tedious and more painful process often without a clear, clean ending.

> Or if I ever sobbed. Its on there somewhere about sobbing. I looked at that for a long time, because I don't think I ever get to that...I don't need to apparently. And I don't think I'm denying what kind of crying I've done. My memory is not that great and maybe I sobbed younger, I don't know. But I don't think of myself as getting that emotional, that its a sobbing-type thing. And maybe its because I'm letting it leak out a little at a time. I don't know.

> I've gotten in touch with that and have developed an awareness of it in the past year or so and am working to remove that block.

Things begin to happen for her and new perspectives open up, either through a slow progression of events or during some sudden insight; at this point her awareness of life begins to change.

> All of a sudden, the light bulb just went on with me that a year ago, we probably would not have hesitated over this with "Boy, sign this thing and get (participant's name) more money when (participant's name) needs it," you know. And yet, here we sat discussing it and I looked at him and said, "We've got to stop this assuming, 'I'm going to bury you' business." Because chances are, as it looks right now, it's about the most unlikely thing. Nobody would be willing to put any money on it that way. And it kind of got to me later when I realized that is a big change to make after forty years.

> You don't have that many that you can be that honest with I don't think. Although I'm finding there's not many people that I can't be. What have I got to lose, you know I'm at this point in my life its out there. Its always been out there, but I've tried to curb it and not make it so harsh,

> and I don't think its harsh now, but I think don't curb it so much. I mean that's the way it is and whatever reputation I have is what I have you know. If people see that as threatening, I don't think they do, but if they do, that's the way it will be. But I feel comfortable saying what I think because I have good ideas.

These changes are experienced as occurring in her and in relationships she shares with others; sometimes the world changes, or how she views the world.

> I've talked to her about that and I've told her that's the way I see it which is a change for me, because we do talk about things more; call them the way we see them more than we used to. And I don't have expectations of or for her any more.
>
> I feel like I have more confidence in my judgment because so many things that I really felt internally judgmental about I was right. I don't have to be told by anybody else that I was right. I know within myself I was right. And I think I needed that support, you know, others to say I was looking for others to reaffirm that in me, and if they didn't, I felt badly about it. Now I really don't care. I mean I don't feel badly. I'm sorry about it, but I don't feel badly about it and I'm not going to feel guilty about it. I've had all the guilt I want. I wish I had felt this way twenty, thirty years ago.
>
> The way the perspective shifts is that things that were important don't seem important anymore,. All that is important is , I mean its not like I'm even thinking logically to process what's happening. Its just the experience is. The here and now is just prominent, absolutely prominent. I just well up with the fullness of it all.

For a woman with cancer, the disease itself may provide some shift to a new and/or different perspective. Some women choose to focus on its positive aspects.

> "This could be a blessing." Because, I do appreciate life more now. I wake up in the morning and say, "Man, its great to be alive." People who die in car accidents or die suddenly of a heart attack, you know, they don't have the opportunity, or most of them don't have the opportunity to appreciate life. If they knew they were going to be killed in a car wreck tomorrow, then they would certainly look at today in a different light. If that makes any sense. You know, sometimes I think cancer has given me some really crazy thoughts but I do try not to let it control my life. There are times when I have to face the reality of it. I do have cancer, I could die from it, and it does scare me.
>
> I think I've given myself permission to be selfish. (laughs) You know, to not put myself down for things, or think I should be different. This is the way I am, and its a lot less trouble. Its a lot easier. And I guess cancer

> did that for me. You know, it helped me to allow myself to be who I am and to accept that. You know you're always supposed to be "better" and I think you hear that message as a child and so, you're always dissatisfied with who you are to some extent. I've been working on this a long time, this isn't something that just appeared with cancer, but I think cancer helped me to get it more in perspective.

As changes occur, a women may experience catharsis -- a release -- and Letting Go describes moving into experiences of joy, freedom and sometimes to connection with herself and/or to others.

> I had just finished something that was true and real for me. It didn't matter whether it was good or not good. It had been sort of like a little part of me. Now, the part's out here and I can look at it or something.
>
> It was almost like the relationship with him wasn't so important anymore. Something deeper had come to the surface inside of me, something that needed to come to the surface. So, it was a very cathartic experience.
>
> it's kind of cathartic in a way, I think. Sort of like you had a dam in your emotional river there, and once it broke through, you know, then it would never be quite as pent up again, maybe.

Joy is experienced as lightness, freedom, and as being connected to someone or something thing greater than one's self alone. During this experience , a woman lets go of sadness, of pain, and experiences connection to significant others or to herself.

> It feels like a kind of joy...It's a feeling of things sort of going out from you like, rather than pulling in or holding in, it's more like things are sort of being released from inside of you. It's the same kind of feeling that I've had about people at times with my husband, especially in that kind of feeling and exuberance that you have when you first fall in love with somebody, it's something you experience that's really powerful. So I think there are three almost polar kinds of this inside emotion that is often manifested through some kind of tears and one again sort of opposite sides, one with negative things or sadness, that side, and the other with feeling of being uplifted and free and... I guess it's a feeling of suddenly being connected with something, not just in here, but you feel connected with something out there. I don't know if that's saying it very well.

A woman is able to overcome the experience of Barrier that was brought about by experiences of a buildup of Tension -- tension which derives from her attempts at restraint -- by Letting Go. The process may be as simple as becoming aware of her situation, recognizing herself, the blocks she has set up or those imposed on her by others or it may be more difficult. The woman may have to spend some time working through the difficulties surrounding her, or she may become immersed in her experience, getting into it totally and allowing deeply held emotions to be released. When this happens she becomes able to experience freedom, joy, a lightness of being that changes her and brings her to a "new perspective" as she moves toward reconnection or Being In Unity With.

Experiences of Connecting account for about half the experiences of Being In Unity With. Connecting is an experience of both autonomy and unity. A woman's connections to others, to her identity in the world, and to her life situation provide her with a sense of safety and security and lend a sense of permanence to her experience of things even as they change. In addition, relationships with others are meaningful. A woman may experience closeness and intimacy with others, perhaps even feeling "dependent" and "bonded" just as she may be "touched" and "moved" by sharing with others. Experiences of Connecting make figural the awareness of others, e.g. as she identifies and empathizes with them or is helped and/or protected by them. Connecting describes an ability to "get in touch" with personal feelings, beliefs, and ideas, and may even include especially meaningful places in the surrounding world. Connecting also encompasses the experience of accepting limits and changes as these occur in her life.

Being bonded to others was experienced as offering a woman an experience of a sense of identity. The bond may exist between her and others who share similar experiences, members of her family, or even strangers she hardly knows.

> I just felt this bond and it was sad to see so many people so sick, all there fighting for the same results and some win, some lose. I don't

> even know what triggered it off, just walking down the hall and every room I looked in.
>
> I just ran to him and really let it all go. And he just kept patting me and giving me what I needed, you know, in the way of love and sympathy, and didn't express any of his worries and fears at all, I only learned much later that he had...that he had known it otherwise.

In connecting a woman may experience being dependent on someone else or otherwise a sense of being "protected" by another.

> We've been together for thirty five years. And we depended on each other.
>
> We were like one person almost, we were so close. We always knew what the other was thinking. If something hurt one of us, it hurt the other. I don't know how a person gets to be that close to someone but I was that way with him.

It may be another's intuiting or empathy for her, even their "being for her," that she finds meaningful.

> Its difficult to find people who really, truly care, you know. Even when I was doing things Mother disliked, and that disturbed her, she always thought of what would be best for me. She had hangups and she couldn't always get the effect she wanted; we certainly had mis-understandings. But, in essence, she really wanted what was best for me.
>
> I do have another significant other that lives with us. It's a graduate student, a Chinese girl and she's lived with us for 25 years. And she knows. I don't have to say anything. I don't have to talk about it. She just knows. There's just something there. The sensitivity factor that is not there (very difficult time talking here) with my own husband that I've lived with for forty some odd years.

Simply being close and/or sharing meaningful experiences may also be expressed as increasing a woman's feelings of connection to others.

> And then the beautiful thing about it, is that my husband hadn't come down with me and when I turned around to go back, he was sitting on the beach watching me. And I just said, "Didn't you want to come down and get your feet wet, or..." "No," he says, "I just knew that this is a special place for you and I thought you'd want to be alone." And I just thought that was pretty intuitive. That was kind of a special thing, too. He realizes my connections there. So that's kind of neat.

> There's also the crying I used to do with my one friend who loved old movies and British drama. We would have like five-hanky movies we would watch on a Saturday afternoon. We still call each other and tell each other about sad, silly movies that we saw separately and thought of the other when we were watching some schmaltzy movie: "I thought of you so much, I watched a 5-hanky movie."

The importance of communicating with others also becomes an aspect of the experience of connection.

> I was supposed to keep secrets and I just couldn't do it! (laughs) So, I guess that's when they decided. once I got to where I could talk, he just went into a respectable business! (laughing) So, being able to say something means a lot to me. Being able to air it out helps a lot. There's a lot packed up in there.
>
> I remember apologizing to him. I remember him looking at me with this very serious look on his face. I remember telling him I was very sorry that I couldn't do that and he looked at me as though he was as serious as I was. A couple of weeks after that, I though, "Well maybe you made a mistake" because he would chew around on the nipple of the bottle and he didn't like it much. I went back and thought, "well, maybe I've made a mistake and should breast feed him - maybe it (the bottle) was bad for him" and I offered him the breast again - I still had milk. He refused it. So, it was this communication or something between us.

Empathy for another's pain, sadness or a loss of someone special also makes crying figural for a woman.

> It wasn't my tears...That's the way it felt, like I was crying for him...The tears were coming through me but they were not my tears, they were his tears. And, the interesting part of that experience was that they were falling on him as I was bathing him and I was thinking you know, being bathed in your tears. There was something healing about that. In that situation, the bathing was a big part of the healing process, the touch is important. In this process of bathing, it was very painful to this young man. I believe I was feeling that pain and the tears were a part of that, yet the tears ah, the bathing - maybe the tears too - were helping him to feel better, to heal.
>
> However, quite often the tears just come and its like I'm in their pain. Its not my pain but I can see what their pain is. Just thinking of it, I know what suffering means. I know how that feels and I know how that pain can be isolating.
>
> I was just thinking that you're being moved by what I'm telling you is another way that I cry as an empathy with another person. Probably

> more apt to cry for another person's sadness or tragedy, or whatever, than I am my own. It seems I am very moved by other people's experience.

Similar to experiences of empathy, but less detached, are experiences of self-identity that become figural to a woman through an awareness of some one else's experience.

> I guess that's true because whenever I cry in a movie or something, its something that directly hits me. I mean there's some connection. It may not be obvious, but its something that I feel directly connected to, that fits me and causes the tears.
>
> I shared with them that my husband had died of cancer also and that I had been through fighting cancer at a young age with him. It wasn't all just empathy. It was remembering too as I listened to their story. That felt like a bonding to share that. I cried a lot when my husband died.

Getting in touch may enable a woman to experience acceptance. A woman with cancer may begin to accept various aspects of her disease as well as the changes and/or limitations the disease places on her as she attempts to adjust to life with cancer.

> it was dealing with unfinished business with my parents and my children, and I think talking about that also got me in touch with the fear of dying and maybe that's been... going through that year with, you know, with someone, maybe that's part of the acceptance that I've felt.
>
> ...a big change in my life, is not having the energy that I used to have and having to deal with that and accept that. That's been a big thing to accept.

Being able to view herself through the mirror of others is another way connecting becomes figural for a woman when she cries.

> I wouldn't come between them. I just didn't want to be a problem. After he died, she started coming and sittin with me. She'd talk to me like he used to. She'll be six in May and she can reason so well. So, we'll talk and stuff and I notice my sister-in-law looking at that and worrying about what that might be doing. It means so much to me to have part of him that she'll have to figure out a way to get around it.

> It made sense to her and she lost her irritation with the other personality and became warm towards this personality and decided she really liked her instead of hating her. All of a sudden, she had this admiration and respect for this Persephone personality. I think at that time, I even said out loud, "Oh, my God, now I understand." So, this awareness just came up, through the unconscious or whatever. out of this dialogue between these two parts of myself and I started to cry.

Experiences of special places, objects, or experiences of being touched by wonderful or exciting events enable a woman to feel connected and may bring tears more easily than close personal connections, relationships, or even tragic events.

> I could go to a movie and be moved to tears at something that touched my life. Or I could be in the mountains hiking and just remembering being at my grandfather's farm and how the smell of the earth or something very basic to me would just make tears come to my eyes. That's something I needed and I felt I had to get over to the mountains, you know, to get it touch with that, to stay in touch with that. It used to amaze me that I could cry more when I was happy than I could when I was...the opposite. The tears could come when I'm happy more than when I wasn't.
>
> There are certain pieces of music that invariably I will feel tears just because to me it's so beautiful and I guess I recognize parts of the music almost before they're played and it's kind of...it's almost...kind of nostalgia in a sense, like going home after you've been away for awhile, and you hear this again.

Sometimes being in different places can facilitate an experience of connection to others important to her in her life.

> I don't pay much attention to it, because it just all goes on in here, and I am wise enough to know that things do have a personal connection, and I'm sure it's with my father, although he would probably not have walked across the street to see the Mona Lisa.
>
> Now that has to do with my father. And I know that. My father was a Latin buff and he made one out of me. And I adored it. I said I was very interested in Roman history, and I'm sure while I was standing there I wish daddy could have seen that, because he would have loved that. And he always wanted to go to Italy, and he never did. But, the thing that touches me is that it's so old, and I'm so new! (laughs) It puts me in the real universe there.

Some participants characterized their experience as religious and/or spiritual; in some of these cases, it seemed a connection to all existence. There is a timeless quality to this experience -- as both time and space cease to exist -- there is unity and all things are experienced as one. In the profound quality of this engagement, a woman may experience difficulty with the description.

> ...it's close to the religious feeling, I think...Well, it has something to do with what we call the spirit, whatever that is, with the soul, or something. Which so often is hidden from ourselves because of all the things around us and our routines and everything. And every once in a while, it's as if though all that is, like you pulled some curtains away and all of a sudden something is very clear and right and it's like you're a part of the whole universe, or whatever. You feel a sort of "at oneness" with everything, I think that may be what it is, as though you belong there at the moment and you understand, you just know something. I don't know how else to say it.

During such experiences, a woman may become aware of the perfection and the grandeur of life. She feels struck by the beauty, the perfection of life and things "bigger than life itself."

> Oh, its just overwhelming, just the bounty of life is so overwhelming and I'm so touched. My throat sort of swells or tightens, or sometimes, it throbs. Tears well up and my face gets warm and my heart kind of gets warm and just the beauty of existence. Sometimes when I'm in the mountains and just sitting, watching the stream or the wind in the leaves, I just get this overwhelming feeling of the perfection of it all. And, sometimes when I hear a child's voice. You know, that sweet quality that children's voices have. Just the sound of their voice, not what they're saying at all, just the tone of the child's voice will touch me like that...Its more than connectedness. Its like - this is existence and there is no other. There is just existence that flows whether its in the leaf of a tree or the tone of a child's voice or a kind action.

The flow of these experiences does not end with Being In Unity With. They simply change and continue. Recognizing that Things Are and that they may be Different than she previously experienced them also involves an experience of getting over bad times and accepting that what happens, is just what happens.

> I think if I died now, I would feel like I had a very happy life. Then, when I think about losing people, you know, you cry so much, so that's why

> death is just momentary and you survive it, you get over it. You don't ever throw away the memories, you keep the happy ones.
>
> Maybe I can be a person now. See, even in the most tragic parts of my life, there is this "okayness" about it. I accept it. I really accept it. I would not pray for pain to go away. Nor to come. No, I just accept it if that's what its about, if that's what it takes, if that's what happens, you deal with it.

The paradoxical nature of a woman's experience of crying is captured in the experience of Being Separate From which pulls her back from the natural flow of events often as a result of expectations set up by her world view, her vision of what the world and she are "supposed" to be. Her behavior, and her awareness of her behavior, are greatly influenced by these expectations and they determine to some extent how she attempts to control events and to deal with losses as they occur. A Barrier is essentially a self created event wherein a woman removes herself, or blocks herself off, from experiencing others, herself, emotions and her life to the full extent possible. Letting go and changing perspective enable her to experience reconnection. Ultimately, it is only through a process of connecting to others and to herself that she becomes open, vulnerable, authentic and able to experience Being In Unity with the flow of life. In this process, she comes full circle in experiencing the reassertion of herself in a relational world where Things are Different as she begins to experience them from her new and different perspective.

Quantitative Analysis of Themes:

A summary table listing average percentage of significant statements in each of the major categories across all three themes as they emerged from women's experiences of crying is presented in Table 17. Three overarching themes emerged from the analysis: Being Separate From, Barrier, and Being In Unity With. Being Separate From accounted for 46% of all descriptive statements provided by women in

the study. The two major subthemes in this category are Tension which is figural in 24.1% of all descriptions provided by women without cancer and in 25.6% of statements made by women with cancer. Loss was figural in 20% of statements describing experiences of Being Separate From among women without cancer and in 21% of statements provided by women with cancer.

TABLE 17

NUMBER AND PERCENT OF SIGNIFICANT STATEMENTS

FOR PARTICIPANTS IN BOTH GROUPS ACROSS MAJOR CATEGORIES

OF THREE THEMES IN THE EXPERIENCE OF CRYING

BEING SEPARATE FROM (46%)* n = 463			
TENSION		LOSS	
NONCANCER	CANCER	NONCANCER	CANCER
24.1% (n = 91)	25.6% (n =158)	20% (n = 77)	21% (n = 129)
BARRIER (15%)* n = 154			
CONTROL		IMMERSION	
NONCANCER	CANCER	NONCANCER	CANCER
10% (n = 39)	15% (n = 93)	5.3% (n = 20)	<.002% (n = 1)
BEING IN UNITY WITH (39%)* n = 387			
LETTING GO		CONNECTING	
NONCANCER	CANCER	NONCANCER	CANCER
15% (n = 58)	22.2% (n = 137)	24.4% (n = 92)	16% (n = 100)

* % of total pool of statements

Fifteen percent of all statements describing experiences of crying concerned the Barrier theme. The two subcategories comprising this theme are Control which was figural in 15% of statements described by women with cancer and 10% of descriptions provided by women without cancer. The second subcategory of Barrier is Immersion which was described in 5.3% of all statements made by women without cancer and in only .002% of statements made by women with cancer. The final theme of Being in Unity With accounted for 39% of all descriptions provided by women in the study. Two subcategories account for these experiences. These are Letting Go and Connecting. Letting Go was figural in 22.2% of descriptions for provided by women with cancer and in 15% of experiences provided by women without cancer. The Connecting subtheme was figural in 16% of descriptions provided by women with cancer and in 24.4% of descriptions provided by women without cancer.

There are several interesting aspects to this table. Overall, each woman without cancer provided more descriptive statements for each theme than women with cancer. Women with cancer provided 618 Significant Statements in a total pool of 995 while women without cancer provided 377. The average number of statements provided by each woman with cancer is about 56 and the average for women without cancer is about 75. It is worth noting from figures presented in Table 17 that women without cancer talked about Connecting almost three times as often as women with cancer. Loss was figural about twice as often in the descriptions of women without cancer as those of women with cancer and Immersion was figural for women without cancer and practically nonexistent among descriptions provided by women with cancer. Experiences of Tension were described by women without cancer about twice as often as in descriptions from women with cancer.

