Communication Perceptions Related to Life-Threatening Illness in a Relationship: A Q Methodology Study

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Abstract

A severe or life-threatening illness can be difficult in a relationship. A situation as serious as a spouse becoming ill can be overwhelming, especially if the care giving spouse has never considered what their reaction would be in such a case. Couples go into relationships with a certain set of beliefs and behaviors that can help or hinder the dyadic coping styles used and the subsequent marital quality (Berg & Upchurch, 2007). Similarly, couples are often unaware of their communication styles and their perceptions, or their scripts, of what is appropriate, (Walker & Dickson, 2004). These self-misunderstandings and partner misconceptions can leave couples ill-equipped to cope with the challenges an illness can inflict on a committed relationship. However, researchers have a rather limited comprehension of how premarital candidates would view life-threatening illness (LTI) in a marriage or their perceptions on the level and quality of communication behaviors individuals who are in or are not in a relationship expect. Current research has focused mostly on chronic illnesses typically among older couples who have been married for an extended period of time (e.g., Berg & Upchurch, 2007; Lavery & Clarke, 1999; Walker & Dickson, 2004). Very little focus has been allotted to the relational expectations of illness-related communication over a wide range of ages and development. Understanding these relational expectations concerning communication behavior in the event that a relational partner is diagnosed with a LTI is the focus of this investigation.

Relevance of Life-Threatening Illness in Relationships

Illness can strongly influence the flow and quality of a marital relationship. Significant support exists in research that illness in a marital relationship can affect the communication and coping styles of a couple (Berg & Upchurch, 2007).The hardships that accompany a LTI diagnosis can be a significant source of uncertainty that begins a period of distress and adjustment for both the patient and their relational partner. Couples must begin to make difficult treatment decisions, redistribute household responsibilities, and regulate emotions concerning potentially life-threatening and long-term

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illness (Berg & Upchurch, 2007). Many couples are unprepared emotionally and communicatively to face this circumstance. Often relational partners have never even considered what their behavior and communication would look like in an illness situation. However, the way in which couples communicate about health and illness is indicative of couples' marital culture and how their communication styles are pervasive in every aspect of their relationship. Walker and Dickson (2004) suggest, "By examining the intersection between health problems and marital interaction, we gain an enhanced understanding of the relational culture in marriage. Illness scripts elucidate the couple's co-constructed relational culture" (p. 541).

Relationships are affected by a LTI in that the illness causes expectations to surface and coping styles to form that in turn affect relationship quality. Couples may not have thought in detail about their expectations in an illness situation prior to or when engaged in a relationship. Thus, the stress of an illness' introduction may force couples into poorly controlled response behaviors. As a result, researchers have been able to note the forging of a link between health problems and marital culture. According to the dyadic perspective, when couples encounter stressors like chronic illness, the stress management assets of both partners may surface to maintain and or restore relational equilibrium (Berg & Upchurch, 2007). Thus, illness can affect the way couples cope from day to day as well as approach conflict that is inseparably affected by gender, ethnic background and current relationship quality (Berg & Upchurch, 2007; Berg et al., 2008). Marital partners must understand one another's background and communication behavior patterns when one or both partners are not feeling well (Walker & Dickson, 2004).

A couple's development of healthy communication and coping styles in the face of illness has been shown in research to be the best way to perpetuate unity and bring about better outcomes for the patient and the illness. However, the type of coping couples employ once the stressor is in place can be beneficial or detrimental to the relationship as well as to the development of the illness. Research on individuals coping with cancer revealed that patients employ many coping responses yet some responses are more used than others. "Popular [coping] strategies include support and acceptance, denial, and diversion by thought and action" (Lavery & Clarke, 1999, p. 290). Higher marital satisfaction is related more closely with supportive and collaborative forms of dyadic coping and lead to increases in relational satisfaction (Berg & Upchurch, 2007). It would seem there is a fine balance between helping and hindering once the stressor is introduced. Even an action such as protective buffering, for example, can be supportive or extremely detrimental. This can be seen in that when women were the patients and were experiencing high stress and physical impairments, buffering by a husband led to lower marital quality; however, when men were the patients, buffering by the wife led to higher self-efficacy (Berg & Upchurch, 2007). How a person chooses to cope, communicate and behave

has much to do with the thoughts, ideas and perspectives they held before they were in a relationship, which is why research related to understanding these perceptions is important.