A subsequent rank ordering of subcategories based on percent of total descriptions provided by women in each group also proved interesting. When the data

are viewed in this fashion, differences between the groups that were not previously discernable become more figural. Of interest is the similarity between Loss, Control and Immersion in the rank order for both groups. Even though Immersion was described much more often by women without cancer, both groups mentioned it less than any other theme. Loss and Control also occupy the same position for both groups (3rd and 5th respectively) although women with cancer focused on Control more than women without cancer. Connecting was mentioned most frequently in descriptions of women without cancer with Tension following closely. The remaining order for women without cancer includes Loss, Letting Go, Control and Immersion respectively. Tension was most figural in descriptions given by women with cancer followed by Letting Go, Loss, Connection, Control and Immersion.

Tension is an important aspect of crying experiences for both groups of women (mentioned more than any other theme among women with cancer and second only to Connection among women without cancer). Little difference was noted, however, in descriptions of experiences of Tension among women in either group. Nor are experiences of Loss more or less figural for either group of women. More distinct differences may be noted between the groups in statements describing experiences of Control, Letting Go, Connecting, and Immersion. Cancer patients tended to focus more on experiences of Control and Letting Go than do women without cancer and women without cancer tended to talk more about experiences of Connecting and Immersion than did women with cancer.

About 5% of all responses for women without cancer described experiences of Immersion while only one response in a total pool of 618 given by a women with cancer resembled these descriptions. All descriptions of Immersion that were provided by women without cancer included an experience of clarity with some resolution resulting from the immersion. Each woman described a sense of participating fully in the

experience and at the same time being an observer -- equally fully aware that it would soon be over with some positive result. Although the description given by the woman with cancer does not mention similar themes, she described feeling a need to get really "saturated" in the experience:

> I'm in the process in the last few years of trying to erase the slate of childhood experiences and learning, modeling, because of all that was faulty and doesn't serve me any purpose today and in the process of kind of starting over from scratch. Its kind of hard to carve something new out of some emptiness. I think part of what's going on with me these days, in all this voluminous crying I'm doing, I'm emptying myself of all this "old stuff" these shameful feelings and yearning. I keep hoping that's what's going on here. You kind of have to get real saturated in it and feel the full impact of it before its finally able to be let go.

Since other essential aspects of the Immersion theme are lacking, this statement could have been included in the Working Through category of Letting Go. Being "saturated" seemed to better fit the Immersion theme, however, and was included here. Some implications of this and other relevant findings will be the focus of the Discussion section.

CHAPTER 6

DISCUSSION

OVERVIEW

The goal of this research has been to understand crying as it was described by women with and without cancer. The experience has been approached from biological, psychosocial and historical perspectives. Standard psychological tests were used to obtain general information regarding each participant's personal style and manner of dealing with emotions. In addition, four different behaviors involved in crying were tracked over a period of thirty days and across four levels of intensity. Written descriptions of experiences of crying were collected, and one-third of all participants provided in-depth interviews describing crying episodes that have been meaningful in their lives. Results of these studies will be discussed in an effort to understand various aspects of crying as presented by the women who participated in this study.

General Characteristics of Participants:

Although a random sample of women would insure the greatest probability of representing the general population of women who cry, the specific focus of this study concerned crying among women with cancer -- specifically those who participate in psychosocial support groups and those who do not. Cunningham (1985) noted previously that despite variable results, research findings suggest that people with cancer are not a psychologically random sample of the population. A comparison group of women without cancer provided an interesting contrast to data obtained from both groups of women with cancer. None of the three groups could be considered representative of the general population although an effort was made to obtain a sample

of women with cancer who participate in psychosocial support groups as well as those who do not. Women without cancer were volunteers from among friends, family members, and co-workers of cancer patients. This group was selected as a comparison group in an effort to obtain a more comparable sample and to follow Stanwyck and Anson's (1986) suggestion that some problems affecting persons with disease may simply signal dysfunctional family patterns or dysfunctional social support systems. The general characteristics of participants -- 92% white, 67% careerwomen -- are consistent with the general population of the geographical area from which they were drawn.

Many more women were invited to participate in the study than actually agreed to do so. When 150 women with cancer were initially contacted by letter, 148 of them simply did not respond. Thirty-two of these women were subsequently contacted by telephone and queried about participating in the study. Of those, four declined to participate on the basis of disapproval of spouse or family members. Five women declined to participate for reasons of health, e.g., effects of chemotherapy, radiation, etc. Sixteen of the women stated that they were "not a crier," and seven simply stated that the topic would be too difficult for them to talk about. Among women with cancer who volunteered for the non-psychosocial support group, three stated to the researcher that they would have declined had their physician not recommended they participate. From these responses, it is evident that many women with cancer were reluctant to talk about crying. Extreme care must therefore be taken when drawing conclusions from the data, and an effort must be made not to generalize findings to the general population or even to all women with cancer. It seems most reasonable, in fact, to address these findings within a framework of women who are willing voluntarily to discuss crying while recognizing that many women with cancer are neither inclined to volunteer for a study of this type nor to discuss experiences of crying openly.

TEST RESULTS AND BEHAVIORAL DATA

Quantitative analysis of behavioral data collected over a 30-day period in each participant's life revealed no statistically significant differences in total number of crying episodes or in the average intensity of episodes among women with cancer when compared to women without cancer. Nor were any differences noted when women with cancer who participate in psychosocial support groups were compared to women of similar health status who do not participate in such groups. No significant differences were noted in scores derived from any of the psychological tests administered either within the cancer group or between the cancer and non-cancer groups. Significant findings derived from multiple correlation and discriminant function analysis include:

Findings Significant for All Women:

(1) On average, the intensity of a crying episode increases as the number of episodes increase among all women, regardless of health status;

(2) The more positive a woman's body image, the better able she is to identify and distinguish between feelings and bodily sensations of emotional arousal. Women who are satisfied with body appearance and processes typically experience little difficulty in describing feelings regardless of health status;

(3) The number of times a woman cries and the intensity of crying episodes cannot be reliably predicted by any single variable or by any interaction between variables chosen for this study when all groups are considered together.

Findings Significant for Women Without Cancer:

(4) Younger women without cancer tend to be more "other centered" as well as being more concerned with interpersonal relationships than similar women who are older;

(5) Women without cancer who are empathic, helpful, and concerned about relationships with others also are more active, self-confident, and autonomous;

(6) Neither frequency nor intensity of crying episodes could be predicted by any single variable nor by any interaction of variables included in this study for women without cancer.

Findings Significant for All Women With Cancer:

(7) When both groups of women with cancer are considered, fewer episodes of crying occurred among older women than younger and, when crying occurred for older women with cancer, it was less intense than among younger women;

(8) When older women with cancer have a poor body image, or express dissatisfaction with body parts and/or processes, they also are more likely to express their feelings in a concrete cognitive style and are less likely to distinguish between feelings and bodily sensations of emotional arousal;

(9) No single variable or interaction of variables used in this study was a reliable predictor of crying frequency and/or intensity when all women with cancer were considered together.

Findings Significant for Women with Cancer in Psychosocial Support Groups:

(10) Older women in psychosocial support groups feel less emotionally vulnerable than younger women in the same group;

(11) Women with cancer in psychosocial support groups are likely to have difficulty expressing feelings and tend to use a concrete cognitive style of expression when they report dissatisfaction with body image, appearance, and/or processes;

(12) Variables used in this study, neither singly nor in interaction, could reliably

predict frequency and/or intensity of crying episodes among women with cancer who participate in psychosocial support groups.

Findings Significant for Women with Cancer Not in Psychosocial Support Groups:

(13) When older women have cancer and do not participate in psychosocial support groups, they tend to cry less frequently and with less intensity than younger women in the same group;

(14) Women in this group tend to be more active, more autonomous, more self-confident, and more self-reliant when they have a positive body image;

(15) Approximately 51% of the difference in number of crying episodes among women with cancer who do not participate in psychosocial support groups may be predicted on the basis of age alone;

(16) Approximately 76% of all differences in intensity of crying episodes among these women may be predicted on the basis of an interaction between age, a tendency to be emotionally expressive, and an ability to distinguish and talk about feelings;

(17) Regardless of age, 69% of all differences in crying intensity among women in this group were predictable on the basis of an interaction between the ability to distinguish between bodily sensations and feelings, to talk about feelings, and degree of emotionality and capacity for empathy and warmth.

Several patterns are evident when all correlations are considered together. With regard to the relationship between age and both the frequency and intensity of crying, the relationship for women without cancer, though not statistically significant, was positive, e.g., as age increased, frequency and intensity of crying episodes also increased. The strong correlation between age and crying frequency and intensity for

women not in psychosocial support groups for cancer patients, however, was negative, e.g., older women in this group cried less frequently and with less intensity. The correlation between these factors for women in psychosocial support groups for cancer patients, although also in a negative direction, was not statistically significant. The suggestion here is that as they age, women with cancer have a tendency to cry less frequently and with less intensity than women without cancer. Participating in a psychosocial support group, however, seems to mediate this tendency.

A second pattern emerging from correlational analyses concerns scores on the Toronto Alexithymia Scale (TAS) and the Body Cathexis Scale (BC). Results here indicate a moderately significant tendency regardless of health status for all women as they age to report a greater number of characteristics of alexithymia, e.g., difficulty in describing feelings, restricted imaginative processes such as daydreaming, externally oriented thinking with a concrete, reality-based cognitive style and difficulty identifying and distinguishing between feelings and bodily sensations of emotional arousal (high TAS scores). The relationships between alexithymia and poor body image was highly significant, however, only among women with cancer who participate in psychosocial support groups. This correlation may simply suggest that women who participate in such groups are qualitatively different in their style of emotional expression than women with cancer who do not participate in such groups. Concomitant with that possibility is the moderately positive relationship between emotional vulnerability and age in the same group. Overall, women with cancer who participate in psychosocial support groups are less emotionally vulnerable as they age; when they feel positively about the processes and appearance of their body they also tend to be more in touch with their feelings, to distinguish between feelings and sensations, and to be able to describe them as well.

When women with cancer who do not participate in psychosocial support groups have a positive body image and/or feel positively about their appearance, they

also tend to be more agentic, more active, self-reliant, self-confident, goal oriented, and autonomous. The intensity of crying also tends to decrease with age. The more a woman with cancer who does not participate in a psychosocial support group is concerned with others, however, and the less she aware of her own feelings, the more predictable will be decreases in the intensity of her crying.

These findings are consistent with a study by Todarello, La Pesa, Zaka, Martino, & Lattanzio (989) linking characteristics of alexithymia to breast cancer patients. Results of this study revealed evidence that patients with cancer typically have personalities characterized by constrained imagination and fantasy, difficulty verbalizing emotions and/or a tendency to express them in at a motoric, e.g., concrete level. Similar characteristics have been noted in patients with cancer, primarily in retrospective (Leshan, 1959; Blumberg, 1954;) and post diagnostic studies (Kissen, Brown, Kissen, 1969; Bahnson, 1970; Greer & Morris, 1975; Voth, 1976; Wool, 1986). It has been suggested by Todarello and colleagues that these characteristics imply a psychosomatic component associated with the disease.

QUALITATIVE DATA ANALYSIS

The hermeneutic analysis of qualitative data revealed three themes that describe the experience of crying for women in this study. When women talk about crying, they usually begin by setting a context. The context of the event involves more than the immediate setting or some definite point in time; it also includes a woman's way of thinking about things, how she sees the world and what she expects to happen in certain circumstances. Women anticipate that past, present, and future events will occur according to expectations; or the Way Things are "Supposed to Be." Certain expectations may have influenced the woman since childhood and continue to affect perceptions and determine which will become focal in present awareness. The "way

things are supposed to be" may be different for different women or even for the same woman in different situations, and such a context-setting concern is important both to women with and without cancer. Some events tend to become more focal for a woman with cancer as she attempts to make sense of situations surrounding her disease, e.g., what to expect from treatment, how her family would do things, what might be the consequences of following or not following medical recommendations, etc.

When things do not happen the way they are supposed to, women respond by feeling disappointed, puzzled, or "put off" that things are different. "Being Separate From" self and/or others becomes figural when Tensions build up as a result of contrasts between actions and feelings, when differences between one's thought, feelings, and expectations become apparent, or when similarities and differences between one self and others emerge. At this point, women feel pulled between poles, both weak and strong. Things may be funny and frustrating at the same time. Women experience various emotions as these tensions build up, e.g., frustration, anger, or even resentment that things are being dumped on her. The repercussions may be expressed physically as "painful" (in the form of aching in the chest, throat, or stinging eyes) as the woman feels a need to cry. When she does cry during experiences where Tension is figural, the tears do not necessarily make her feel better. Among women with cancer, certain limitations placed on them by the disease may be particularly frustrating. A woman may feel weak; simple tasks like taking a bath, washing her hair, or getting dressed wear her out. In addition to making her feel more physically ill, sometimes her treatments yield pressures never before experienced by her family, e.g., separation when hospitalized, lost income from work, or other difficulties that arise as the woman's family attempts to handle the consequences of her disease. Many of these events result in increased feelings of personal responsibility, less connecting with others, and increased feelings of being out of control.

Whether or not they have cancer, women respond similarly to losses that occur in their lives. Themes comprising Being Separate From become figural when women cry, whether the loss involves a loved one, a beloved pet, or potentially a loss of self. All women in this study mentioned being overwhelmed from time to time by events that occur in life. When things become difficult, women feel powerless and often have to admit there is nothing to be done and no way to "get" in control. Women with cancer may feel powerless, or overwhelmed as a result of the diagnosis itself. They also may feel consumed by the intensity of treatments, overwhelmed by a vast quantity of information received in a short time from health professionals and unable to accept opportunities to control when these are offered. Such women also become aware of lost opportunities. Certain things expected to happen as life followed a normal course are endangered by the diagnosis, e.g., seeing a child graduate, enjoying retirement with her spouse, seeing her children age, watching her grandchildren grow up.

As a consequence of experiencing Being Separate From, a woman may begin to set up barriers or blocks to control her emotions, or her fears of isolation from others; perhaps even the threat of being taken over by the needs and wishes of others. Some women begin to question themselves and may attempt to change situations so that they will feel more in control. As life intrudes on the way things are supposed to be, a woman may feel controlled by the situation, by events, or other people. If so, she may attempt to control her emotions to avoid appearing weak. Taking "time out" may become necessary when a woman feels the need to be alone, or to remove herself from others as a way of coping or balancing things out. Women with cancer as well as women without cancer, describe holding back emotions as a result of being aware of the demands of the situation, e.g., the way things are supposed to be, the way she is expected to be, or as a choice not to appear vulnerable (or weak) whether or not some other person might also perceive her so. Another major issue for a woman with cancer

involves coping with her disease by taking responsibility for it, or by blaming herself for events that have occurred, e.g., not following a healthy lifestyle, not going to the doctor soon enough, settling different opinions among physicians, making difficult decisions about treatment, surgery, reconstruction, etc.

The experience of Immersion allows a woman to confront the Barrier directly. This experience involves a woman getting into her emotional experience totally, and allowing herself to experience it fully. At the same time, Immersion also involves recognizing that becoming totally involved in the intensity of her emotions will enable her to let go of the tension and/or grief more easily and will help her regain a sense of balance. Only one woman with cancer in this study described any experience resembling Immersion. The prevalence of these descriptions among women without cancer makes their absence among women with cancer quite evident. One possibility is that women with cancer do not experience Immersion; it is equally possible that they do. Since such experiences are characterized by intense emotionality they may become less figural in awareness for women who experience difficulty in expressing or talking about feelings as seems to be the tendency for women with cancer and, indeed, for most women as they age.

Crying is figural for women when they experience Being in Unity With. Such unity is experienced as involving connecting with themselves, their emotions, and/or needs and expectations; it is also expressed in reaching out or feeling intimate with others as well as by sharing and being touched by people, places, or events that are meaningful. Sometimes women feel bonded to other people. They may experience being dependent or depended on, or even feeling protective in and by their relationships with others. Feelings of empathy for others also are figural for women at this time. Among women with cancer, empathic relationships with others provide a way to express emotions and to get in touch with feelings that may be difficult to experience directly.

Special places, meaningful works of art, music, and the beauty and perfection of nature also provide opportunities for Connecting. Among women with cancer, emotions expressed when Connecting with special times and/or special places and/or during experiences of empathy for others, are often more easily acknowledged than feelings for themselves. For women, both with and without cancer, the experience of Connecting involves experiences of continuity of existence and a unity in space and time with all existence.

Experiences of Letting Go also were described when women talked about Being in Unity With. A woman may let go of events she found difficult or problematic in a slow process of working through and by attempting different solutions. She may also let go by learning to deal with difficulties, by recognizing differences in the way things "fit," or by coming to expect different things than she did previously. Letting Go may also occur suddenly when a woman comes face to face with some new perspective: a turning point may be reached in conjunction with some clash of feelings, thoughts, and emotions. When a woman becomes aware of things in a new way, the realization clarifies things and enables her to view her situation from a new perspective, e.g., to realize some loss, recognize the source or consequences of tensions, or even feel increased connections or awareness of self and/or others. During this process, a woman may feel empowered; as things open up, she experiences being able to effect changes and to accept things as they are even while she seeks new opportunities and directions. Letting go may involve a process of self-transformation: a woman may view herself as being able to do things she never experienced as possible before. Letting Go may empower her to be open to things happening "as they happen," to acknowledge things she is able to do, and to recognize that she doesn't have to do everything, or to be perfect. For women with cancer, just having the disease may bring her to a crisis point and force her to examine her world and her place and meaning in it. Having

cancer makes some woman more aware of their life. Some women reported seeing cancer as a blessing and as an opportunity to do some things others cannot do. Being able to change expectations of the way things are supposed to be may allow a woman to acknowledge that some things simply "Are," and other Things Are Different. In spite of cancer, she may experience many things as "better." Having cancer may empower a woman to change and to make things happen in her life just as it may encourage her to appreciate and accept many of the things she cannot change.

CONCLUSIONS

Social, behavioral and psychological correlates of crying have been examined in this study. Had the study been confined to quantitative correlates alone, the results would have indicated no differences in the occurrence and/or intensity of crying among women with cancer relative to each other and to women without cancer. Nor were any statistically significant differences among the groups in agentic or communal style of emotional expression, body image, or in their respective ability to differentiate and describe feelings and bodily sensations. Qualitatively, however, there were some differences and marked similarities between descriptions of crying provided by women who have cancer and women who do not. Fundamentally many similarities may be noted, although the way the world is taken up and lived is different depending on whether or not a woman has cancer.

Women with and without cancer talked more or less equally about their experiences of Tension and Loss. These themes describe essential aspects of crying for everyone. The more significant themes for women with cancer were Control and Letting Go; for women without cancer, the more significant aspects were Connecting and Immersion although women in all these groups experienced all themes. Tension and Loss have in common that they become figural when a woman experiences some

separation from her world. This separation occurs either as a result of events that do not go as expected or when conflicts arise within her. A woman may be similarly affected when conflicts that arise between her and some other person or, even, between others who are important to her. Experiences of being separate from also emerge as situational demands impose constraints on a woman. She may also feel a sense of separation when she loses someone or something important in her life, e.g., the death of a loved one, a financial disaster, physical collapse, the threat of death for herself or someone else, a loss of self awareness. Tension and Loss are both aspects of a fundamental ontological state -- a threat of non-existence and the anxiety intertwined in living with that threat.

A person's awareness of the threat of nonbeing is usually called anxiety, and Tillich (1952) has distinguished three types of anxiety according to the three directions by which nonbeing threatens being: (1) the anxiety of fate and death, (2) the anxiety of emptiness and loss of meaning, and (3) the anxiety of guilt and condemnation. The meaning of our anxiety reveals itself in whatever complex network of relationships, projects, and identities we assume to hold or "fix" our place in the surrounding world, e.g., in the ways we expect things to be, how we deal with tension and loss, etc. When women experience tensions building up between themselves and others, within themselves, or between others important to them, the need to control their emotions must not be misinterpreted as a cognitive decision to hold back their expression but rather as an expression of the will to be. When women experience tangible losses, the threat of nonbeing becomes even more figural, e.g. "what was so important to me is now gone, a part of me went with it, perhaps I am in danger of going as well." For women with cancer, the threat is still more tangible; all too frequently the diagnosis of cancer is experienced as meaning death and the threat becomes real indeed.

Crying about tensions that affect one's life or about losses that threaten autonomy may not relieve the fundamental existential angst or anguish and dread (May, 1983) of NonBeing at its root. The tension may be relieved temporarily, however, when the argument is resolved, the laundry clean. Sometimes something emerges that offers a more enduring possibility, an opportunity for "things to be different" than one expects and, paradoxically, such an opportunity is often experienced as threatening to destroy the security of the present, the Way Things are Supposed to Be. Tension and Loss reflect common experiences from which crying emerges in women with and without cancer. How women in these groups deal with these experiences, however, is quite different.

According to Pollio (1982) "we have two possibilities with regard to anxiety: to defend against it or to recognize it as one aspect of our attempt to grow and change." Women with cancer report defending against anxiety and threats of loss largely through efforts at Control. When they acknowledge the anxiety resulting from Tension and Loss, and work through the Barriers created to help maintain Control, they are able to Let Go and accept change. Women without cancer use similar techniques to defend against anxiety although Connecting with others provides a more salient method for dealing with both Tension and Loss. Some of them are able to Immerse themselves in grief or fear and simply go with it until they are able to release it and move into a new perspective. These two methods of dealing with existential crises are quite different: A woman with cancer finds figural that which moves the world away or separates her from the world; a woman without cancer is more aware of that which connects her to deeply felt emotions and/or draws the world closer.

The primary defense against being overwhelmed by tension and loss appeared in the descriptions of women in this study as Control. Control is simply a way many women attempt to set up a Barrier to defend and protect themselves against increasing

tension (anxiety) and/or threats of loss (non-being). The experience of control is more figural for women with cancer than for women without cancer. This difference may simply be a consequence of the disease itself which confronts a woman directly with the possibility of Non Being. Much of control has to do with containment; of keeping things concrete and of setting limits. A number of possible ways of dealing with these issues were included in descriptions which seem to provide women with the possibility of experiencing control when emotions threaten to overcome them. Some women reported protecting themselves by simply refusing to perceive it, e.g. by not being involved, by being detached and unaware. Some women reported rationalizing events by turning them around and by thinking about something pleasant. Sometimes a woman reports acting oppositely to her feelings, that is by putting up a "strong front" to keep others from knowing when she feels weak.

Feeling guilty also provides a sense of efficacy and control against threats of non Being. Being guilty also has the signification of "being responsible for", e.g., of being the cause or author or even the occasion for something (Heidegger, 1962). Guilt is intimately related to possibility or potentiality (Yalom, 1980), for knowing and experiencing that she cannot or will not actualize her potential (May, 1969). According to Rank (1945), one feels guilty on account of the unused life, the unlived life. The anxiety of this guilt is essentially a moral condemnation, and can drive the woman toward self-rejection and feelings of despair for having lost her destiny (Tillich, 1952). Obedience to the moral norm which forms the basis for one's essential being excludes emptiness and meaninglessness -- the sort of spiritual anxiety derived from a loss of meaning that gives meaning. When spiritual meaning is lost, responsibility and guilt offer a way to rediscover meaning. For instance, one woman felt responsible for her own cancer because she had been so busy taking care of her husband when he was hospitalized with terminal lung cancer she didn't take the time to go for a mammogram.

Guilt and responsibility, therefore, may also be viewed as existential mechanisms of defensive control.

By stopping or not allowing herself to express emotions when she feels vulnerable, a woman may be able to maintain control until she gets to a place she feels safe, where she can let go and release her feelings at will. At other times, she may be overwhelmed by the intensity of her emotions and the strain of always expecting to control them. Not being able to express how she feels may leave her feeling trapped, overwhelmed and overstressed. If the woman is unable to break the cycle, she may feel she has become addicted to the negative, as the downward spiral of self-negation takes her ever deeper into despair.

In such cases, the underlying angst is not resolved until some change occurs. As women in this study described it, change occurs for women with cancer most often through Letting Go. For these women, a major aspect of Letting Go involves a slow, tedious process in which some issues must be repeatedly worked through; "scenarios" must be created, tested and retested until a release occurs and the woman becomes aware of some new perspective. For women who are proficient at blocking, acting oppositely to their feelings, changing situations in their mind or focusing on something pleasant, it is evident that a slow progression might be necessary to allow time for the woman to assimilate changes as she becomes more aware of herself. Sometimes cancer serves to facilitate this process. For some women, a sudden shift in relations or intense experience of affective engagement would not only be frightening but might even increase existential angst. When cancer brings her face to face with the source of her dilemma, the anxiety she feels is no longer a nameless dread, it has acquired a name, a concrete identity, and the woman may feel more congenial to dealing with it than she did to something sensed but unseen.

Cancer was viewed by some women in this study as an opportunity for change. When she was able to confront Barriers to her existence, the experience may lead to a realization that she has been "ready to die without having lived." It is Frankl's belief that human beings are able to find meaning and purpose within the most inexplicable and degrading of circumstances through self transcendence (Frankl, 1963). Self-transcendence is the capacity to reach out beyond oneself, to extend oneself beyond personal concerns, to take on broader life perspective, activities, and purposes. An earlier study of women with advanced breast cancer (Coward, 1989) revealed that some women found meaning in their lives in the face of their life threatening illness. Women in the present study also found that reaching out beyond oneself, without having to devalue the self by assuming guilt, caretaking, or becoming a "server," led to finding meaning in life. For women in this study, Letting Go involved seeing things differently than before. As women with cancer worked through their lives some discovered a broader understanding of themselves and of the meaning of their existence. Some of these experiences included finding one's "mission" in life and reaching out to others with cancer; still others include learning to appreciate things more, to accept limitations and to learn to appreciate the things one can do well. Some women learned that having an imperfect body may be better than having none at all. For others, just being able to laugh and enjoy life became more important once it seemed it wouldn't always be possible to do so.

For a woman without cancer, crying allowed her to sink into her experience and to become one with it. The experience of Immersion also allowed her to experience herself in unity with the intensity of her emotions and to feel confident and assured the experience would have a positive result. The fundamental orientation in the world of a woman without cancer is different than that of a woman with cancer in that she is able to reach toward her emotions even when they involve intense sadness or grief. At these

times, she is able to welcome such emotions and simply go with the experience. A woman with cancer's self-boundaries are experienced as so tenuous that to engage in such an experience might be terrifying; she might literally experience it as a death of self.

Experiences of Connecting are similar in many ways. Women without cancer reach toward the world and what is figural for them is that which moves the world toward them and brings them into intimate contact with other people and the surrounding world. When Tensions give rise to anxiety and losses or threats of Loss give rise to the existential angst, this woman turns into rather than away from the intensity of her emotions. In so doing, she is able to release her anxiety, to reach out and embrace life and to invite others to participate with her.

Findings Relevant to the Literature on Cancer and Emotions:

When human beings cry, what does it mean to them? Two women stand together in the same place and share an experience. Each woman cries. The only difference between them is that one has cancer and one does not. When asked what they cry about, each woman mentions the same event. Does that mean their tears have the same meaning for both? According to findings in this study, it does and it does not. Had she been a woman in this study, the woman with cancer would most likely describe how she tried to hold back her emotions during the event, the attempts she made to control herself and/or the situation, how overcome she felt before the tears finally came and how crying helped her to realize that even though the event changed her life, some of the changes were better and she could go on from there. The woman without cancer would most likely describe the event as one in which she also felt the intensity of the emotion, a desire to hold back or control the emotions, and that she decided to "go with them," to allow them to emerge fully recognizing that getting into it would allow her to

emerge feeling a new sense of clarity. Her tears would serve to bring her closer to the event, enable her to get more in touch with herself and others that might have been involved and provide her a sense of the timeless continuity of existence.

Both viewpoints characterize human conditions of ultimate limitation and dependency that necessitate a heroism in everyday life (Becker, 1962). Such heroism requires the support of beliefs in immortality and transcendence according to Becker. Each human being is caught between two equally compelling and conflicting ontological needs: To assume the stance of "being apart from" the other, to stand out from the masses and to realize one's uniqueness, and specialness. At the same time, human beings long to "be a part of," to achieve merger, communion, and solidarity with as wide a personal reality as possible. Each possibility evokes terror of death and the threat of nonbeing. The fear of abandonment and isolation, and death in relationships is inherent in affirmations of one's particularity. The experience of merger also threatens to overwhelm or dissolve the uniqueness of self through engulfment. Such is the ambiguity of human existence, an ambiguity that arises from the essential dilemma of having a body and being a body (Plessner, 1970). The body in its ambiguity is forever an aspect of each human being's fundamental unity and of a distanced and distancing part (Zegans, 1987).

In crying, we live the existential angst in terms of the body. To be fully embodied is to recognize the ambiguity of Being. One may attempt to confront the existential dilemma by moving through the body and connecting with one's self and others only to be thrown back into the body when sadness, grief, and anxiety drive us there. Or, we may attempt to escape the body, only to be recalled by situational demands and/or an emptiness that threatens to overcome us. Even in transcendence, whether through experiencing the unity of connection with all that exists or simply by accepting that things are as they "Are," the threat of nonBeing is only temporarily

overcome. In human being we move between freedom, autonomy, and isolation and merger, communion and boundedness. It is at this boundary of "between" that crying occurs; at the juncture between person and world that our emotions spring to life and at the juxtaposition of being and Non Being that the body takes form.

The correlation previously noted between characteristics of the alexithymia construct and poor body image, which tend to increase as women age regardless of whether or not they have cancer, strikes at the heart of that sense of agency that is commonly referred to as "self" (Zegans, 1987). This unity is capable of change in its continuous striving toward equilibrium. We have a sense of what properly fits and reflects ourselves and what is unassimilated and alienating. This sense endows us with an evolving "meaning structure" that interprets events, unifies personal characteristics, and provides a basis of acting. The way this process is carried out reveals a signature or style of being which we recognize as uniquely expressive and true to each of us. We tend to project our experience of our body onto others (Merleau-Ponty, 1962) and when we witness the body and actions of others, we find meaning therein since they provide possible themes for our activities and self-development.

Schilder (1950) posited that body image is, to a large extent, created by social interactions with important others and that emotions play a central role in shaping each person's perspective. Sometimes we neglect our body because it does not conform to our image of how it should appear: poor body image among women with cancer is associated with a concrete, reality based cognitive style as well as with a lowered ability to distinguish feelings and emotions. Women with cancer in psychosocial support groups became more connecting. They are better able to distinguish between feelings and bodily sensations and to describe them when they feel positively about their bodies. When women who did not participate in such groups have positive body image they further isolate themselves from others. They feel more agentic, autonomous, self-reliant,

and seem to follow more closely the pattern of moving away typically associated with cancer patients. The implications here are that when women with cancer who participate in psychosocial support groups feel positively about their bodies, they are able to connect. Instead of moving more toward autonomy and individuality -- which for a woman with cancer signals an attempt to escape the existential angst -- such women also are able to move toward the world, others, and themselves. In so doing, they embrace life in spite of the irrevocable fear of its loss. For women who are not in psychosocial support groups, the sharp decreases in crying intensity with age may indicate the extent to which they are being challenged by these underlying existential fears which they are ill equipped to face. By becoming more agenic, more removed from connecting with others they are simply exerting their essential need to move back from a world in which the only way to be is Not.

Applying characteristics commonly associated with existential fears and negative affect to patients with cancer is not new (Kirkcaldy & Koblinska, 1987; Yalom, 1983) and the appearance of these characteristics in cancer patients by no means implies that these traits pre-existed the illness although findings from longitudinal studies by Thomas (1988), Shekelle, Raynor, Ostfeld, Garron, Bieliauskas, Lui, Maliza & Paul (1981) may be interpreted to support this view. Although women with and without cancer respond in similar ways both behaviorally and cognitively to life situations, it seems apparent that these experiences mean different things to each of them. Obviously all women confront similar fears, especially when they cry. As findings from women without cancer indicate, however, they commonly exhibit characteristics of <u>both</u> agency and community in that empathy, helpfulness, and concern with relationships correlate highly with characteristics of autonomy, self-confidence, and increased activity.

According to Goldstein (1939) this tendency toward a concrete, reality-based cognitive style occurs in response to some overwhelming anxiety which leads a person

to exist in a narrow, orderly world and behave in a rigid, unspontaneous way. This overwhelming anxiety is experienced as a "catastrophic collapse." Following it, the rest of a person's life may become nothing more than an attempt to avoid having to face the experience of Non Being again. For this reason, such individuals turn away from choosing and toward avoiding. All living becomes defensive under this strategy and one is always defending oneself against the possibility of a new catastrophic collapse.

Voth (1976) explored a concrete cognitive style as it is exhibited among cancer patients by testing them for the ability to perceive movement from a pinpoint of light in a darkened room, an ability which ostensibly reflects a central aspect of personality organization. Persons with cancer not only perceived less movement in Voth's study than persons without cancer, they also exhibited a cognitive style associated with some sense of helplessness and hopelessness, coupled with a degree of resignation from life. Voth also reported persons with cancer to be more field dependent, to perceive movement differently on the autokinetic task and to characteristically lack "psychological mindedness" which also happens to be a characteristic in descriptions of the alexithymia construct (Taylor, Bagby, Ryan & Parker, 1990). Witkin (1954) earlier reported that field dependence is more common among children and among adults with poor body image. As Pollio (1962) pointed out, the poorer one's body image, the more likely that person is to depend on some external frame of reference and to base perceptions on the world around them. Yalom (1983) described field dependent people as experiencing a fusion of body and field. As a result, these people experience difficulty distinguishing themselves from the surrounding world. According to Yalom, this style is not limited to perception but is a pervasive cognitive style evident in intellectual activities, body concept, and sense of separate identity.

The implications of these findings to the present work involve the existential stance of a woman with cancer. Whether or not a "catastrophic collapse" occurred

underlying angst remains, and release comes only through confrontation and/or transcendence.

When physiological correlates do not meet self-report claims, (Kraemer & Hastrup, 1988) perhaps it is simply another indication that perceptions of reduced tension have to come through the world as it is lived rather than through the intellect alone. In other words, in our zeal to make mind the god of body, we gave priority to reflected consciousness, having forgotten along the way that thinking about being and Being are two different things entirely.

Perhaps it is unclear from the findings presented in this study that thinking about living and living are different, that thinking about crying and crying are different. When we watch movies, read books, or listen to other people talk about their lives we may be able to get in touch with similar experiences in our own lives: this is the basis of empathic response. But, as the descriptions of women in this study described, one can empathize, even experience crying in response to someone else's pain or loss, and still remain detached. How we experience the other or even ourselves depends upon whether or not or experience is "as is" rather than "as if" (Pollio, 1962). When we experience the world "as is," the experience of the other is no longer theirs alone, we engage in it as well. As I sit in my living room in my favorite chair reading Charles Dickens, the whirring of the air conditioner disappears, as does the feel of the fabric against my skin, and I hear instead the clip-clopping of horses hooves on cobblestone streets, wince as the acrid smell of smoke from nearby chimneys assaults my nostrils, and turn, with a welcome smile upon my face as Tiny Tim approaches with hat askew and little crutches scraping along beside him. I have never been to England; certainly not to England in the time of Dickens, and yet, the sounds, smells and sights are more real to me than my own living room. In those moments of reading, the story was not experienced "as if" it were true but rather as it "is" for me. Certainly it is possible to

read and enjoy Dickens as a marvelously well written story without being there, without hearing, seeing, smelling London in the present here and now. The difference between that possibility and the experience I've described are precisely the differences between thinking about an experience and living it, between an "as if" and an "as is."

Perhaps it is simpler to think of these experiences as getting "carried away." That which we are carried into is the unity of existence, the timelessness of time and space, and the continuity of past, present and future. As we are carried away, Tiny Tim's plight becomes ours, the death of Scrooge is experienced as our own. Women with cancer, at least in this study, have difficulty living in the day-to-day world "as is." Being carried away by intense emotional experiences is difficult for them, and they continually distance themselves by living "as if." For many of them, only through experiences with movies, books, and the experiences of others are they able to access the authenticity of "as is" through empathic response to the plight of others but not by being fully engaged in their own. A rather disconcerting possibility presents itself as we begin think about how difficult it is to live "as is." This is the possibility that "as if" is becoming the expected, the "way things are supposed to be" according to the traditions of our Western world.

Crying is a behavior, an emotional expression, and a relationship that exists between people or between the person and her world and makes manifest the connections among biological, psychological, and social phenomena. Emotions are world dependent (Harre, 1986), but the dependency is not that emotions are created and nurtured by the world as some social constructionists would have us believe. Emotions in the Jamesian sense are inextricable from the world. Though we may choose to give precedence to one over the other, we do not live body and mind but rather person/world. The experience of body/mind unity expresses itself in the presence and engagement of a self in the world.

A colleague was recently asked whether or not his department was continuing to fund research on cancer and the emotions. He responded by saying, "No, we decided it was too messy." Indeed it is. And yet, is not all of existence a "messy field" which Being paints with vibrant colors and which, like the lilies in Monet's pond, diffuse back into haze the more closely we approach. All the more reason to take a step back, to take the time to reflect on the whole and recognize:

> Reflection does not withdraw from the world towards the unity of consciousness as the world's basis; it steps back to watch the forms of transcendence fly up like sparks from a fire; it slackens the intentional threads which attach us to the world and thus, brings them to our notice; it alone is consciousness of the world because it reveals that world as strange and paradoxical (Merleau-Ponty, 1962, xiii).

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APPENDICES

APPENDIX A-1

INITIAL LETTER OF INTEREST TO POTENTIAL PARTICIPANTS

(DATE)

Dear (Name of Potential Participant):

I am a doctoral candidate in the Department of Psychology at the University of Tennessee currently doing research on the way people with cancer express emotions. Many psychologists and physicians consider emotion to be simply a biochemical process that goes on in our brain. Others believe emotion is determined by the situation we are in. As a result, most of psychology has interested itself in looking at the causes of our emotions: what event triggered our anger or tears.

My research is not focused on brain states or causes. It is focused on what your emotions mean to you. In this research, you are the expert. Think about a time when you cried or felt like crying. What was it like? This research considers your point of view. I am interested in talking with you about these things as an academic psychologist. After receiving my Ph.D., I will be doing research and teaching in a medical school. My students will eventually work in the health professions as nurses, therapists and doctors. It is important to the field of medicine and also to other cancer patients to know how cancer patients feel.

My basic underlying belief here is that cancer patients can be helped by hearing about the experiences of other cancer patients. Also, cancer patients have something to teach all of us, the rest of medicine and psychology as well. What you have to teach is what I am interested in learning so that I can go back and share your thoughts, your feelings and your experiences with others in an effort to help them understand what emotions mean to other cancer patients.

Everything you talk with me about will be kept confidential as regards your identity. Your name will never be used in connection with the study nor will your identity ever be revealed. Your thoughts, your experiences, and your feelings will be included in an over all picture of what crying means to cancer patients. When the study is complete, I will bring my results to you first and we will go over those results together. If you disagree with my findings, we will work together to get those findings to fit your experience. The study will be incomplete until it fits with what cancer patients experience when they cry.

If you are interested in knowing more about the study, or if you would like to participate, please call me (H) 579-0924 or (W) 974-6060. Or, you may leave your name and a phone number where you can be reached during the day with the (name of physician or contact agency) at (phone number of physician or agency). I will plan to return your call as soon as I receive word of your interest.

Thank you very much for your interest and consideration.