People are often unaware of or have not thought about their perspectives on illness, and the communication inherent therein. The distinct needs and expectations each partner has prior to the introduction of an illness can strongly affect the coping style employed (Walker & Dickson, 2004). For example if a couple is trying to make treatment decisions and one partner has a differing emotional coping style (Berg & Upchurch, 2007), couples can sometimes confuse collaborative coping with social control. It is the difference between "My wife is being very supportive" versus "My wife is always telling me what to do" (see Berg et al., 2008 for more details). The perceived outcome of buffering can have much to do with the expectations a partner in a relationship has going into the illness at the initial introduction of the stressor (e.g., LTI). Based on these previously developed expectations, the couple decides how they will take ownership of the illness, and this perspective of ownership (e.g., "this thing in side of me" or "this parasite") impacts illness outcomes (Berg & Upchurch, 2007). The viewpoint held by each party individually and jointly will also affect the way in which the couple shares stressors, develops coping styles and adjusts to relational challenges (Berg & Upchurch, 2007). An attitude that demonizes the illness or problem-focused coping can even lead to avoidant styles of coping which tend to report greater depression and more caregiver burden (Berg & Upchurch, 2007). Avoidant styles are more damaging than other styles of coping to the marital relationship and to illness progression (Berg & Upchurch, 2007). "On the other hand, both optimism and fighting spirit have been associated with good mental health, and survival [in] patients suffering from breast cancer" (Lavery & Clarke, 1999, p. 290). Therefore, due to the significance expectancies and coping styles play in emotional and physical outcomes for the couple related to LTI, exploring the role of illness in a relationship from both individuals' perspectives can help better prepare individuals to take a more active and healthy role in illness communication and preserve relational quality.

Relevance of Perceptions and Communication Behavior in Relationships

Perceptions, or an attitude or understanding based on what is observed or thought, has a major impact on the individual communication styles a person brings into a relationship, because people have expectancies regarding their own and others' behavior (Bachman & Guerrero, 2006). What someone thinks is going to happen, or what they think should happen (expectation) often drives how one communicates with others especially in a relationship. Understanding how one communicates prior to or during a relationship can

be a preventative measure concerning divorce since the quality of premarital communication impacts divorce and relational distress (Bachman & Guerrero, 2006). In a different study by Markman et al. (2010), "premarital observed negative and positive communication nearly reached significance as predictors of divorce, while self-reported negative communication was significantly associated with divorce" (Markman et al., 2010, p. 289). The scholars also asserted that couples who had better premarital communication developed less marital distress and better communication over time. Thus, the more effective couples communicate at the onset of their relationship, the more positively communication impacts the relationship in its progression. Since expectations have a large impact on the type of communication couples enjoy, premarital expectations and communication styles begin to take on a more significant role.

In committed relationships outside of a marital relationship, for example, perceptions and expectations may change as a result of the uncertainty of the bond. Communicating commitment and health concerns in this context depends heavily on the rules a couple has established up to the point the stressor is introduced. The act of voluntary commitment itself can change the way a couple reacts to problems.

> "Dating relationships evolve as partners negotiate mutual understandings and expectations that define appropriate behavior. Thus not only the life span development but the status of the relationship and where the couple is in defining their joint rules is essential for the development of their communication styles (Samp & Solomon, 2001, pp. 138-139).

Samp and Solomon (2001) argue that the level of relational dependence one or both members has concerning the other can heighten the challenge of coping. Thus, in a case where one partner is more dependent, the challenge of coping with a relational problem can be far more difficult. The dependence of one partner influences the communicative decisions about relational problems as well (Samp & Solomon, 2001). In illness-related communication, where one partner is periodically or chronically more dependent on the relationship and on the other partner, the perceptions may greatly differ about how to communicate about the illness and its progression due to the increased likelihood of relational threat.

Though researchers have explored problematic events in relationships and the influence of premarital communication on relational outcomes, there is still much left to explore. As Markman et al. (2010) argue, "We know most people decide to marry due to the presence of positives and divorce due to the presence of negatives or the absence of positives. However, we know very little about how negatives and positives before marriage influence the course of marriage and how changes in positive and negatives over time influence marital outcomes" (p. 290). An insufficient understanding of one's own personal communication style, along with the introduction of a stressor or a problem such as a LTI can prove too challenging for a couple.