Sincerely,

Jean W. Hunt

APPENDIX A-2

VOLUNTARY CONSENT FORM

Presently I am conducting my doctoral research in psychology at the University of Tennessee, Knoxville, under the direction of my faculty advisor, Howard R. Pollio, Ph.D. It is toward this end that I request your participation in this project. The purpose of this research is to investigate how different people experience crying. The field of psychology has long been interested in emotional expression since it is an important aspect of human experience. Descriptions of crying episodes may tell us something about the way human beings experience emotions. Descriptions of the experience may help us understand what crying means to us.

The study consists of three phases:

Phase 1 will ask you some questions about age, sex, type of cancer, a short medical and drug history (some types of hormone therapy and/or chemotherapy interfere with a person's ability to tear). Then, you will be asked to complete a 50 item questionnaire. The questions deal with bodily felt sensations and "feelings" about emotions. Some questions will ask what you do to deal with emotions as they come up. This part of the study will take about 30-45 minutes to complete.

Phase 2 is simply a checklist of five or six behaviors such as "wanting to cry but didn't," "feeling teary-eyed," "crying moderately," "sobbing." You would be asked to check off which items you did each day for a period of one month. This phase of the study should take no more than a couple of minutes each day during the month. At the end of the month, before handing the checklist in, you will be asked to recall some time during the month when you cried or felt the need to cry and could not - any one of those times you recorded on your checklist. A journal will be provided so you can write down your description of that experience. This usually takes about an hour to complete.

In Phase 3, participants will be asked to talk with me about their experience of crying. These talks will be tape recorded and usually last from 1 to 1-1/2 hours. We will begin by me

asking you, "Can you describe your experience of crying?" You may talk about any experience you have had - at any time in your life - that involved crying.

At a later date when all interviews are complete, questionnaires and checklists have been filled out, each participant will be contacted for a brief, followup interview lasting approximately fifteen minutes. During this interview, the participant will be given feedback regarding findings in the study. Each participant will be asked whether anything needs to be added or changed in their own report.

All information obtained will be held in strictest confidence. A list of participants names will be kept by the Program Director of the American Cancer Society, Knoxville, Tennessee, for the duration of the study. All interview audiotapes and the list of participant names will be destroyed following completion of the project. It is hoped that you will find the research topic interesting to think about and to discuss. This study involves minimal risk to participants and will serve as pilot to a larger study of similar issues. Your participation will enhance our ability to understand the meaning of crying. It will provide information valuable in designing a study to target a broader segment of the population. If you agree to participant, please understand that you are free to withdraw your consent at any time, without questions or penalty. If you have questions at this point, or at any point later on in the study, please do not hesitate to ask.

Jean W. Hunt, Psychology Doctoral Student
Univ. of Tennessee, Dept. of Psychology
(615) 974-6060

I have read the above information and consent form and agree to participate in this study.

_____ _____

Participant Signature Date

FACULTY ADVISOR: Howard R. Pollio, Ph.D.
University of Tennessee
Department of Psychology
307 Austin-Peay Building
Knoxville, Tennessee 37996 (974-4361)

APPENDIX A-3

DEMOGRAPHIC & HEALTH QUESTIONNAIRE

1. ID#: _____ 2. Age: _____ 3. Sex: Male _____ Female _____

4. Marital Status: _____ 5. Do you live alone? Yes _____ No _____

6. Who provides your closest emotional support? (Please rank order 1 = closest, 2 = next closest, etc)

   Spouse _____ Children _____ Parent _____ Siblings _____

   Other Relative _____ Friends _____ Co-workers _____ Support or Therapy

   Group _____ Other _____.

7. If you have any chronic health problem (example: arthritis, lupus, CANCER etc), please list:

_____

8. Please list any medications or treatments you are currently taking for chronic health problems.

_____

9. Do you have any acute health problems for which you are currently receiving medical attention (example: colds, flu, broken bones, etc)

   Yes _____ No _____

10. Do you have normal menstrual periods?

    Yes _____ No _____

11. If #10 is NO, did menstruation stop: NATURALLY _____ SURGICALLY _____

12. If #10 is YES, when was your last menstrual period? _____

    How often do you menstruate (21, 28, 30 days, etc)? _____

12. How many days do you normally menstruate? _____

13. Do you take any form of hormones or birth control pills? Yes_____ No_____

14. Please list any hormones or birth control pills

_____

APPENDIX A-4

INSTRUCTIONS FOR CRYING BEHAVIOR CHECKLIST

Definitions people often use to describe experiences of crying and/or weeping are listed here. Use as many as you need completely describe each day during the month. Please report any experience of these symptoms whether or not they seem to be related.

Choose a number from the list below for the category that best describes specific symptoms you had during the day listed.

Category 0 you had **none of these symptoms** during that day

Category 1 you had these symptoms in a **mild** form

Category 2 you had these symptoms in a **moderate** form

Category 3 you had these symptoms in a **strong** form

Category 4 you had these symptoms in a **severe** form

Write the number of the category that **best** describes your symptoms in the space provided. Do not leave any spaces blank.

EXAMPLE 1: If, on the first day you had one mild episode of watery eyes and a later episode with strong feelings of needing to cry and can't, your checklist should look like this:

CATEGORY	(DAY 1)
need to cry & can't	3
watery eyes	1
crying/weeping	0
sobbing	0

EXAMPLE 2: If you have more than one episode on any given day, record the number that fits your experience for that day. Example: If you cried moderately on day 2 and again later in the same day with no other symptoms, your record should look like this:

CATEGORY	(DAY 1)	(DAY 2)
needs to cry & can't	3	0
watery eyes	1	0
crying/weeping	0	2, 2
sobbing	0	0

Even if none of the categories is exactly correct, choose the one that best describes your experiences. Remember, **do not leave any spaces blank.**

Crying Frequency Checklist

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	Date	Date	Date	Date	Date	Date	Date
Needs to Cry & Can't	1	1	1	1	1	1	1
Watery Eyes	2	2	2	2	2	2	2
Crying/Weeping	3	3	3	3	3	3	3
Sobbing	4	4	4	4	4	4	4
	Date	Date	Date	Date	Date	Date	Date
	1	1	1	1	1	1	1
	2	2	2	2	2	2	2
	3	3	3	3	3	3	3
	4	4	4	4	4	4	4
	Date	Date	Date	Date	Date	Date	Date
	1	1	1	1	1	1	1
	2	2	2	2	2	2	2
	3	3	3	3	3	3	3
	4	4	4	4	4	4	4
	Date	Date	Date	Date	Date	Date	Date
	1	1	1	1	1	1	1
	2	2	2	2	2	2	2
	3	3	3	3	3	3	3
	4	4	4	4	4	4	4
	Date	Date	Date	Date	Date	Date	Date
	1	1	1	1	1	1	1
	2	2	2	2	2	2	2
	3	3	3	3	3	3	3
	4	4	4	4	4	4	4

Intensity Key

0 = None
1 = Mild
2 = Moderate
3 = Strong
4 = Severe

APPENDIX A-6

FORMS FOR WRITTEN DESCRIPTION

ID#

Choose one of those times when you experienced symptoms during the past 30-days. Describe what happened in as much detail as you can in the space provided. Please record your experience as specifically as possible i.e. **what** did you experience.

APPENDIX B-1

THANK YOU LETTER FOR PARTICIPANTS NOT INTERVIEWED

(DATE)

Dear (Participant's Name):

Thank you very much for participating in the first two phases of our current research on crying. The study has gone very well and nearly 50 women have participated. Many more people have said "yes" to being interviewed than I expected and I now have enough interviews to complete Phase 3 of the research. The information you have already provided in Phases 1 and 2 was a great help to me in understanding women's experiences of crying and you will not need to proved any additional information.

Thank you very much for your participation and your interest in this project. I will contact you again with some feedback on the results of the study once all the information has been analyzed. If you have any questions regarding the study or your participation, please do not hesitate to contact me.

Best wishes to you for health and happiness.

Sincerely,

Jean W. Hunt

(579-0924 H)
(974-6060 W)

APPENDIX B-2

VERBATIM INTERVIEW TRANSCRIPT

KEY: I = INTERVIEWER; 208 = PARTICIPANT)

PARTICIPANT: 208
51 YEAR OLD MARRIED WHITE CAREERWOMAN
TYPE OF CANCER: BREAST
DATE OF FIRST DIAGNOSIS: 1990
CURRENT TREATMENT: POST BILATERAL MASTECTOMY, POST CHEMOTHERAPY, W/RECONSTRUCTION

I: TODAY, I'D LIKE TO ASK YOU ABOUT YOUR EXPERIENCE OF CRYING AND TO BEGIN, I'D LIKE TO ASK YOU TO TELL ME A LITTLE BIT ABOUT YOUR DIAGNOSIS, WHEN YOU WERE DIAGNOSED,THE TYPE, YOUR TREATMENT AND SUCH.

#208: My diagnosis was one of those, to me, a rather dramatic event in that I had been on the phone preparing, in fact it was this time of the year, two years ago, and I had been on the phone talking with my sister in New England who had breast cancer four years before at that time, and we were making plans for the holidays and so we talked and I asked her how she was and so she said everything was fine. So I said, "Well I've got this spot and I've been wondering if it was changing." She said, "Oh, it's probably nothing. Just keep an eye on it." So then the next day I get a phone call from a friend at church saying that a mutual friend of ours from the church who had been diagnosed just about the same time that my sister had four years before, was in her dying days from breast cancer. Maybe I had gotten that phone call the night before because when I hung up from my sister. I thought, "well, watch it, (my sister) has done so well, but (friend) hasn't done so well. I'd better get this thing checked." And so I went and I had it checked and my internist said, "I don't think it's anything, but since you think it's changing, we'll get it checked." So when I came down to the Center and had a mammogram and had an appointment with a surgeon, I think she knew that day that it was malignant. She told me that it was highly suspicious and then I went a week later for a biopsy and it was malignant. So all through that it was kind of one of those feelings of, "Gee, what really prompted me to take care of this at this time?" It was kind of, "was this really a coincidence?" But at any rate, I kind of felt that maybe things were happening in my life that were certainly in the control of 'the powers that be' rather than myself. The day of my visit with surgeon, she told me that she felt it was highly suspicious. She proceeded to give me the barrage of information. It was just like she told me everything she knew about breast cancer in ten short minutes. And it was just such a load. That's when I think it hit me and since we're talking about tears, that's when the tears came. But they didn't really come out in a flush shall we say until that evening. My husband knew that I was so very upset about everything, he says, "well let's go to the movies." So we went to the movies. And what movie did we go to see, because I didn't have any idea what this movie was, was Steel Magnolias. Well with all of those hospital scenes and with all of that sadness, and with all of this mother and daughter scene and all of that, well I sat there and I cried my heart out and I am not one to cry and the other thing that was strange about that is that my husband has always been one, "now don't cry." He doesn't like to see me cry. It upsets him to see me cry. So I've gone through thirty three years of marriage with very few tears. But he didn't say anything about the tears that night. He just let them come. He comforted me as much as he can in the movie, but it just kind of flushed an awful lot of that out and then after that it was kind of well, let's just deal with it one day at a time. That had been a Friday and the surgical biopsy

was scheduled for the following Friday. So all of that week in between I didn't tell anybody because I thought, my inner feeling was that I knew it was malignant. I just really knew that it was going to be. But, in the event that it's not I don't want to get everybody else all worried about it. So I didn't tell anybody. So my husband's the only one that knew that I was going in for the biopsy until the day before. All that week, my approach at work was, tie up loose ends, I don't know what's going to happen after this and finally had to go to my boss and operations manager and that sort of a thing and saying, "Look, I'm going to have this thing done tomorrow and I don't know whether I'll be back." So that was the first time that I had told anybody. So then when they came in after the surgery and said, "Yes, it was malignant" my reaction was, "Well, damn." But there wasn't a lot of tears. And I guess that there some later with some fright later on that day and some real, real, real confusion, but not with a lot of tears.

I: WHEN YOU WERE THERE WITH A SURGEON AT FIRST, AND SHE WAS GIVING YOU ALL THIS INFORMATION AND YOU SAID YOU JUST BEGAN TO CRY....

#208: No I didn't begin to cry even when she was talking to me. All the tears came out later.

I: OKAY, THEN I MISUNDERSTOOD YOU. I THOUGHT YOU SAID SHE WAS GIVING YOU THIS BARRAGE...

#208: She did. She just dumped everything on me and my head was just spinning and I just finally said to her; I think she said, "I want you here next Friday for a surgical biopsy." And so I said, "Well I'm going to have to go home and talk to my husband all about this and kind of, you know, digest some of this." And she leaned over and she put her hand on my knee and she said, "You MUST have this biopsy." And when she said it that way, that's when I think that I thought this lady really knows, but she's just not able to say until, well... So, when she was talking with me that day and telling me all of this about mastectomy versus lumpectomy and chemotherapy versus radiation, and French studies and United States studies and chemotherapy treatment. I mean, she just laid every bit of it on me. But no, there wasn't any tears, it was just like, (laughs) I wanted to draw away from her I think.

I: SO WHEN YOU AND YOUR HUSBAND WENT TO THE MOVIE, CAN YOU TELL ME ABOUT YOUR EXPERIENCE OF CRYING IN THE MOVIE, WHAT YOU WERE AWARE OF?

#208: I guess two things: I'm really close to my daughter and there was a real strong mother-daughter relationship in the movie. And I have a very good relationship with my mother and if I put myself in that role-I'm thinking out loud here now and this...I know was not part of my experience that night-but,that mother-daughter relationship was different than my mother-daughter relationship. So I guess I think the tears were more from my relationship with my daughter. I think just the diagnosis of a really life-threatening illness and then watching that on the screen, that this girl was fighting for her life, and I think that the first...the one part that really got to me was when she was in the hospital room and the monitor was just ticking away and it was so dark, and just so lonely and so stark, and I remember thinking, "is this what's....am I watching my future?" So that was probably the most...So that was fear.

I: IT SOUNDS LIKE A SENSE OF IDENTITY WITH WHAT THEY WERE GOING THROUGH CERTAINLY WITH THE GIRL IN THE HOSPITAL. KIND OF A "WILL I BE IN THIS PLACE?"

#208: Exactly. Exactly. And that "will I be in this place..."because I knew that my friend, she had a horrible, horrible five year battle with breast cancer and the way the sequence of things went...I went to her funeral the day before I went to my first doctor's appointment. So, I had

made this decision that I was going to go and get this checked because I knew that she was in her last fight. I have forgotten dates, I think that I went to see him around the first or second of December. I got this and...I've forgotten when I got the "suspicious" diagnosis, but then on the ninth of December I had the biopsy that was definitely malignant, and then I had on the fifteenth of December, I had the mastectomy. So, I think she died just a few days after Thanksgiving. So, I had made this appointment, I was going to go to see my internist and then he was the one who then sent me on to the surgeon, so her last days were just horrible from what I understand, and so I had a tremendous number of tears at her funeral. This was before I even knew, but as I say, I just had this gut feeling, because I knew that this thing that was in my breast was different.

I: WERE YOU AWARE OF THAT AT HER FUNERAL OR WAS THAT..?

#208: Yes, No. See I had spots on either side that every time I went for a mammogram they'd say they were fine. Every time somebody would examine me they'd say, "Well you've got it on the same spot on both sides, that's just you. That's just your anatomy." But a couple of, oh I'd say early fall, I don't even know exactly when I was lying in bed one night and I felt this thing and my immediate reaction at that time was "Muffy." Muffy was my dog. Many years before, I had been rubbing her belly and found that she had some hardened lumps on her milk teats. And so I took her to the vet and darned if she didn't have malignancies in her breasts. And they did mastectomies on the DOG! And when I felt this thing on my side, on the side of my breast, I just had this -- the word -- MUFF flash through my mind. Because I realized that what I was feeling had much the same texture as what I had felt on her. And then I thought, "Oh, you're being foolish." And then I'd feel the other side and think, "Well, this is about the same size," and I'd go back and I'd say, "No, I think it's getting a little bigger." But then as a few weeks went on, I really did feel that it had changed size and shape, and then when I would feel the other side, I KNEW that they were different size and shape and before they were always the same. So that's why I say, I was pretty sure that that's what they were going to find. I don't know, I guess because of knowing that my sister had it and I was at such a high risk, anyhow.

I: YOU WERE VERY AWARE OF THE DIFFERENT FEEL.

#208: Well, I think because of my sister having had it and surprisingly, over the years, I have been in contact with a good number of women who have them. From the standpoint of my background as a sewing teacher, and at one point I was teaching sewing classes where we were sewing bra cups into bathing suits and part of the dialogue we used was, "Now if you know someone who has had a mastectomy," and I'm talking in the early seventies now, so this was kind of, people didn't talk about this in the seventies. It was just right after when Happy Rockefeller had kind of come public with it and, at any rate, part of the dialogue that we used was, "If you know someone who has had this and bathing suits are always such a problem for them, this is a way that you can show them to help wear their bathing suits so that they will be more comfortable with them." So I had talked this out before. A lot of people wouldn't have been able to do that. And inevitably, if I had a class of 30 women, almost always somebody would hang back after class and then they'd come and they'd say, "Well, I know somebody," or "I have had," and you know, they'd never talk about it in class, but they would come and do it on a one to one. So I guess the awareness was there.

I: WHEN YOU WERE AT YOUR FRIEND'S FUNERAL, AND YOU BEGAN CRYING, YOU HAD A LOT OF TEARS THEN?

208: Yes, a lot.

I: CAN YOU TELL ME ABOUT THAT?

#208: Yea. Because I think it's had a big effect on my life. We go to the (name) church, so her funeral was a memorial mass, a eucharist. But right after she had finished her chemotherapy, we happened to be at a Christmas party together and my sister's diagnosis, again there's another ironic thing here, is that my surgery was on the 15th of December, my sister's surgery was on the 16th of December, four years before. So again, this Thanksgiving to Christmas interval is a unique time, shall we say. So I had met (Judy) at a Christmas party and had not known that she had the breast cancer. But we sat down and we talked because we were at that particular party, were the only two women there of about the same age, so we kind of filtered together, and so she told me she had just finished her chemotherapy and was looking forward to Christmas and all that, and I said, "Goodness, I didn't know that you had just been through that," and told her that my sister had just gotten the diagnosis and I'm not sure, maybe she was one or two days post-op, or something like that. So Judy took it upon herself to call me every once in awhile after that to see how my sister was doing. And so she would tell me little things about herself so that I would know what my sister was...and this helped. My sister is in Vermont, so I wasn't getting day-to-day information and I think I've shared with you before that my sister has never been one to really talk about her experiences at all. But during the years, we got to know each other more, we ending up being in a Sunday school class together and she had a recurrence the following February, so she had a very, very short time and from then on, she had more treatments and more chemotherapies and more radiations than anybody I have ever...I mean she just had it bad. She did say that she took some blame on the thing because she had been following, and also had the same idea, and that may have been one of the reasons what prompted me to go and take care of it because she said she knew she had something change for about seven months before she finally went to have it checked out. And so she says that "I know that dragging my feet for seven months, I am paying the price for." Well, she paid a very dear price for it. Of course, who knows, whether that seven months was the difference between life and death, you don't know. But it was a long battle that she had. But her hair would grow back and then the cancer would come back, and then she'd go for more treatment and then she'd put her little scarves back on, but she'd come to church and she'd always have a smile and she'd always talk to people. Not necessarily always be talking about herself. But I always thought, "this lady is such a fine example of not just shutting herself in the house and she showed a lot of strength. Well, I have since found out and I did not know this before she died, that she evidently was one of these women who, when she went for her treatments, would go around and encourage all of the other people. So she was a special lady. So, to get back to the experience of her funeral. I went up to the communion rail it was just kind of like, (teary) "Well if this is what I'm going to have to deal with, please let me do it with as much grace as she has done." And "if I can help somebody the way she has helped me as an example, that's what I want to do." And, I've tried to make that my mission since... So I feel real connected with her. Have had a couple of conversations with her husband. He had a real rough time, but then there's a nice ending to that story, too, and I know this isn't part of your thing, but her husband was just right at her side the whole time and I had gone up to him the night of the viewing and had just said, "I just want you to know that I think that Judy was such an example to women. I think indirectly a lot of people have watched her and have just thought "this lady is carrying a burden. But she's carrying it with grace." And his comment to her, to me, was, "She was a special person. I didn't know how special she was until she became ill, but it was a privilege to have been married to her." I thought, " Well that's a real tribute!"