Some research has even suggested that age plays a significant role in a couple's ability to adjust to problematic events in a relationship, such as an LTI. Though there are exceptions to the rule, often those in a premarital state are younger, and as early research by Krain (1975) points out though relational communication is stressful at all ages, older individuals are better able to handle difficulties that may arise. Thus, enacting prevention-oriented research and programs aimed at individuals who are not yet in a relationship, in a committed relationship, or in a marital relationship can aid in the development of a framework for the cultivation of healthy individual, relational and social stressor-related communication programs. Additionally, understanding how individuals in different types of relationships view communication in situations where a relational partner is diagnosed with a LTI can aid in the creation of more effective communication programs in counseling. The research question associated with this investigation probes perceptions about how individuals are likely to communicate and are likely to anticipate their relational partner communicating at the onset of a LTI.

RQ1: What are the prevailing viewpoints about communication behavior if a relational partner is diagnosed with a severe LTI?

Method

Development of the Q Concourse

To identify prevailing viewpoints, Q methodology as advanced by Stephenson (1953) and as used in a variety of contexts (e.g., Cuppen et al., 2010 and Gregg, Haddock, & Barrowclough, 2009) was used, because it involves "nothing more than a *person's communication of his or her point of view*" (McKeown & Thomas, 1988, p. 12). The Q sample for this study (the set of statements describing communication behaviors) was derived from two main sources: (1) the existing research literature; and (2) semi-structured preliminary interviews with individuals who were not included in the data collection process.

The existing research literature. The conceptual formation for statements used in the investigation stemmed from reviewing multiple studies (e.g., Berg & Upchurch, 2007; Berg et al., 2008) to discern the types of communication behaviors referenced in research. Terms such as "collaborative" and "avoidant" as well as various emotional states and coping styles that were referenced in the literature were incorporated into the statements.

Preliminary interviews. Along with using the extant literature for conceptual formation of the statements, interviews were conducted with 5 individuals (2 males and 3 females) who were not included in the Q Sort process. These individuals were asked to discuss their views on illness-related communication and the likely impact that a LTI has on relationship dynamics. The individuals were allowed to talk freely and candidly about

their views, and the researcher noted fears, grievances and other strong emotional components in their responses, which were then incorporated in the statements.

Final Statements

Using the existing literature review and interviews to inform conceptualizations, a set of statements was developed that reflected a range of communication behaviors related to including and not including others in conversations about the LTI and the illness' progression. After conceptualization, the researcher who conducted the preliminary interviews drafted 68 statements that captured different forms of coping and communication styles. Statement reduction was then conducted by both researchers with the aims of avoiding duplication of similar statements and insuring communication behavior was referenced in each statement. Additionally, statements were revised to include a focus on who individuals were communicating with (e.g., partner, family, friends, doctor, etc.) and what they were communicating about (e.g., the illness, finances, treatment decisions, etc.). This process of statement reduction resulted in a final concourse of 23 statements (see Table 1) for inclusion in the final Q Sort.

Participants

Fifty-nine participants completed Q Sorts for this investigation. The sample consisted of 23 men (39%) and 33 women (56%) with 3 participants not identifying their gender. Participants ranged in age from 19 to 51 with a median age of 26. Thirty (51%) participants were Caucasian/White, 11 (19%) were Asian, 7 (12%) were African American, 5 (9%) were American Indian/or Alaskan Native, 4 (7%) were Hispanic/ Latino, and 2 (3%) indicated ethnicity/race backgrounds from two or more races. The majority of participants were single (39/66%) with a smaller percentage of participants who indicated they were married (15/25%) or divorced (4/7%). Forty-two (71%) participants had no children, 11 (19%) had one child, 5 (9%) had 2 children, and 1 (2%) had more than 2 children. Out of the 59 participants, 26 (44%) were in a committed relationship while 31 (53%) were not.

Experimental Design and Procedures

To facilitate participant Q Sorts in a manner where more than 20 participants could simultaneously complete the sorting process in a timely manner, statements were printed on removable file folder labels for participants to easily place (and remove, if they changed their minds about placement) each statement in the appropriate area on the Q Sort response matrix (See Figure 1 for the response matrix). Each participant received a sheet of file folder labels that contained the 23 randomly numbered statements along with an enlarged copy of the response matrix for affixing each label in the position that best represented the participant's view.

The procedures followed in collecting the demographic data and in facilitating the Q Sorts began with securing an Informed Consent from participants. After providing Informed Consent, participants completed a questionnaire designed to obtain demographic data and other relationship information including gender, ethnicity/race, age, year in school, international student status, marital status, number of children, and committed relationship status. Participants were instructed to complete the paper questionnaire until they reached the "Stop" sign printed on the paper, which instructed them to wait for further instruction.