So, he is now getting ready to get married in February. And when I first heard that, that he had this lady-friend, and his lady-friend was a woman from our church, that really bothered me, really bothered me. But I worked through that, too. It was kind of like, "so soon?" Is this what would happen if this was my situation with my husband?

(pause)

I: SO YOU STILL FEEL A REAL CONNECTEDNESS WITH HER?

#208: Yes, I really do. So, anyhow, that's fine. I have met the girl that he is going to marry and as I say, I didn't know all of this before, but as it has come out, the girl that he is going to marry was his wife's oncology nurse and I have talked to her and she told me how much Judy had taught her, too. She says, "Before I was a nurse that gave medicines.: She said, "Now, I am a nurse that treats people." So she says "she taught me a lot too." So this lady really had a very great impact.

I: SHE FELT SOME CONNECTEDNESS WITH HER, TOO?

#208: Must have. Must have. Kind of a unique situation. So that was what my experiences were at the funeral. It was just like, "If I am going to have to have this, let me try to do it the way she did it." She had a big influence on a lot of people's life.

I: AND STILL DOES.

#208: Oh, Yes. I am sure she does. If she went around and talked to people in the oncology unit, there's probably people out there remembering her than we'll ever know...

I: YES.

(Pause)

I: WELL, HAVE YOU CRIED AT OTHER TIMES?

#208: Not a whole lot. I guess after I had the diagnosis and once I knew what it was, I was surprised. I can't remember how much I cried that day. That day that I went home, it was just like, "Now what? Now what? Now what?" A lot of practical decisions: What am I going to do about work? What am I going to do...I think I've told you before that my husband had just made the decision to retire, so we didn't even know what kind of income we were going to have. We knew he was going to have a pension, but we knew it was going to be a damned small pension! So, was I gonna be able to work? Was I gonna have to go back to work? I have since been told when I called my employer, and told him that the diagnosis had been positive and that I was not going to come back to work between then and the surgery, I was just done until I knew what was going on. He had since told me that it was the only time in his life, in his relationship with me, and I had worked there for eight and a half years, he said, "Its the first time I have ever heard you when you just were a little out of control." And I hadn't realized when I was talking that I was out of control, but I think that my approach to him on a business level had always been before when I went and talked to him, I knew what I was going to talk about, and I knew how I was going to say it. And I didn't know what I was going to do! So, as I say, that's the state of mind that I was in. I don't remember tears that day. There may have been, but they were not long, prolonged tears, because I really felt as I look back on it and have talked to other people about it, my tears of grief of my situation came out that night when I was sitting in the dark movie and I was crying by myself and my husband was there with me. And I don't know whether that's a part of me that I had to do it in private, in a dark area...I don't know. There may be some connection there. But in the light of day, and in the working, getting through the practical things of living, there really was not that much. And as the week went on and I prepared for that surgery, I can remember having this sense of feeling of, "I'm being carried

through this. I am surprised at how well I am handling it." Because I am not just so devastated that I can't function. And I think that if someone had told me, "in the future you're going to deal with this," I probably would have said, "There's no way I could ever deal with that." I talked a little bit about my sewing background, and I think that's always been a big part of...I've been talking to women about fitting their clothes, and if you move your dart a quarter of an inch higher, it was going to make your bustline look bigger. So I'm pretty focused on how you look and those things were not issues for me. As I was preparing for it. I had the surgery, came out of the anesthesia and had such a neck-ache I just couldn't believe it. I have a little bit of arthritis and I guess they had put my hands and my arms, because when they did the surgery, they removed the breast on one side then they did a biopsy on this other lump that I had said was a mirror-image. So they evidently had been working on both sides and my arms were stretched in strange positions. Well, I had a nerve that was pinched in the back of my neck, so when I came out of it and was in the room, not in the recovery room, my daughter was there with me, When I had gone into the surgery, the agreement had been that they would remove the one breast, they would do the biopsy on the other breast, but if the other breast was malignant, they would go ahead and take it off. Well, my daughter tells me when I first woke up, the first thing I did was put my hand to the other breast. And she just says, "Mom, it's there." And then I felt on the other side and it wasn't there. And then I realized this horrible pain that I had in my neck. Well, then the tears came for a very brief time. My daughter said she just couldn't figure out, she says, "You were complaining. You were touching the breast that was there. You were complaining about the pain in the back of your neck, and then you would touch the other. I didn't know what you were crying about!" And I do remember kind of having that feeling of "Well it really did happen." So there were some tears. They didn't last long, but they were pretty strong feelings, of being overwhelmed.

I: CAN YOU DESCRIBE THAT FEELING OF BEING OVERWHELMED? WHAT WAS THAT LIKE?

#208: Probably the same kind of feeling that I had as when I was at the movie. Just something that had consumed me, just taken over my body. Just wells up from the depths of my heart I guess and comes upward and engulfs my mind and my brain. Just a total, not just tears that come from the throat, not just watery eyes, just a total body involvement I guess is the best way to put it. And I must say, it didn't last long. Once I got over it, that was the only time that I can remember really crying while I was in the hospital and I was in the hospital for two or three days. Oh, I remember when the girl from the Reach to Recovery Program came in and talked to me. She was the first person that I had talked to in all of Knoxville that had this. So, I think that there was kind of a little bit of a sense of, "I know, you know." And I think that is one of reasons that I am finding my ministry, if you want to call it that, as a Reach to Recovery Volunteer, when I go and I talk to these women, I can remember what that feeling was of connectedness with each other -- a bond. So I guess there was kind of a filling up with tears at that point.

I: WHEN YOU GO OUT AND DO THAT NOW, DO YOU FEEL TEARFUL?

#208: No, I don't surprisingly. I can recognize the feelings that they are having, but it's not like I reenact mine, if that's what you mean. No, I do not. I can go and just try to give them encouragement. Now, when I go back to like what I was thinking about, the communion rail and all of that, that's pretty...I guess that's my connection with the Lord, and my spirituality and then, that becomes me again, that's not the mastectomy, that's not the cancer. Does that make sense?

I: YES.

#208: (Laughs) Its a different part! Now let's see, what else? When I came home and got

through the mechanics of having had the surgery and the recovery of the immediacy of surgery, the night before my chemotherapy was to begin, I had a real rough time. I'm not crying about that, this is a tear left over from our other conversation, here! (laughs) Just real fear, so I know that I had some tears of fear and I had some real tears of frustration, too. And this is kind of a funny story, but yet it probably says something -- psychologists would find something to say about it. My husband, the day before my mastectomy, all of a sudden developed severe, severe pain in his shoulder. Now the day before my surgery, we were in Nashville. In fact they scheduled my surgery and I scheduled my surgery around the fact that this was the week that he was having all of his celebrations for his retirement. And so his retirement dinner was the night before my surgery. So we were in Nashville for that. And we had gone down, I guess, early that morning and he was saying, "Gee, I've got a sore shoulder." And as the day wore on, this man was just in dire, dire pain. And I was kind of an emotional basket-case trying to hold it all together, because I knew that I was gonna have this surgery the next day, so he was trying not to put too much of it on me, but I knew he was uncomfortable. And when we were driving home from (another city) that night, it was kind of like, "Well, come on, let me drive, there's nothing wrong with me right now, you're hurting!" "No, and he's not gonna let you hurt, ah not gonna let you drive." Well he spent a miserable night. Took me to the hospital the next morning for my surgery and I think we had to be there like at six in the morning, and I'm opening doors for him. I'm helping him out of the car. I'm the one that's going for surgery, and I'm taking care of him! And finally when they took me, you know you go in and go through all the hospital routine, and they said, "We're going to take you down for some x-rays." I just turned to him and I said, "Look, while I'm down having those x-rays, go to the emergency room and find out what the heck's wrong with you!" So, as it turned out, he had a flair-up of bursitis. So, without going into any more details of it, that's what had happened that day. Well now here we are, three weeks later after the surgery, and I'm ready to have my chemotherapy the next day, and he is prone to migraines, and he came down with one of the worst migraines that he has had in a long, long time. Here he...I had this feeling as if, "Well, you really weren't there for me the night and the morning of the surgery because you were in such dire pain and here I am struggling because I am going to have this chemotherapy tomorrow and you can't even talk to me, because you're so sick! So I really felt real, real low and so I'm sure I had some tears in my fear. I don't remember, specifically, an episode of it, but yet I think that I just had that awful feeling as if "I am so alone..."

I: AND FRUSTRATED...

#208: Yes, yes. I mean not in anger at him, but just "why is this happening?" That type of a thing.

Now at one point, and I don't remember the time frame, I don't know whether it was before chemotherapy or whether it was right after, but it was in the first eight weeks because I was out of work for eight weeks, so it was within that time frame. I did go through a period of time as if "why have all of these things happened to me in my life?" And I just went through and listed all of the "awfuls," and I remember saying something to him about it, and he says, "If you feel that bad about all of this, maybe you need to go and talk to Art." Art is my friend who is a psychologist." And I said "first of all, Art wouldn't talk to me because we're too close." I said, "second of all, if I told him all of these horrible things that have happened to me, it would blow his mind!" So I went through a real 'poor me' time and I know that were some tears with that. And then, by my second or third chemotherapy treatment, my first couple of chemotherapy treatments went very well, I wasn't really all that sick. I was sick a little bit, but it wasn't that bad, but each treatment got a little bit harder for me to get through, and so somewhere mid-treatment -- and my treatments were for six months -- so let's say, maybe around month three or four, the day after my treatment I was really just so, so nauseated, then I had some real crying, I

just can't get through three more months of this, or four more months of this, or whatever it was. And I think that was a real, real gut wrenching crying that I had.

I: CAN YOU DESCRIBE TO ME WHAT WAS GOING ON WITH YOU, WHAT THAT WAS LIKE?

#208: Well, as far as the actual occurrences or what was happening physically was that when I was having my chemotherapy, I could just feel this, I described it as a toxicity, maybe that's what it was, I could just feel these chemicals kind of taking over my body and terrible taste, couldn't eat because I just had such a horrible taste in my mouth and a lot of throwing-up. They told me that I had to drink a lot of fluids so that the medications didn't pool in your kidneys, because if they pool in your kidneys, you could have some kidney damage, or at best, you would get some kind of a yeast-type infection because of the chemicals, so in other words, just had to flush. Well, every time I'd drink something, I would throw up, so it was again this feeling as if "it's controlling my body" and I think that I am pretty much a person as if, "I want to be the one in control!" And, it was beyond my control. So, it was a helpless feeling. And I guess that's the way it is each time I'd go into the bathroom and I throw up and then I just sit on the floor because I'd just be so exhausted. What am I going to do? So, the helplessness. Is that the kind of thing that you want me to describe or did you want me to describe, or do you want me to describe the...I don't know how else to describe the tears, because the tears were out of my feeling of, "What next?"

I: IT SOUNDS AS THOUGH YOU'RE SAYING, YOU DESCRIBED IT LIKE A FEELING OF NOT BEING IN CONTROL.

#208: I don't know that I made that kind of connection with the chemicals, I just knew that these chemicals were taking over my body. I don't know whether I was able to try to think thoughts beyond that. It was just what was happening. I also went through a real, real period of re-evaluation because the job that I had was a very stressful job and I have come to the conclusion from everything that I read that stress is such a big part of suppressing the immune system and I had threatened to leave this job any number of times, but never really had the power of my convictions because there were good things about the job and there were bad things about the job and it was kind of like, "Well, you can get through it." I was putting my kids through school and so forth, but I had reached the point where my kids were out of school, and I knew that there wasn't that monetary need, not that there's never a need. You can always find ways to spend your money, but there wasn't that imperative thing. But yet, "what am I going to do?" My kids are gone, so there was this identity thing that I went through. Getting through all of this with the cancer and everything, I think I was also having a little bit of an emptiness, and I remember then that I was also having an identity crisis as far as, "If I'm not the carpet lady anymore, if I'm not the decorator anymore, then what am I?" It's taken me a good while to work through that.

Then, I guess, beyond that, once I got beyond that chemotherapy, I think most of the tears of what had happened, ended. Until...all along I was knew I was going to have to have the second mastectomy, because they found that when they did the biopsy on the other side, it was pre-malignant. They strongly recommended that because of the type that I had in the one breast and the type that my sister had, they just felt that I was kind of a sitting duck. So the game plan was to get through chemotherapy, get over the chemotherapy and let my body recuperate. Then I would be ready to have the second mastectomy and have my reconstruction. That put me right up with the holidays again. And I'm not going to be at the holidays, again. So I waited until after the first of the year, and so then I had the second mastectomy in January of this past year. That's when I kind of hit my wall. I guess about three or four days... here I'd had a whole year of talking about 'gonna have this other breast off,' and

the closer I got to it, the closer I thought "I'm not going to let them do this to me." And then, I'm saying that and maybe they are words that have been put into my mouth. I don't really have the feeling that somebody was doing something to me. Maybe I had the feeling that someTHING is doing something to me. Maybe the CANCER is doing something to me, but I didn't have the feeling as if these 'awful doctors' were doing things to me. But, I had read so much about pros and cons and American Cancer Society takes the point of view of not necessarily endorsing the idea of prophylactic mastectomies, and I was having a hard time differentiating in my mind whether or not this was a prophylactic mastectomy, or rather this was a mastectomy out of necessity. Along with that there was a little bit of a conflict about the vanity of the reconstruction. I guess I can admit it now, but I didn't want to admit it before, but my sister, who had the mastectomy, and has never talked about it very much, when I first asked her about " have you ever considered reconstruction," she said, "Well, that would never be an option for me." And so when they first mentioned reconstruction for me, my first comment was, "Well, my sister didn't have it, I guess I don't have to have it." Then this little voice in the back of my mind says, "But you're not your sister." My evaluation of that now, is that with my background of sewing and appearance and 'move the dart so you look better.' My sister's background is of a physical therapist. Her whole attitude toward a handicap, is "get on beyond it." So she 'got on beyond it.' She didn't need this other. So we kind of come from different points of view, but it took me a long time to realize that. I think I felt that there was probably disapproval from my family-my mother and my sisters-and "Why in the world would she go through that again?" And, the second mastectomy, maybe that's so that I can be 'even' rather than 'different.' So, do I have to have this other mastectomy? Some doctors that I talked to would say, "You don't HAVE to have it, you just have to watch real, real closely." Then I talked to another doctor and he said, "Well you really need to have that done because of the family history" and so forth. I was really in a conflict about what to do. And so about a week before, I just told my husband, "I am not going to go through with it. I am going to have a reconstruction on one side, I'm not going to have them take the other side off," and I know he just about boiled because he said, "Well, I'm not going to tell you what to do, BUT, you know how worried you were before you had the cancer in the first place, because you knew that there were these lumps there. Every time you find another little spot, you're going to go through all of that again." So, based on that, that's why I decided to go through with it.

The hindsight of it was, I had three more pre-malignant spots. My logic of not having it done, was "Well, they did a lumpectomy, they took it all out, so the pre-malignancy is gone. Mammograms don't show anything. So, maybe I don't need to have this off." But then when they did it, they found three more pre-malignant sites, so I was just a sitting duck. Tears that came from there were kind of like tears of relief of "Cheese and crackers! I almost made the wrong decision!" So I did have some real tears after that and just a real realization of this really did happen. I've had both of my breasts removed, and that was hard. That was really a hard time for me. I think that all along I had this attitude first time, that women can go through one, they can get rid of one, and lots and lots of women do it, and if they can get through it, I can get through it too. But I didn't know anybody who had gone through it and had both breasts removed. If I ever had any kind of identity crisis because of the cancer, it came after I had the second mastectomy. And it wasn't a long period of time, but, boy it was six weeks of really...and along with that I had talked about my identity crisis before not knowing whether to go back to work. After the first one I went back to work. After the chemotherapy was all finished, and you make all of these resolves of, "Oh, I'm not going to let this stress get to me. I am not going to get back into the rat race." Gradually, I got back into the rat race. One day I wasn't feeling well because of having a cold or something like that, and I was pushing myself the same way I used to, when I just thought to myself, "this is insane." So I went in and I gave my resignation, and because I knew I was going to have this other surgery. And I knew that the reconstruction process was a long involved process, and I thought, "I don't want to be working and going through that, too." So I quit. So come January, when I had lost both of my breasts

and I didn't have a job to go back to, I think that was why after the second one I really had a real rough six, or eight weeks. And along with that, my father was dying of cancer also. So , I mean there was just an awful lot in the early part of this year.

I: WAS THAT WHAT YOU WERE REFERRING TO WHEN YOU SAID, "I THINK THAT'S WHEN I HIT THE WALL?"

#208: Um Hum.

I: AN ACCUMULATION OF ALL OF THESE THINGS HAVING TO DO WITH IDENTITY, WORK, YOUR BODY, APPEARANCE AND...

#208: Right.

I: BEING SO CONCERNED ABOUT HELPING OTHER PEOPLE LOOK THEIR BEST. YOU LOST YOUR FRIEND, YOUR SISTER'S HISTORY AND THEN...

#208: And then around the time too, I don't know whether the first couple of weeks in December AGAIN! My father received his diagnosis of cancer on December 12th last year, and when I was talking a little earlier about Christmas, I hadn't even thought about it until right now, but you know, Christmas right now, is kind of not the real focus because last year, as soon as he had the diagnosis, I went up to (state) to help my mother because she's eighty and she doesn't drive, and they were back and forth to hospitals...so all this Christmas season last year was a real trial and then I had my surgery that was coming up, so while I was recuperating from my surgery -- my dad, well my surgery was the ninth of January, and he was put into the intensive care unit I think it was on the seventh of February, and was in the intensive care unit until April the ninth, which is just a horrendously long time to be on a respirator. I was dealing with all of that while I was recuperating, you know, and it was cancer, and so it was just a real bunch of stuff.

I: SOUNDS EXHAUSTING?

#208: I really was. I had told a friend one time, I was talking to her, I said, "The only way I can describe it, is that I'm numb. There's just been so much, that I'm numb." I couldn't feel anything any more. So again, there weren't any tears. It was just, "Get through this day." I would go up and sit with my dad and realize how really very, very ill he was, and he wasn't able to talk, so there wasn't any communication cause he had all that stuff in his mouth, and you would just kind of put yourself in his place and think, "What in the world is going on in his life?" But I could not sit there and cry over what was happening to him. I did ask him one time, I said, "Daddy are you able to keep a clear mind?" I said that was really important to me when I was dealing with my things, just not to let my mind get too muddled. And when it would start to get muddled, I would kind of try to erase the board. And he would just kind of shrugged his shoulders a little bit and shook his head that he was okay. He wasn't sitting there mulling over an awful lot of stuff. So, there were not a tremendous amount of tears over his illness. I'm just trying to think of when all of the tears part of it pretty much ended and it did you know. Of course there were some tears at the funeral, and that was in April. The process of reconstruction was a long haul. My surgery was the ninth of January. I had my final procedure on the eleventh of September, so all during those months, it was like every two weeks I was going back for injections and so forth, and then more surgery in May, okay, he died in April, I had more surgery in May, and the rest of the summer was fine. You heard me say we're building a house and so that has been kind of my hope to the future. It's been wonderful to have that. In September when we were just getting ready to go on vacation, and I remember

mentioning to you, it'll be interesting marking off that chart while I'm on vacation. And it turned out to be not that I was, well yes, when you're doing the chart, you are more aware of your tears there are no two ways about it...but it wasn't as if I was looking for things to cry for or anything like that! I did my visualizations while I was having chemotherapy. Once my chemotherapy was over, somehow, I was not really able to do that any longer. It was kind of like, "Well this is over, so.... But in times of stress, I have kind of tried to recapture my images that I used i n the visualization. And my special place is the beach. And so when we went to the beach, and actually this happened last year, also, but it happened in a different way. Last year I had finished my chemotherapy at the end of June, I think, and we went to the beach in September. It was kind of like a pilgrimage to this place that had helped me. This time it was a pilgrimage, but it was also a "we go on from here" attitude. When I would go down and I would lie on the beach and I would think about all of these things, it was kind of "well, yeah, it happened..." There wasn't a whole lot of emotion to it, but it was just that it was nice to be in my place that I think is so wonderful. (teary) But then, when it rained, this may have some bearing on the emotions that happened, we went to the movies and we went to see the Doctors. And of course that brought a lot of feelings back, and I thought that was a pretty nice movie. So then we went back, I guess we had a few more nice days of the beach, but the day that it was time for us to go home, I just told my husband, "I'm going down to the beach to say 'goodbye'." (crying) It's just real special.