Next, participants were handed the sheet of statements on the labels and an enlarged response matrix with boxes large enough to fit the removable file folder labels for ease of statement placement. The researcher then instructed participants to assume that their relational partner had been diagnosed with a severe, life-threatening illness. Participants were then told to review each statement on the labels and (1) place a "star (*)" on those statements that they agreed with; (2) place an "X" on those statements that they disagreed with; and (3) leave blank those statements that they were neutral, unsure, or ambivalent about.

Next, participants were instructed to review their statements that were marked with a "star (*)" and select the two that they most strongly agreed with and place them in the (+3) column of the response matrix. Next participants were instructed to review their statements that were marked with an "X" and select the two that they most strongly disagreed with and place them in the (-3) column. Participants were instructed to continue working with the extremes until eventually placing the remaining statements in the middle or (0) column of the matrix.

The final positioning of statements was completed by participants themselves through their respective placement of each label on their own enlarged response matrix rather than being recorded by researchers. These measures (e.g., the use of removable file folder labels and an enlarged response matrix for sorting the labels) were taken to ensure accuracy in the Q Sort process. In this way, participants could communicate effectively their position to researchers without researchers intervening to record participant responses.

Results

Principal components analysis resulted in a three-factor solution, on which 42 of the sorts loaded and 56% of the variance was explained. Thirty-one participants loaded exclusively on Factor 1 (accounting for 39% of the variance), 5 loaded on Factor 2 (accounting for 8% of the variance), and 6 loaded on Factor 3 (accounting for 12% of the variance). Three participants loaded on 2 factors and 14 participants' sorts did not load on any of the 3 factors. These 17 were excluded from the factor arrays (see Table 2) and do

not contribute to the interpretations below.

Interpretation of the Q Sorts

Factor 1: 'Communicative and Inclusive'. This factor consisted of people (n = 31) who primarily wanted to discuss the illness and its progression, changes to daily responsibilities, and emotions with the relational partner, the doctor and with friends and family. This viewpoint consists of little avoidance. They desired discussing the illness with their relational partner's doctor (+3) and keeping the lines of communication open regardless of the illness' progression (+3). They did not want their partner to avoid communicating information from the doctor to them me about their illness (-3), and they did not expect their partner to be secretive and withhold information related to the illness' progression (-3).

Factor 2: 'Secretive and Withholding'. This factor consisted of people (n = 5) who were open to discussing fears and finances associated with the LTI. These people allowed room for secretive and withholding behaviors by their partner about the illness and its progression towards them and others (+3). They allowed for closed lines of communication as dictated by the ailing partner (-3). This group wanted to discuss emotions associated with the illness and its finances (+3) with the relational partner if the partner so desired, but not with the doctor (-2) or with friends and family (-1). This viewpoint consists of high levels of avoidance (see Factor 2 in Table 2) where individuals are willing to allow the partner to set the tone of communication behavior.

Factor 3: 'Communicative and Exclusive'. This factor consisted of people (n = 6) who indicate a willingness to talk openly primarily with both the relational partner (+3) and the doctor. These people allowed for open communication about the illness and other aspects of life within the context of the couple's relationship and within the confines of the doctor-patient relationship. These people did not however wish to share detailed information with friends and family (-2). They were quite collaborative but exclusive in their collaborations (see Factor 3 in Table 2). This viewpoint consists of low levels of topic avoidance in the couple (-3) and doctor-patient (-3) relationship and high levels of avoidance outside of these relationships. However, finances were a topic that was avoided (+3).

Discussion

The overall aim of this investigation is to explore the prevailing viewpoints about communication behavior if a relational partner is diagnosed with a severe LTI. The investigation used Q methodology to investigate the self-reported communication expectancies held by individuals who were single, in a committed relationship or married to determine if there were prevalent views on illness-related communication. The expectation of the

majority of participants in the study (39%) was that they and their partner would engage in *Collaborative Inclusive* communication styles which persisted regardless of gender, age and relationship status. This preliminary finding is encouraging because the extant literature suggests that the communication style most strongly associated with positive outcomes in an illness is a more open collaborative style of talk (e.g. Berg & Upchurch, 2007; Berg et al., 2008; Lavery & Clarke, 1999). This view took into account the communication style (Collaborative) and the scope of communication partners (Inclusive). This included talking to each other as a couple, talking to the doctor and to the extended friends and family for support and advice.