I: WHAT IS THE 'BEACH'?

#208 You mean "where?"

I: WHAT IS THE 'BEACH' TO YOU? WHAT ARE YOU FEELING RIGHT NOW?

#208: (crying) Boy, that's hard. I don't know. It's uh...I think it's my place of connection. Water has always been a place of power and peace for me. And that day when I went down and I kind of walked in the water, it was kind of cleansing. My visualization, when I did my visualization, I had a real hard time with the...are you familiar with the (name) tape? You know his dialogue that he uses? Okay. He talks about using, imagining the golden light? Well I couldn't imagine a golden light. Then he talked about those powers of the universe doing the healing, tapping into the powers of the universe for your healing. And I was fighting it. I didn't know why I was fighting it. So one night when I went to bed, I was lying there thinking, "Why can't I do this visualization?" I couldn't imagine 'packman', I couldn't imagine....I listened to a tape of (name) the other day where somebody said they used 'Tinkerbell'. I couldn't, maybe I'm not, I'm too graphic a person? I'm not a cutesy, I don't like a little, not that I don't like them, it's just not me, all these little symbols and so forth, so I was having a hard time with this visualization. So when I went to bed that night, it just kind of struck me. I know why I can't do this. My healing isn't going to come from the powers of the universe. My healing is going to be a gift from God. So when I took the power of God and changed the dialogue in my mind when I listened to it, then I was able to get into my visualization. And I have always felt that the power of God is light. I've had a real connection with light for some reason. And I've had a real connection with water. I'm not quite sure why, maybe it's just from the different Bible stories.

Okay, so in my visualizations, I was able to imagine, and my daughter helped me with this, too, because she's a good writer, can describe, she can express herself really well, and so, and the other side of...oh boy, there's a lot of stuff here. I just told her that I was having a real hard time with this visualization and another thing that I did have trouble with was when I first had the diagnosis, and had the mastectomy and then found out that the lymph nodes were okay. Then I went through a period of time saying, "Well, do I have cancer, or did I have cancer? They've taken my breast away, they've taken all of the cancer cells, so, in my mind, they're not there any

longer." So then to start listening to a tape that is saying, "Imagine your body fighting the cancer cells within your body..." and I'm having a hard time with this because my gut feeling is saying, "It's gone. I don't have the cancer cells in my body anymore." And that was important for me to have that feeling. So my daughter says, "Why don't you change the dialogue and just imagine your chemotherapy just kind of cleansing your body to get rid of any stray ones, you know, that you don't know that are there. Okay, don't think about it attacking a cell, can you think of your chemotherapy getting rid of any possible cells left there. So, then I thought of the message of the tape as being maybe a combination of the power of God and the chemotherapy and I could lie down or sit in my chair when I was doing this, and I always felt that the cancer was a dark shadow. You'd ask me about how my feelings were with the tears, what was happening in my body any time I cried or related to the cancer I felt it as being something very dark within me, so with the power of God and the light and the fact that this chemotherapy was kind of 'washing' the cancer away, I could lie there and imagine just a lightness coming over my body. It wasn't a golden light, but it was a light. And the power that this light had was coming from God, and that's what my visualization was. And along with that in the tape was your special place. And my special place was the beach. So this day when I went down to say goodbye and I was walking in the ocean, it was about eight o'clock in the morning, so the sun was up but it wasn't real bright yellow, yet. And I stood in the water and there just was this beam of just shimmery, shimmery, shimmery white light and it just kind of overwhelmed me. I just felt like it was a message and it was like "Peace. Have peace. Be at peace. Don't fret." (Crying) And I really haven't fret much since then. So I had this same kind of feeling that I'm having now, it's just kind of like beyond me. I said I like to be a person that's in control, but this isn't in my control. And I think that was kind of my assurance, or I felt that was my insurance. And then the beautiful thing about it, is that my husband hadn't come down with me and when I turned around to go back, he was sitting on the beach watching me. And I just said, "Didn't you want to come down and get your feet wet, or..." "No," he says, "I just knew that this is a special place for you and I thought you'd want to be alone." And I just thought that was pretty intuitive. That was kind of a special thing, too. He realizes my connections there. So that's kind of neat.

I: HE WAS WITH YOU?

#208: Oh yeah, he was tuned in. But it was like, I kind of had the feeling that I did with I guess, special times, I don't think that you have to be in church to have religious experiences. I've had religious experiences on a mountain top. I've had religious experience watching a sunset. This was just one of those times. I just think he knew that beach had gotten me through a hard time. So, I had no tears when I was standing there experiencing this, but when I came back and talked to him about it, that's when the tears came. And it wasn't for a long period of time, but that's the way that was. And I probably haven't cried this much since. In fact, I'm just trying to think, I know I haven't.

I know another reason why that was kind of a, that was an introspective thing, too. While we were on this vacation. While we were on vacation, he called his answering service to get messages, and there was a message for me to call (name) and well, I didn't know who she was, so he called and he said he was my husband and he was calling to answer the message when we were out of town. It turned out that it was (place). They had recently opened a boutique for mastectomy patients and chemotherapy patients for prosthesis and wigs and they had only been open for about six weeks and the girl that had opened it and had arranged for all of this to be there, she found herself having to have an urgent hysterectomy. They had no one to run the shop that knew anything about prosthesis and anything about business, and he didn't feel that they could take anybody off of their staff, so they called the American Cancer Society and asked if there was a Reach for Recovery volunteer that could possibly help them out. She evidently talked to two or three different people and every time they talked to them, guess whose name

came up? Was mine. So she was calling me to offer me a job and my husband came down to the beach and says, "Well are you ready to go to work?" I said, "You mean we've got to go home?" I said, "What's come up?" and I thought he was saying that he needed to go home and go to work, being in business for himself, I thought maybe an emergency had come up. And he says, "No, there's somebody on the answering set that wants to hire you." And I said, "I don't want to go to work!" So, when I was standing there having these very reflective moments in this shimmering light, I kind of had this feeling as if I have kind of made this vow or commitment that I would try to help other women get through it, and here all of a sudden, somebody's coming and asking me to come and help mastectomy patients...just kind of out of the blue? I have never even been to (place). I knew that it existed and that was all. So again, that's almost too much of one of these things that are just a little bit too much to ignore.

I: SO, YOU WENT?

#208: So I went. So I helped them out while she was in the hospital. Now, the practical side of it is that this lady has her new boutique that she has opened. She is the manager of it. There is an office manager as part of (place), and she was afraid she would take over. So she got back real quick. They had asked me to come in for about six weeks, and she wasn't out six weeks, because she was afraid of losing control. But that's fine. They have kind of tapped into me. They have asked me to go to a couple of things as their representative. One was over at the Cancer Society and they had been invited to have somebody from the Knoxville Breast Center to go, and so they asked me if I would go in their name. And you know, just those little things. So there's a connection there that just kind of came out of the blue. So yes, it kind of carries on what I had said that I wanted to do.

I: IT WAS THE NEXT STEP.

#208: Oh definitely, very definitely. All along, since I have shared some of these religious things, as I had pondered over a lot of what was going on,and I am a woman of action, I know that. My father as I was growing up, always said, "You are the most impatient person I ever saw." When I would try to make plans for the future, and "What am I going to do? Should I go back to college? I don't have my degree, that's unfinished business. Is that what I need to do?" But I get this little voice coming from somewhere, that says, "Be patient. I'll show you the way. Be patient. I'll show you the way." and I've just tried to be attuned to it.

So that's where I am at this point. (laughing)

I: REALLY A NICE EXPERIENCE!

(pause)

YOU MENTIONED AN EXPERIENCE IN OUR INITIAL MEETING, AND THE REASON I'M BRING IT UP IS THE POINT YOU MADE EARLIER ABOUT YOUR HUSBAND. YOU SAID THAT WHEN YOU WERE MARRIED FOR ALL THIS TIME...

#208: Thirty-three years...

I: YOU NEVER CRIED VERY MUCH, IT UPSET YOUR HUSBAND AND YOU STOPPED AND YOU MENTIONED TO ME IN PASSING IN THAT EARLIER MEETING...

#208: I know what you're going to say.

I: AN EXPERIENCE WITH YOUR AUNT. COULD YOU TALK A LITTLE BIT ABOUT THAT?

#208: Well, this was an aunt who had been unable, she had one child that died and she was unable to have any more children. The child that died was a little girl and she would have been slightly younger than me and just a little bit older than my other sister, and so this aunt and uncle when they wanted to do things would be more family oriented, they would take one or both my sister and I, there were four girls but we were the two middle girls. So this aunt and uncle would take the two of us, or usually, they would do it on a one-to-one, one this time, one the next time. They'd take us to the beach or take us to a movie, and at any rate, because of that kind of connection, I felt rather close to this aunt. She became a diabetic and once she was diagnosed with diabetes, she just evidently had a real body chemistry change that they were not really able to control. Now this was back in the early fifties when she was diagnosed, and I don't know whether they didn't know what to do with diabetes then, but at any rate, she had a pretty rough time, and she became blind. My uncle just was very caring and solicitous and took good care of her and I as a young teenager by this time, observed it. Also, I had started to date my husband. I started to date my husband when I was fourteen. And so this was a place for us to go. You know you'd look for a place to take your boyfriend, and so forth. So we'd go down and we'd visit. She would always be delighted to see us and sometimes she'd say, "Well I can't really see you, but I remember." So there was the connection there. And I guess at age fourteen or fifteen, I don't know how old I was when she died, but I do know that (name of husband) was already in my life. When she died, we went to the funeral. My mother was the oldest daughter of six girls and then she had two brothers. I would say this sister was like three or four. I don't know what place in the family she was. But when we went to the funeral, we were in the funeral parlor, they'd had the eulogy or whatever, the "talk" and it was time to go to the cemetery and I saw my uncle go up and say good-bye to her, and it just tore my heart and I started to cry, much the way we are now. And my mother came over to me and she took hold of that little pinch place behind the arm, and she says, "You stop that. We don't do this." and by-George, she didn't! I think that made quite an impression on me. I think that where she was coming from was this school of thought that you do not show emotions in public. I can remember one time, now this might have to do with sexuality, but one time my husband, we had been dating for a couple of years and he was away at some Boys State or something like that. And we went up to see the ceremony and I hadn't seen him for ten days and so we gave each other a big hug and a big kiss and I caught the Dickens from having shown public affection. So that's kind of where that came from. But even with my illness and my diagnosis, and I think it's one of the reasons why I have had to work through a lot of family feelings and a lot of the way my family dealt with my father. I guess I've wanted to express my emotion my own way, but talking -- what we're doing now -- would be, I don't know as they would think it was wrong, but they would think it was just kind of totally unnecessary and 'why do you do this to yourself, and why do you look into things?' and I had felt that all along and my even coming to the (support group). I had this sense of this is something that I want to do. This is something that I feel that I need, if I need permission, my husband's given me permission. It's kind of like, "Do for yourself what you need to do." But then, when I tell my mother that I'm doing a Reach for Recovery, or coming to the Wellness Community, she said, "Why don't you just leave all that?" Because see, my sister left it all, so I'm not following the family script and I knew that when I started coming here, that I wasn't following the family script. And I've had conflict with that. And the family script also is, "We don't show emotion." Now my poor mother, since my dad has died, has shown more emotion than I think she has ever known she ever had in her body. It's scary to her. It was scary to me to all of a sudden to be at a place and be with people that I thought I can kind of show what I'm feeling inside, so with her, at age eighty, it's real difficult for her. So does that explain this other experience?

I: YES, IT DOES. AND I HEAR TWO THINGS OVER AND OVER, LIKE A THREAD WOVEN THROUGH THESE. ONE IS THE THREAD OF CONNECTION -- YOU FELT A CONNECTION WITH YOUR AUNT, WERE VERY CLOSE WITH HER.

#208: We were closer than I was with my other aunts.

I: YOU IDENTIFIED SOME WITH HER DAUGHTER WHO WAS SO CLOSE TO YOUR AGE WHO DIED, YOUR FRIEND, HER DISEASE, AND LATER WITH HER SPIRITUALLY. ALSO THEN,WITH YOUR SISTER WITH THE DISEASE AND WITH YOUR FATHER. THE OTHER THREAD I HEAR IS OF DIFFERENCE, "I DIDN'T FIT THE FAMILY SCRIPT." SOMETIMES THAT WAS A CHOICE "I AM THERE. I AM CONNECTED. I AM A PART OF THAT. BUT, I AM ALSO DIFFERENT."

#208: Yea, yea, and that's right on key. One of the trips up to New Jersey when my dad was in one of his crisis stages, this particular sister came down from Vermont, and so we were both there. In fact this was probably the first of the series of crises. And I was only a couple of weeks post-op, still very definitely in a weakened, emotional and physical state and had spent all day in the hospital the day before, and so everybody convinced me that I needed to stay home the next day. So that was quite an experience to be home, in the family home where I grew up, all by myself for a whole day. Being in this state of mind of reflection, anyhow, because of all of the things that were going on, and I could not let go of this anger at my sister and I did finally recognize that it was anger. That she had not shared with me some of her experiences. It was kind of like maybe I hadn't recognized this not showing emotions, not following the family script. All I knew is that I sensed without anybody ever saying it to me, I sensed the fact that they thought I was being very emotional about my cancer, that I was being very emotional, and the only reason I was having reconstruction, was because I was emotional about it. You know, why can't you not be that way? From all outward appearances, she had hers. My husband's evaluation of my sister was, "Well, she had a cold and she got over it." She had cancer and she got over it -- that has been her approach. She hasn't talked about it. I have no idea whether she had any introspective feelings at all, I can't imagine anybody ever going through it and not having it, but she never did. If she did, she sure kept it to herself, and I think that I resented the fact that if I could come to a place like this and share with people and then I also, I think I've told you that my very best friend ended up with breast cancer six months after I did, and the two of us have become even closer. There's a bond and an empathy that was never there before, and my feelings were, "If I could vent this with someone who was at one time a stranger, WHY can't I have that feeling with my sister?" And so I confronted her with it, that night that she came home. Well, it kind of blew her off the wall, I mean, she cried, just was very shocked to hear me say this. I said, "I just resent the fact that you've just never been able to share with me. I have felt so alone in all of these feelings that I have had and wondered why I had them, and you didn't have them?" And you know, when I think about it, I don't think she ever did admit that she had them. I think that her reaction was, "Well, it's all so new to you." So maybe she was saying, "Well when it was new to me, I had problems, but I was in (state) and you were in (state) and you didn't know about them, and I'm not going to talk about them now." And that very well could be. But, I told her that I missed that connectedness because we were the best of friends when we were growing up.

Anyway, I was glad that I got it out in the open to her. And maybe it made a difference, and made me feel better. I'm going to go see her. We are going to do this Christmas trip that we were going to have two years ago, and then I got sick. We are doing it this year, so we are going, and we haven't been up to her house since I've been sick, so we're going up.

I: AND IN THAT TWO YEARS A LOT OF CHANGES?

#208 Oh, I'm a different person, I mean, I'm a different person inside.

I: WELL, WHAT YOU'VE SAID TODAY HAS REALLY REFLECTED THAT.

#208: Well, I was just a pretty, almost regimented person, I think. "Good Girl Syndrome." Very definitely Good Girl Syndrome. Always, couldn't admit....(interruption). I think that, you know, I was bound and determined to be the good wife, the good mother, the good churchgoer...

I: AND YOU WERE.

#208 Yea! Well, yeah, probably, but....I mean enough to feel as if I was successful. I can remember saying something to my one employer when I first.... I said, "Look, I know there's people that have been here for years and years and they know their job, and they do it well, but I've never done anything that I haven't worked my way up to the top, because that's just the way I am, and I said, and I expect to do it here." And I did it. And I was their top sales woman for about three years. So, that's just kind of one of those things, now maybe I'm looking to be the best Reach to Recovery, I don't know, but I do know that before I had gotten sick, I had been kind of on my own search of "Now that I don't have my children that I am taking care of, I don't feel as if I'm doing for someone else, and I want to do for someone else." So I worked as a volunteer for the (hospital) for awhile and I really didn't care for that, and I worked as a volunteer at a (telephone ministries), and I really didn't like that all, and so now it's finished and so this daughter that I have, that's introspective, she says, "Mom, I think your ministry has found you." Well, maybe it has. And the nice part about it, the beautiful part about it is that our economic situation with my husband's business has just done so very, very well, so I don't have to work, and he doesn't want me to work, so I'm free to do this. It's really a neat place to be. Now after I finish this house, I might go back to college, I don't know! I think that maybe the thing that I am finding, is that I am much more opened to letting things happen to me as they happen. This kind of tickles me that my son's out here. He's the one that's married to the musician and I was saying that they're just going to have a different lifestyle, and that used to just bother me that my children weren't following in the same path. And I see families.... and I don't care. And I wouldn't have said that two years ago. I know what I would like to see, and I'd like to the little girl have all the love and security and I can give her that from my point. I was in a discussion group on Tuesday night at church, and we were talking about unconditional love and somebody was saying that one of the purest, unconditional loves that you can ever have is the love of the grandmother to the granddaughter, and I thought, "I recognize that." So, when you're raising your own kids, it's "I'll love you if you do this, this, and this..."

I: WELL, I APPRECIATE YOUR SHARING ALL THIS WITH ME. ARE THERE OTHER EXPERIENCES YOU'D LIKE TO TALK ABOUT?

#208 That's all I can think of right now!

I: WELL, AGAIN, THANKS FOR TALKING WITH ME TODAY.

APPENDIX B-3

SUMMARY OF TRANSCRIBED INTERVIEW

The participant is a 51 year old whife female careerwoman who was first diagnosed with breast cancer in 1990. Since the time of first diagnosis, she has undergone double mastectomies with subsequent chemotherapy and reconstruction. She currently works part time and regularly devotes volunteer service to several agencies providing educational and peer support to cancer patients. In addition, she is a participant in a regularly scheduled psychosocial group for cancer patients facilitated by a licensed therapist. The most prominent themes in her description are those of "The Family Script or Game Plan," "Being Practical, " "Facing it Alone and Feeling Consumed," "Being Close," "Confusion and Conflict Living in the Rat Race,"," and "Being Guided and Feeling Communion."

Our interview may be summarized best as a progressive flow. She began by discussing some recent experiences while visiting a movie theatre which carried us into a narrative description of many earlier experiences which continue to influence her approach to life over time. Her description of the family of origin's way of doing things , the "Family Script" indicates the impact of things she learned as a child, both her parents' expectations of her and expectations she had of herself, and how these things continue to effect her now. Her husband and his expectations also influence her actions as well as her self view to a large extent. In times when she wants to or can freely express her views in her own way, the expectations of others and her perception of how thing should be done continue to be a focal aspect influencing both actions and feelings. Crying is one experience among several that her family disapproved of in public as did her husband prior to her diagnosis.

Practical decision making has provided her with experiences of being in control of things, maintaining both a family life and a busy career. With the diagnosis of cancer,

she found herself faced with major decisions about whether or not she would continue working at her "rat race" pace. She is able to experience "closeness" with a friend who died of cancer at the same time she faced choices about treatment alternatives which made focal some conflict between the way she wanted to handle her disease and the way her family would find most congenial. Often her treatments left her feeling "consumed," her body taken over by the toxicity of the chemotherapy just as her body and her life seemed to be taken over by the disease. She struggled to maintain her identity as her whole life changed around her and during such periods, her tears were most often of frustration intermingled with fear, and confusion.

She begins to reflect on her life and to allow herself to let go, get some things out in the open. In this process, she experiences some meaningful spiritual connections. As she accepts the changes that have taken place in her life, she feels as though she is being "guided" in her recovery process to reach out to other women with cancer in volunteer service work. Crying is cleansing for her in this process, associated with feelings of peacefulness and deep connection which she describes as a "mountain top" or religious experience. Over time, she recognizes changes in herself, experiences her self differently. Her differences seem appropriate, have a positive effect on her self perception as well as her way of relating to others. She comes to appreciate her own ability to change some things that have been problematic for her and looks forward to more changes; knowing she can connect to family, friends and other cancer patients freely and openly in the future.

APPENDIX B-4

FOLLOWUP LETTER TO ALL INTERVIEW PARTICIPANTS

(DATE)

Dear (Name of Participant):

I am enclosing a typed copy of our recent interview for you to review. Please feel free to add any information to the material that you feel is necessary to completely describe your experience. If any information in the interview seems unnecessary or is typed incorrectly, please make notes or comments you feel will clearly describe your point of view. A copy of a summary statement is also enclosed. Please review this summary and make any commetns about your impression, agreements, and/or disagreements with the summary statements. The summary statement is my understanding of our interview and may not reflect your view so please, feel free to correct my statements if these do not fit with your experience.

If you would like to discuss your response to the interview, please feel free to contact me when you have had a chance to digest the interview and the summary comments. If you will call me at your convenience, we can discuss your reactions by phone or we can meet if you prefer. I have also enclosed a self-addressed, stamped envelope in the event you want to reply in writing.

I very much appreciate you taking the time to review our interview. Again, it is most important that the transcript and the summary reflect your experience and if they do not, we will continue the process until they do fit!

Thank you again for your interest in this study. I look forward to hearing from you soon.

Sincerely,

Jean W. Hunt

(579-0924 H)
(974-6060 W)

Enclosure

APPENDIX B-5

SIGNIFICANT STATEMENTS FROM INTERVIEW TRANSCRIPT

208:1

My diagnosis was one of those, to me, a rather dramatic event in that I had been on the phone preparing, in fact it was this time of the year, two years ago, and I had been on the phone talking with my sister in New England who had breast cancer four years before at that time, and we were making plans for the holidays and so we talked and I asked her how she was and so she said everything was fine. So I said, "Well I've got this spot and I've been wondering if it was changing." She said, "Oh, it's probably nothing. Just keep an eye on it." So then the next day I get a phone call from a friend at church saying that a mutual friend of ours from the church who had been diagnosed just about the same time that my sister had four years before, was in her dying days from breast cancer. Maybe I had gotten that phone call the night before because when I hung up from my sister. I thought, "well, watch it, (my sister) has done so well, but (friend) hasn't done so well. I'd better get this thing checked." And so I went and I had it checked and my internist said, "I don't think it's anything, but since you think it's changing, we'll get it checked." So when I came down to the Center and had a mammogram and had an appointment with a surgeon, I think she knew that day that it was malignant. She told me that it was highly suspicious and then I went a week later for a biopsy and it was malignant. So all through that it was kind of one of those feelings of, "Gee, what really prompted me to take care of this at this time?"

208:2

I have forgotten dates, I think that I went to see him around the first or second of December. I got this and...I've forgotten when I got the "suspicious" diagnosis, but then on the ninth of December I had the biopsy that was definitely malignant, and then I had on the fifteenth of December, I had the mastectomy. So, I think she died just a few days after Thanksgiving.

208:3

But right after she had finished her chemotherapy, we happened to be at a Christmas party together and my sister's diagnosis, again there's another ironic thing here, is that my surgery was on the 15th of December, my sister's surgery was on the 16th of December, four years before. So again, this Thanksgiving to Christmas interval is a unique time, shall we say. So I had met (Judy) at a Christmas party and had not known that she had the breast cancer. But we sat down and we talked because we were at that particular party, were the only two women there of about the same age, so we kind of filtered together, and so she told me she had just finished her chemotherapy and was looking forward to Christmas and all that, and I said, "Goodness, I didn't know that you had just been through that," and told her that my sister had just gotten the diagnosis and I'm not sure, maybe she was one or two days post-op, or something like that.

208:4

When I had gone into the surgery, the agreement had been that they would remove the one breast, they would do the biopsy on the other breast, but if the other breast was malignant, they would go ahead and take it off.

208:5

And then around the time, I don't know whether the first couple of weeks in December AGAIN! My father received his diagnosis of cancer on December 12th last year, and when I was talking a little earlier about Christmas, I hadn't even thought about it until right now, but you

know, Christmas right now, is kind of not the real focus because last year, as soon as he had the diagnosis, I went up to (state) to help my mother because she's eighty and she doesn't drive, and they were back and forth to hospitals...so all this Christmas season last year was a real trial and then I had my surgery that was coming up, so while I was recuperating from my surgery -- my dad, well my surgery was the ninth of January, and he was put into the intensive care unit I think it was on the seventh of February, and was in the intensive care unit until April the ninth, which is just a horrendously long time to be on a respirator. I was dealing with all of that while I was recuperating, you know, and it was cancer, and so it was just a real bunch of stuff.

208:6

I sat there and I cried my heart out and I am not one to cry and the other thing that was strange about that is that my husband has always been one, "now don't cry." He doesn't like to see me cry. It upsets him to see me cry. So I've gone through thirty three years of marriage with very few tears. But he didn't say anything about the tears that night. He just let them come. He comforted me as much as he can in the movie, but it just kind of flushed an awful lot of that out and then after that it was kind of well, let's just deal with it one day at a time.

208:7

So the game plan was to get through chemotherapy, get over the chemotherapy and let my body recuperate. Then I would be ready to have the second mastectomy and have my reconstruction. That put me right up with the holidays again.

208:8

I saw my uncle go up and say good-bye to her, and it just tore my heart and I started to cry, much the way we are now. And my mother came over to me and she took hold of that little pinch place behind the arm, and she says, "You stop that. We don't do this." and by-George, she didn't! I think that made quite an impression on me. I think that where she was coming from was this school of thought that you do not show emotions in public. I can remember one time, now this might have to do with sexuality, but one time my husband, we had been dating for a couple of years and he was away at some Boys State or something like that. And we went up to see the ceremony and I hadn't seen him for ten days and so we gave each other a big hug and a big kiss and I caught the Dickens from having shown public affection. So that's kind of where that came from.

208:9

But even with my illness and my diagnosis, and I think it's one of the reasons why I have had to work through a lot of family feelings and a lot of the way my family dealt with my father. I guess I've wanted to express my emotion my own way, but talking -- what we're doing now -- would be, I don't know as they would think it was wrong, but they would think it was just kind of totally unnecessary and 'why do you do this to yourself, and why do you look into things?' and I had felt that all along and my even coming to the (support group). I had this sense of this is something that I want to do. This is something that I feel that I need, if I need permission, my husband's given me permission. It's kind of like, "Do for yourself what you need to do." But then, when I tell my mother that I'm doing a Reach for Recovery, or coming to the (support group), she said, "Why don't you just leave all that?" Because see, my sister left it all, so I'm not following the family script and I knew that when I started coming here, that I wasn't following the family script. And I've had conflict with that.

208:10

the family script also is, "We don't show emotion." Now my poor mother, since my dad has died, has shown more emotion than I think she has ever known she ever had in her body. It's

scary to her. It was scary to me to all of a sudden to be at a place and be with people that I thought I can kind of show what I'm feeling inside, so with her, at age eighty, it's real difficult for her.

208:11

They told me that I had to drink a lot of fluids so that the medications didn't pool in your kidneys, because if they pool in your kidneys, you could have some kidney damage, or at best, you would get some kind of a yeast-type infection because of the chemicals, so in other words, just had to flush.

208:12

...each treatment got a little bit harder for me to get through, and so somewhere mid-treatment -- and my treatments were for six months -- so let's say, maybe around month three or four, the day after my treatment I was really just so, so nauseated, then I had some real crying, I just can't get through three more months of this, or four more months of this, or whatever it was. And I think that was a real, real gut wrenching crying that I had.

208:13

I'm not going to be at the holidays, again. So I waited until after the first of the year, and so then I had the second mastectomy in January of this past year. That's when I kind of hit my wall.

208:14

Every time somebody would examine me they'd say, "Well you've got it on the same spot on both sides, that's just you. That's just your anatomy."

208:15

I think because of my sister having had it and surprisingly, over the years, I have been in contact with a good number of women who have them. From the standpoint of my background as a sewing teacher, and at one point I was teaching sewing classes where we were sewing bra cups into bathing suits and part of the dialogue we used was, "Now if you know someone who has had a mastectomy," and I'm talking in the early seventies now, so this was kind of, people didn't talk about this in the seventies. It was just right after when Happy Rockefeller had kind of come public with it and, at any rate, part of the dialogue that we used was, "If you know someone who has had this and bathing suits are always such a problem for them, this is a way that you can show them to help wear their bathing suits so that they will be more comfortable with them."

208:16

I talked a little bit about my sewing background, and I think that's always been a big part of...I've been talking to women about fitting their clothes, and if you move your dart a quarter of an inch higher, it was going to make your bustline look bigger. So I'm pretty focused on how you look and those things were not issues for me.

208:17

I'm not a cutesy, I don't like a little, not that I don't like them, it's just not me, all these little symbols and so forth, so I was having a hard time with this visualization.

208:18

I am a woman of action, I know that. My father as I was growing up, always said, "You are the most impatient person I ever saw." When I would try to make plans for the future, and "What

am I going to do? Should I go back to college? I don't have my degree, that's unfinished business.

208:19

All I knew is that I sensed without anybody ever saying it to me, I sensed the fact that they thought I was being very emotional about my cancer, that I was being very emotional, and the only reason I was having reconstruction, was because I was emotional about it. You know, why can't you not be that way? From all outward appearances, she had hers. My husband's evaluation of my sister was, "Well, she had a cold and she got over it." She had cancer and she got over it -- that has been her approach. She hasn't talked about it. I have no idea whether she had any introspective feelings at all, I can't imagine anybody ever going through it and not having it, but she never did. If she did, she sure kept it to herself

208:20

I was just a pretty, almost regimented person, I think. "Good Girl Syndrome." Very definitely Good Girl Syndrome. Always, couldn't admit....(interruption). I think that, you know, I was bound and determined to be the good wife, the good mother, the good churchgoer...

208:21

I said, "Look, I know there's people that have been here for years and years and they know their job, and they do it well, but I've never done anything that I haven't worked my way up to the top, because that's just the way I am, and I said, and I expect to do it here." And I did it. And I was their top sales woman for about three years. So, that's just kind of one of those things, now maybe I'm looking to be the best Reach to Recovery, I don't know, but I do know that before I had gotten sick, I had been kind of on my own search of "Now that I don't have my children that I am taking care of, I don't feel as if I'm doing for someone else, and I want to do for someone else."

208:22

After the first one I went back to work. After the chemotherapy was all finished, and you make all of these resolves of, "Oh, I'm not going to let this stress get to me. I am not going to get back into the rat race." Gradually, I got back into the rat race. One day I wasn't feeling well because of having a cold or something like that, and I was pushing myself the same way I used to, when I just thought to myself, "this is insane." So I went in and I gave my resignation, and because I knew I was going to have this other surgery. And I knew that the reconstruction process was a long involved process, and I thought, "I don't want to be working and going through that, too." So I quit. So come January, when I had lost both of my breasts and I didn't have a job to go back to, I think that was why after the second one I really had a real rough six, or eight weeks. And along with that, my father was dying of cancer also. So , I mean there was just an awful lot in the early part of this year.

208:23

I kind of felt that maybe things were happening in my life that were certainly in the control of 'the powers that be' rather than myself. The day of my visit with surgeon, she told me that she felt it was highly suspicious.

208:24

I didn't tell anybody because I thought, my inner feeling was that I knew it was malignant. I just really knew that it was going to be. But, in the event that it's not I don't want to get everybody else all worried about it. So I didn't tell anybody. So my husband's the only one that knew that I was going in for the biopsy until the day before. All that week, my approach at work was, tie up loose ends, I don't know what's going to happen after this and finally had to go

to my boss and operations manager and that sort of a thing and saying, "Look, I'm going to have this thing done tomorrow and I don't know whether I'll be back." So that was the first time that I had told anybody.

208:25
I had made this appointment, I was going to go to see my internist and then he was the one who then sent me on to the surgeon

208:26
So that was what my experiences were at the funeral. It was just like, "If I am going to have to have this, let me try to do it the way she did it." She had a big influence on a lot of people's life.

208:27
I guess after I had the diagnosis and once I knew what it was, I was surprised. I can't remember how much I cried that day. That day that I went home, it was just like, "Now what? Now what? Now what?" A lot of practical decisions: What am I going to do about work? What am I going to do...I think I've told you before that my husband had just made the decision to retire, so we didn't even know what kind of income we were going to have. We knew he was going to have a pension, but we knew it was going to be a damned small pension! So, was I gonna be able to work? Was I gonna have to go back to work? I have since been told when I called my employer, and told him that the diagnosis had been positive and that I was not going to come back to work between then and the surgery, I was just done until I knew what was going on. He had since told me that it was the only time in his life, in his relationship with me, and I had worked there for eight and a half years, he said, "Its the first time I have ever heard you when you just were a little out of control." And I hadn't realized when I was talking that I was out of control, but I think that my approach to him on a business level had always been before when I went and talked to him, I knew what I was going to talk about, and I knew how I was going to say it. And I didn't know what I was going to do! So, as I say, that's the state of mind that I was in.

208:28
I can remember having this sense of feeling of, "I'm being carried through this. I am surprised at how well I am handling it." Because I am not just so devastated that I can't function. And I think that if someone had told me, "in the future you're going to deal with this," I probably would have said, "There's no way I could ever deal with that..." Well, my daughter tells me when I first woke up, the first thing I did was put my hand to the other breast. And she just says, "Mom, it's there." And then I felt on the other side and it wasn't there. And then I realized this horrible pain that I had in my neck. Well, then the tears came for a very brief time. My daughter said she just couldn't figure IT out. She says, "You were complaining. You were touching the breast that was there. You were complaining about the pain in the back of your neck, and then you would touch the other. I didn't know what you were crying about!" And I do remember kind of having that feeling of "Well it really did happen." So there were some tears. They didn't last long, but they were pretty strong feelings, of being overwhelmed.

208:29
Just something that had consumed me, just taken over my body. Just wells up from the depths of my heart I guess and comes upward and engulfs my mind and my brain. Just a total, not just tears that come from the throat, not just watery eyes, just a total body involvement I guess is the best way to put it.

208:30

I could just feel this, I described it as a toxicity, maybe that's what it was, I could just feel these chemicals kind of taking over my body and terrible taste, couldn't eat because I just had such a horrible taste in my mouth and a lot of throwing-up.

208:31

Well, every time I'd drink something, I would throw up, so it was again this feeling as if "it's controlling my body" and I think that I am pretty much a person as if, "I want to be the one in control!" And, it was beyond my control. So, it was a helpless feeling. And I guess that's the way it is each time I'd go into the bathroom and I throw up and then I just sit on the floor because I'd just be so exhausted. What am I going to do? So, the helplessness. Is that the kind of thing that you want me to describe or did you want me to describe, or do you want me to describe the...I don't know how else to describe the tears, because the tears were out of my feeling of, "What next?"

208:32

I don't know that I made that kind of connection with the chemicals, I just knew that these chemicals were taking over my body. I don't know whether I was able to try to think thoughts beyond that. It was just what was happening. I also went through a real, real period of re-evaluation because the job that I had was a very stressful job and I have come to the conclusion from everything that I read that stress is such a big part of suppressing the immune system and I had threatened to leave this job any number of times, but never really had the power of my convictions because there were good things about the job and there were bad things about the job and it was kind of like, "Well, you can get through it."

208:33

I guess about three or four days... here I'd had a whole year of talking about 'gonna have this other breast off,' and the closer I got to it, the closer I thought "I'm not going to let them do this to me." And then, I'm saying that and maybe they are words that have been put into my mouth. I don't really have the feeling that somebody was doing something to me. Maybe I had the feeling that someTHING is doing something to me. Maybe the CANCER is doing something to me, but I didn't have the feeling as if these 'awful doctors' were doing things to me. But, I had read so much about pros and cons and American Cancer Society takes the point of view of not necessarily endorsing the idea of prophylactic mastectomies, and I was having a hard time differentiating in my mind whether or not this was a prophylactic mastectomy, or rather this was a mastectomy out of necessity.

208:34

"You don't HAVE to have it, you just have to watch real, real closely." Then I talked to another doctor and he said, "Well you really need to have that done because of the family history" and so forth. I was really in a conflict about what to do. And so about a week before, I just told my husband, "I am not going to go through with it. I am going to have a reconstruction on one side, I'm not going to have them take the other side off," and I know he just about boiled because he said, "Well, I'm not going to tell you what to do, BUT, you know how worried you were before you had the cancer in the first place, because you knew that there were these lumps there. Every time you find another little spot, you're going to go through all of that again." So, based on that, that's why I decided to go through with it.

208:35

I had told a friend one time, I was talking to her, I said, "The only way I can describe it, is that I'm numb. There's just been so much, that I'm numb." I couldn't feel anything any more. So again, there weren't any tears. It was just, "Get through this day."

208:36

But I get this little voice coming from somewhere, that says, "Be patient. I'll show you the way. Be patient. I'll show you the way." and I've just tried to be attuned to it.

208:37

My husband, the day before my mastectomy, all of a sudden developed severe, severe pain in his shoulder. Now the day before my surgery, we were in Nashville. In fact they scheduled my surgery and I scheduled my surgery around the fact that this was the week that he was having all of his celebrations for his retirement. And so his retirement dinner was the night before my surgery. So we were in Nashville for that. And we had gone down, I guess, early that morning and he was saying, "Gee, I've got a sore shoulder." And as the day wore on, this man was just in dire, dire pain. And I was kind of an emotional basket-case trying to hold it all together, because I knew that I was gonna have this surgery the next day, so he was trying not to put too much of it on me, but I knew he was uncomfortable. And when we were driving home from (another city) that night, it was kind of like, "Well, come on, let me drive, there's nothing wrong with me right now, you're hurting!" "No, and he's not gonna let you hurt, ah not gonna let you drive."

208:38

I just went through and listed all of the "awfuls," and I remember saying something to him about it, and he says, "If you feel that bad about all of this, maybe you need to go and talk to Art." Art is my friend who is a psychologist." And I said "first of all, Art wouldn't talk to me because we're too close." I said, "second of all, if I told him all of these horrible things that have happened to me, it would blow his mind!" So I went through a real 'poor me' time and I know that were some tears with that.