The second viewpoint suggests a more *Collaborative Exclusive* type of communication style with a narrower scope of communication partners. This viewpoint was held by fewer participants in the study (9%) who were disparate in gender and relationship status as well as age. Those with the *Collaborative Exclusive* viewpoint preferred to keep communication about the illness and its progression between their relational partner and the doctor. This seemed to suggest the presence of a strong internal support system that is opposed to outside influences. This group would talk freely about almost everything with one another excluding finances. Couples showing strong support for one another and an understanding of each other's excluded topics of conversation in the face of illness are in line with phenomena previously reported in research (e.g., Berg & Upchurch, 2007; Berg et al., 2008; Lavery & Clarke, 1999; Walker & Dickson 2004). This body of literature affirms the notion that knowing how a partner communicates and expects to communicate is an important way of offering support.

In line with the majority of earlier studies, a *Secretive Withholding* viewpoint emerged in which avoidant communication behaviors (i.e. avoiding conversation about unpleasant outcomes, avoiding communication about the illness, escaping behaviors, pretending the illness does not exist and rejecting information to the contrary) are exhibited. This style of communication behavior has been shown to be detrimental to illness outcomes (Berg & Upchurch, 2007; Berg et al., 2008; Lavery & Clarke, 1999; Oggins, Veroff & Leber, 1993; Walker & Dickson, 2004). Individuals associated with this Secretive Withholding *viewpoint would talk about issues as dictated by the* ailing partner, but allowed significant room for secretive and withholding behavior. This group also discouraged outside communication with friends and family; however, the doctor was included in the couple's communication.

In summary, the following three viewpoints emerged from participant Q sorts: Collaborative Inclusive (encourages collaborations and open communication with a wide support system as exhibited by little topic avoidance), *Collaborative Exclusive* (encourages relationship communication freely on most every topic except for finances, but prefers to keep conversations and treatment decisions private between the couple and the doctor), and *Secretive Withholding* (exhibits high levels of topic

avoidance about the illness, finances and treatment decisions with each other and with outside parties as dictated by the ailing relational partner).

Earlier studies have been in agreement regarding the link between ideas held about relational communication prior to establishing a relationship and the communication outcomes experienced throughout the duration of the relationship or communicative interaction (e.g. Bachman & Guerrero, 2006;Markman et al., 2010; Niehuis, Huston and Rosenband, 2006; Samp & Solomon, 2001; Walker & Dickson, 2004). Thus, the understanding of one's own style of communication and that of the partner is vital.

Interestingly, there was not a significant difference between the viewpoints of women and men, young adult and adult aged participants or participants who were in or out of a committed relationship. This may be because this study looked at perceptions rather than reported events that are happening or have happened as previous studies have found differences between genders related to illness communication (e.g. Berg & Upchurch, 2007). The current study, however, is the first to scrutinize communication expectancies and perceptions related to a LTI using Q methodology.

Clinical Implications

In an article concerning marriage and relationships, education researchers found that after receiving marital education, couples' communication skills increased significantly with no significant difference in gender (Blanchard et al., 2009). Current relational education purpose and design seeks to help couples form and sustain healthy, stable relationships and subsequently healthy marriages. Most programs of this type are oriented towards "universal prevention," which means that "the interventions are targeted to couples not experiencing significant distress, and their objective is to prevent future relationship problems by strengthening couples' relationship skills" (Blanchard et al., 2009 p. 203). Sufficient replication of studies gives researchers an understanding of the link between early risk and protective factors in determining later relational outcomes" (Markman et al., 2010). As a result, policy makers can work to implement programs that help high risk couples achieve better relational outcomes (Markman et al., 2010). Studying the early perceptions held by individuals on illness-related communication can provide therapists with necessary information that may help them decrease the impact of negative perceptions and increase the impact of positive perceptions. A thorough understanding of the role communication perceptions play in a crisis or LTI situation can allow therapists and the society as a whole a platform for helping couples develop strategies for the production of positive emotions which can help with adjustment in the face of a stressor.

These prevailing viewpoints may be helpful as a therapeutic tool for counselors who are attempting to develop techniques for couples who are contemplating marriage. Results could be used to alleviate some of

the misunderstandings couples experience in stressful or LTI situations. A premarital couple who is thinking about marriage but has never considered the introduction of a LTI stressor may benefit from understanding their own views about communication behavior as well as their relational partner's view about communication behavior. The Q Concourse of statements may also be used to develop a questionnaire that would be beneficial for couples in exploring how their own viewpoints converge or diverge with the results of this investigation.