208:39

She did say that she took some blame on the thing because she had been following, and also had the same idea, and that may have been one of the reasons what prompted me to go and take care of it because she said she knew she had something change for about seven months before she finally went to have it checked out. And so she says that "I know that dragging my feet for seven months, I am paying the price for." Well, she paid a very dear price for it. Of course, who knows, whether that seven months was the difference between life and death, you don't know.

208:40

I'm really close to my daughter and there was a real strong mother-daughter relationship in the movie. And I have a very good relationship with my mother and if I put myself in that role- I'm thinking out loud here now and this...I know was not part of my experience that night- but,that mother-daughter relationship was different than my mother-daughter relationship. So I guess I think the tears were more from my relationship with my daughter. I think just the diagnosis of a really life-threatening illness and then watching that on the screen, that this girl was fighting for her life, and I think that the first...the one part that really got to me was when she was in the hospital room and the monitor was just ticking away and it was so dark, and just so lonely and so stark, and I remember thinking, "is this what's....am I watching my future?" So that was probably the most...So that was fear.

208:41

"will I be in this place..."because I knew that my friend, she had a horrible, horrible five year battle with breast cancer and the way the sequence of things went...I went to her funeral the day before I went to my first doctor's appointment. So, I had made this decision that I was going to go and get this checked because I knew that she was in her last fight.

208:42

But a couple of, oh I'd say early fall, I don't even know exactly when I was lying in bed one night and I felt this thing and my immediate reaction at that time was "Muffy." Muffy was my dog. Many years before, I had been rubbing her belly and found that she had some hardened lumps on her milk teats. And so I took her to the vet and darned if she didn't have malignancies in her breasts. And they did mastectomies on the DOG! And when I felt this thing on my side, on the side of my breast, I just had this -- the word -- MUFF flash through my mind. Because I realized that what I was feeling had much the same texture as what I had felt on her. And then I thought, "Oh, you're being foolish." And then I'd feel the other side and think, "Well, this is about the same size," and I'd go back and I'd say, "No, I think it's getting a little bigger." But then as a few weeks went on, I really did feel that it had changed size and shape, and then when I would feel the other side, I KNEW that they were different size and shape and before they were always the same. So that's why I say, I was pretty sure that that's what they were going to find. I don't know, I guess because of knowing that my sister had it and I was at such a high risk, anyhow.

208:43

So when I went up to the communion rail to take communion, I cried. (teary, pause) She had helped me learn about my sister's situation. This is a girl that I had known, she was there, we bumped into each other over the period of years at the church, but it was a "Hi, how are you," we were never really close friends.

208:44

So Judy took it upon herself to call me every once in awhile after that to see how my sister was doing. And so she would tell me little things about herself so that I would know what my sister was...and this helped. My sister is in Vermont, so I wasn't getting day-to-day information and I think I've shared with you before that my sister has never been one to really talk about her experiences at all. But during the years, we got to know each other more, we ending up being in a Sunday school class together and she had a recurrence the following February, so she had a very, very short time and from then on, she had more treatments and more chemotherapies and more radiations than anybody I have ever...I mean she just had it bad.

208:45

I went up to the communion rail it was just kind of like, (teary) "Well if this is what I'm going to have to deal with, please let me do it with as much grace as she has done." And "if I can help somebody the way she has helped me as an example, that's what I want to do." And, I've tried to make that my mission since... So I feel real connected with her.

208:46

So, he is now getting ready to get married in February. And when I first heard that, that he had this lady-friend, and his lady-friend was a woman from our church, that really bothered me, really bothered me. But I worked through that, too. It was kind of like, "so soon?" Is this what would happen if this was my situation with my husband?

208:47

I have met the girl that he is going to marry and as I say, I didn't know all of this before, but as it has come out, the girl that he is going to marry was his wife's oncology nurse and I have talked to her and she told me how much Judy had taught her, too. She says, "Before I was a nurse that gave medicines.: She said, "Now, I am a nurse that treats people." So she says "she taught me a lot too." So this lady really had a very great impact.

208:48

I really felt as I look back on it and have talked to other people about it, my tears of grief of

my situation came out that night when I was sitting in the dark movie and I was crying by myself and my husband was there with me. And I don't know whether that's a part of me that I had to do it in private, in a dark area...I don't know. There may be some connection there.

208:49

She was the first person that I had talked to in all of Knoxville that had this. So, I think that there was kind of a little bit of a sense of, "I know, you know." And I think that is one of reasons that I am finding my ministry, if you want to call it that, as a Reach to Recovery Volunteer, when I go and I talk to these women, I can remember what that feeling was of connectedness with each other -- a bond. So I guess there was kind of a filling up with tears at that point.

208:50

I would go up and sit with my dad and realize how really very, very ill he was, and he wasn't able to talk, so there wasn't any communication cause he had all that stuff in his mouth, and you would just kind of put yourself in his place and think, "What in the world is going on in his life?" But I could not sit there and cry over what was happening to him. I did ask him one time, I said, "Daddy are you able to keep a clear mind?" I said that was really important to me when I was dealing with my things, just not to let my mind get too muddled. And when it would start to get muddled, I would kind of try to erase the board. And he would just kind of shrugged his shoulders a little bit and shook his head that he was okay. He wasn't sitting there mulling over an awful lot of stuff. So, there were not a tremendous amount of tears over his illness. I'm just trying to think of when all of the tears part of it pretty much ended and it did you know. Of course there were some tears at the funeral, and that was in April.

208:51

I think it's my place of connection. Water has always been a place of power and peace for me. And that day when I went down and I kind of walked in the water, it was kind of cleansing.

208:52

And then the beautiful thing about it, is that my husband hadn't come down with me and when I turned around to go back, he was sitting on the beach watching me. And I just said, "Didn't you want to come down and get your feet wet, or..." "No," he says, "I just knew that this is a special place for you and I thought you'd want to be alone." And I just thought that was pretty intuitive. That was kind of a special thing, too. He realizes my connections there. So that's kind of neat.

208:53

So there's a connection there that just kind of came out of the blue. So yes, it kind of carries on what I had said that I wanted to do.

208:54

She would always be delighted to see us and sometimes she'd say, "Well I can't really see you, but I remember." So there was the connection there. And I guess at age fourteen or fifteen, I don't know how old I was when she died, but I do know that (name of husband) was already in my life. When she died, we went to the funeral.

208:55

I had this feeling as if, "Well, you really weren't there for me the night and the morning of the surgery because you were in such dire pain and here I am struggling because I am going to have this chemotherapy tomorrow and you can't even talk to me, because you're so sick! So I really felt real, real low and so I'm sure I had some tears in my fear. I don't remember,

specifically, an episode of it, but yet I think that I just had that awful feeling as if "I am so alone..."

208:56
They strongly recommended that because of the type that I had in the one breast and the type that my sister had, they just felt that I was kind of a sitting duck.

208:57
I guess I can admit it now, but I didn't want to admit it before, but my sister, who had the mastectomy, and has never talked about it very much, when I first asked her about " have you ever considered reconstruction," she said, "Well, that would never be an option for me." And so when they first mentioned reconstruction for me, my first comment was, "Well, my sister didn't have it, I guess I don't have to have it." Then this little voice in the back of my mind says, "But you're not your sister."

208:58
So I had talked this out before. A lot of people wouldn't have been able to do that. And inevitably, if I had a class of 30 women, almost always somebody would hang back after class and then they'd come and they'd say, "Well, I know somebody," or "I have had," and you know, they'd never talk about it in class, but they would come and do it on a one to one. So I guess the awareness was there.

208:59
I am sure she does. If she went around and talked to people in the oncology unit, there's probably people out there remembering her than we'll ever know...
208:60

So, when I was standing there having these very reflective moments in this shimmering light, I kind of had this feeling as if I have kind of made this vow or commitment that I would try to help other women get through it, and here all of a sudden, somebody's coming and asking me to come and help mastectomy patients...just kind of out of the blue? I have never even been to (place). I knew that it existed and that was all. So again, that's almost too much of one of these things that are just a little bit too much to ignore.

208:61
So there's a connection there that just kind of came out of the blue. So yes, it kind of carries on what I had said that I wanted to do.

208:62
She proceeded to give me the barrage of information. It was just like she told me everything she knew about breast cancer in ten short minutes. And it was just such a load. That's when I think it hit me and since we're talking about tears, that's when the tears came. But they didn't really come out in a flush shall we say until that evening.

208:63
And I guess that there some later with some fright later on that day and some real, real, real confusion, but not with a lot of tears.

208:64
She just dumped everything on me and my head was just spinning and I just finally said to her; I think she said, "I want you here next Friday for a surgical biopsy." And so I said, "Well

I'm going to have to go home and talk to my husband all about this and kind of, you know, digest some of this." And she leaned over and she put her hand on my knee and she said, "You MUST have this biopsy." And when she said it that way, that's when I think that I thought this lady really knows, but she's just not able to say until, well... So, when she was talking with me that day and telling me all of this about mastectomy versus lumpectomy and chemotherapy versus radiation, and French studies and United States studies and chemotherapy treatment. I mean, she just laid every bit of it on me. But no, there wasn't any tears, it was just like, (laughs) I wanted to draw away from her I think.

208:65

Its a different part! Now let's see, what else? When I came home and got through the mechanics of having had the surgery and the recovery of the immediacy of surgery, the night before my chemotherapy was to begin, I had a real rough time. I'm not crying about that, this is a tear left over from our other conversation, here! (laughs) Just real fear, so I know that I had some tears of fear and I had some real tears of frustration, too. And this is kind of a funny story, but yet it probably says something -- psychologists would find something to say about it.

208:66

My kids are gone, so there was this identity thing that I went through. Getting through all of this with the cancer and everything, I think I was also having a little bit of an emptiness, and I remember then that I was also having an identity crisis as far as, "If I'm not the carpet lady anymore, if I'm not the decorator anymore, then what am I?" It's taken me a good while to work through that.

208:67

Along with that there was a little bit of a conflict about the vanity of the reconstruction.

208:68

My evaluation of that now, is that with my background of sewing and appearance and 'move the dart so you look better.' My sister's background is of a physical therapist. Her whole attitude toward a handicap, is "get on beyond it." So she 'got on beyond it.' She didn't need this other.

208:69

My visualization, when I did my visualization, I had a real hard time with the...are you familiar with the (name) tape? You know his dialogue that he uses? Okay. He talks about using, imagining the golden light? Well I couldn't imagine a golden light. Then he talked about those powers of the universe doing the healing, tapping into the powers of the universe for your healing. And I was fighting it. I didn't know why I was fighting it.

208:70

my daughter helped me with this, too, because she's a good writer, can describe, she can express herself really well, and so, and the other side of...oh boy, there's a lot of stuff here. I just told her that I was having a real hard time with this visualization and another thing that I did have trouble with was when I first had the diagnosis, and had the mastectomy and then found out that the lymph nodes were okay. Then I went through a period of time saying, "Well, do I have cancer, or did I have cancer? They've taken my breast away, they've taken all of the cancer cells, so, in my mind, they're not there any longer." So then to start listening to a tape that is saying, "Imagine your body fighting the cancer cells within your body..." and I'm having a hard time with this because my gut feeling is saying, "It's gone. I don't have the cancer cells in my body anymore." And that was important for me to have that feeling.

208:71

I think that all along I had this attitude first time, that women can go through one, they can get rid of one, and lots and lots of women do it, and if they can get through it, I can get through it too. But I didn't know anybody who had gone through it and had both breasts removed. If I ever had any kind of identity crisis because of the cancer, it came after I had the second mastectomy. And it wasn't a long period of time, but, boy it was six weeks of really...and along with that I had talked about my identity crisis before not knowing whether to go back to work.

208:72

she said, "Why don't you just leave all that?" Because see, my sister left it all, so I'm not following the family script and I knew that when I started coming here, that I wasn't following the family script. And I've had conflict with that.

208:73

Being in this state of mind of reflection, anyhow, because of all of the things that were going on, and I could not let go of this anger at my sister and I did finally recognize that it was anger. That she had not shared with me some of her experiences. It was kind of like maybe I hadn't recognized this not showing emotions, not following the family script.

208:74

I think that I resented the fact that if I could come to a place like this and share with people and then I also, I think I've told you that my very best friend ended up with breast cancer six months after I did, and the two of us have become even closer. There's a bond and an empathy that was never there before, and my feelings were, "If I could vent this with someone who was at one time a stranger, WHY can't I have that feeling with my sister?" And so I confronted her with it, that night that she came home. Well, it kind of blew her off the wall, I mean, she cried, just was very shocked to hear me say this. I said, "I just resent the fact that you've just never been able to share with me. I have felt so alone in all of these feelings that I have had and wondered why I had them, and you didn't have them?" And you know, when I think about it, I don't think she ever did admit that she had them. I think that her reaction was, "Well, it's all so new to you." So maybe she was saying, "Well when it was new to me, I had problems, but I was in (state) and you were in (state) and you didn't know about them, and I'm not going to talk about them now." And that very well could be. But, I told her that I missed that connectedness because we were the best of friends when we were growing up.

208:75

But a couple of, oh I'd say early fall, I don't even know exactly when I was lying in bed one night and I felt this thing and my immediate reaction at that time was "Muffy." Muffy was my dog. Many years before, I had been rubbing her belly and found that she had some hardened lumps on her milk teats. And so I took her to the vet and darned if she didn't have malignancies in her breasts. And they did mastectomies on the DOG! And when I felt this thing on my side, on the side of my breast, I just had this -- the word -- MUFF flash through my mind. Because I realized that what I was feeling had much the same texture as what I had felt on her. And then I thought, "Oh, you're being foolish." And then I'd feel the other side and think, "Well, this is about the same size," and I'd go back and I'd say, "No, I think it's getting a little bigger." But then as a few weeks went on, I really did feel that it had changed size and shape, and then when I would feel the other side, I KNEW that they were different size and shape and before they were always the same. So that's why I say, I was pretty sure that that's what they were going to find. I don't know, I guess because of knowing that my sister had it and I was at such a high risk, anyhow.

208:76

then I realized this horrible pain that I had in my neck. Well, then the tears came for a very

brief time. My daughter said she just couldn't figure IT out. She says, "You were complaining. You were touching the breast that was there. You were complaining about the pain in the back of your neck, and then you would touch the other. I didn't know what you were crying about!" And I do remember kind of having that feeling of "Well it really did happen." So there were some tears. They didn't last long, but they were pretty strong feelings, of being overwhelmed.

208:77

I can recognize the feelings that they are having, but it's not like I reenact mine, if that's what you mean. No, I do not. I can go and just try to give them encouragement. Now, when I go back to like what I was thinking about, the communion rail and all of that, that's pretty...I guess that's my connection with the Lord, and my spirituality and then, that becomes me again, that's not the mastectomy, that's not the cancer. Does that make sense?

208:78

Well he spent a miserable night. Took me to the hospital the next morning for my surgery and I think we had to be there like at six in the morning, and I'm opening doors for him. I'm helping him out of the car. I'm the one that's going for surgery, and I'm taking care of him! And finally when they took me, you know you go in and go through all the hospital routine, and they said, "We're going to take you down for some x-rays." I just turned to him and I said, "Look, while I'm down having those x-rays, go to the emergency room and find out what the heck's wrong with you!" So, as it turned out, he had a flair-up of bursitis. So, without going into any more details of it, that's what had happened that day. Well now here we are, three weeks later after the surgery, and I'm ready to have my chemotherapy the next day, and he is prone to migraines, and he came down with one of the worst migraines that he has had in a long, long time.

208:79

So we kind of come from different points of view, but it took me a long time to realize that.

208:80

The hindsight of it was, I had three more pre-malignant spots. My logic of not having it done, was "Well, they did a lumpectomy, they took it all out, so the pre-malignancy is gone. Mammograms don't show anything. So, maybe I don't need to have this off." But then when they did it, they found three more pre-malignant sites, so I was just a sitting duck. Tears that came from there were kind of like tears of relief of "Cheese and crackers! I almost made the wrong decision!" So I did have some real tears after that and just a real realization of this really did happen. I've had both of my breasts removed, and that was hard. That was really a hard time for me.

208:81

when I went to bed that night, it just kind of struck me. My healing isn't going to come from the powers of the universe. My healing is going to be a gift from God.

208:82

It was kind of like a pilgrimage to this place that had helped me. This time it was a pilgrimage, but it was also a "we go on from here" attitude. When I would go down and I would lie on the beach and I would think about all of these things, it was kind of "well, yeah, it happened..." There wasn't a whole lot of emotion to it, but it was just that it was nice to be in my place that I think is so wonderful. (teary)

208:83

I think it's my place of connection. Water has always been a place of power and peace for

me. And that day when I went down and I kind of walked in the water, it was kind of cleansing.

208:84
So when I took the power of God and changed the dialogue in my mind when I listened to it, then I was able to get into my visualization. And I have always felt that the power of God is light. I've had a real connection with light for some reason. And I've had a real connection with water. I'm not quite sure why, maybe it's just from the different Bible stories.

208:85
So my daughter says, "Why don't you change the dialogue and just imagine your chemotherapy just kind of cleansing your body to get rid of any stray ones, you know, that you don't know that are there.

208:86
And my special place was the beach. So this day when I went down to say goodbye and I was walking in the ocean, it was about eight o'clock in the morning, so the sun was up but it wasn't real bright yellow, yet. And I stood in the water and there just was this beam of just shimmery, shimmery, shimmery white light and it just kind of overwhelmed me. I just felt like it was a message and it was like "Peace. Have peace. Be at peace. Don't fret." (Crying) And I really haven't fret much since then. So I had this same kind of feeling that I'm having now, it's just kind of like beyond me. I said I like to be a person that's in control, but this isn't in my control. And I think that was kind of my assurance, or I felt that was my insurance.

208:87
I kind of had the feeling that I did with I guess, special times, I don't think that you have to be in church to have religious experiences. I've had religious experiences on a mountain top. I've had religious experience watching a sunset. This was just one of those times. I just think he knew that beach had gotten me through a hard time. So, I had no tears when I was standing there experiencing this, but when I came back and talked to him about it, that's when the tears came. And it wasn't for a long period of time, but that's the way that was. And I probably haven't cried this much since. In fact, I'm just trying to think, I know I haven't.

208:88
I was glad that I got it out in the open to her. And maybe it made a difference, and made me feel better. I'm going to go see her. We are going to do this Christmas trip that we were going to have two years ago, and then I got sick. We are doing it this year, so we are going, and we haven't been up to her house since I've been sick, so we're going up.

208:89
I can recognize the feelings that they are having, but it's not like I reenact mine, if that's what you mean. No, I do not. I can go and just try to give them encouragement. Now, when I go back to like what I was thinking about, the communion rail and all of that, that's pretty...I guess that's my connection with the Lord, and my spirituality and then, that becomes me again, that's not the mastectomy, that's not the cancer. Does that make sense?

208:90
I'm a different person, I mean, I'm a different person inside.

208:91
I think that maybe the thing that I am finding, is that I am much more opened to letting things happen to me as they happen.

APPENDIX B-6

MASTER LIST OF OVERARCHING THEMES IN THE EXPERIENCE OF CRYING

WITH ASSOCIATED CATEGORIES DERIVED FROM

THREE GROUPS OF PARTICIPANTS

THEME	MASTER LIST OF CATEGORIES SPECIFIC TO THEME FOR GROUP		
ALL GROUPS	**NC GROUP**	**CS GROUP**	**CNS GROUP**
PREFACE	Preface, Context	Pattern, Script	Preface, Way
BEING SEPARATE FROM	Opposition-Tension Loss-Not attached	Tension-conflict Loss	Frustration-Block-Interference Loss
BARRIER	Control Immersion	Control	Containment-Control Saturated
BEING IN UNITY WITH	Connection-Continuity Realization Putting Things Together Differently	Letting Go Change-Continuity Insight	Relax-Release Connection

VITA

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