Limitations and Suggestions for Further Research

The three prominent viewpoints that emerged in this study may not be the only viewpoints present. The amount of statements in the Q concourse, though supported with literature and interviews, was intentionally limited to fit the time constraints associated with a sorting time of 25-to-30 minutes. The inclusion of a greater number and more varying statements in the Q concourse could possibly result in participants loading on similar factors or on different factors. Additionally, it should be noted that Q methodology is best utilized for exploring human subjectivity (McKeown & Thomas, 1988) in such a way that enables participants to offer their viewpoint on the topic at hand rather than for the primary aim of predicting individuals' communication behavior. In future studies, a greater number of statements in the Q concourse may be needed to capture variations, additions, or further nuances to the prevailing viewpoints depicted in this study.

Future research is necessary to understand the relationship between these viewpoints and their impact on relational illness communication in a real world context. Also, future research should probe through surveys or interviews why participants sorted particular aspects of each viewpoint in the manner that they did. This triangulation can provide more meaning when coupled with Q Sorts. This study provides some confirmation of previously established coping and communication styles (e.g. Berg & Upchurch, 2007; Berg et al., 2008; Walker & Dickson, 2004). However, the study's findings require replication on a more varied population and with a wider variety of statements in the Q concourse.

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Table 1
Final Concourse of Statements included in Participants' Q Sorts

No.	Statement
1.	I would want my partner to avoid communicating information from the doctor to me about their illness.
2.	I would rarely discuss things related to the illness that are outside of our control (e.g., lack of a cure, etc.).
3.	I would discuss the illness with my partner's doctors in an effort to give my partner space.
4.	I would talk with my family and friends to come to conclusions about treatment decisions related to my partner's illness.
5.	I would avoid discussing finances associated with paying for things if my partner is severely ill.
6.	I would be uncomfortable discussing fears that my partner and I have about the outcome of the illness.
7.	I would avoid in-depth conversations with my partner about the illness.
8.	I would be open to discussing changes to daily responsibilities necessitated by the illness.
9.	I would discuss the details of my partner's illness with our families in detail.
10.	I would talk with friends and family if my partner is having strong feelings about the illness to understand those feelings.
11.	I would feel more comfortable discussing my feelings about the illness with a close friend rather than my ailing spouse.
12.	I would discuss treatment decisions exclusively with my partner and his/her doctors.
13.	I would stop talking if my partner exhibited extreme anger about the illness and talk to him/her later.
14.	I would prefer to keep information between my partner and me rather than talk with others about the illness.
15.	I would prefer to discuss the finances in detail so that we can then focus on my partner's illness and health.
16.	I would expect my partner to be secretive and withholding of information related to the illness' progression.
17.	I would discuss finances and final preparations with family and friends related to my partner's illness.
18.	I would have minimal discussions with my partner about the illness so that we could just continue to live our lives.
19.	I would keep the lines of communication between my partner and me open regardless of the illness' progression.
20.	I would stop discussing the future and focus on the "now" with my partner since he/she might not be around.
21.	I would discuss with my partner ways to prevent future illness-related problems (e.g., altering diet or habits, etc.).
22.	I would want to talk with doctors about what is going on with my partner's illness progression and care.
23.	I would prefer to discuss all emotions my partner and I are feeling about the outcome of the illness.

Table 2
Factor Arrays

		Factor 1	Factor 2	Factor 3
1.	I would want my partner to avoid communicating information from the doctor to me about their illness.	-3	+2	-3
2.	I would rarely discuss things related to the illness that are outside of our control (e.g., lack of a cure, etc.).	0	+1	0
3.	I would discuss the illness with my partner's doctors in an effort to give my partner space.	0	-1	+1
4.	I would talk with my family and friends to come to conclusions about treatment decisions related to my partner's illness.	+1	0	-1
5.	I would avoid discussing finances associated with paying for things if my partner is severely ill.	-1	-3	+3
6.	I would be uncomfortable discussing fears that my partner and I have about the outcome of the illness.	-2	-2	-1
7.	I would avoid in-depth conversations with my partner about the illness.	-2	-1	0
8.	I would be open to discussing changes to daily responsibilities necessitated by the illness.	+2	-1	+1
9.	I would discuss the details of my partner's illness with our families in detail.	+1	-1	-2
10.	I would talk with friends and family if my partner is having strong feelings about the illness to understand those feelings.	+1	0	-1
11.	I would feel more comfortable discussing my feelings about the illness with a close friend rather than my ailing spouse	-1	+1	-2
12.	I would discuss treatment decisions exclusively with my partner and his/her doctors.	0	+1	+2

13.	I would stop talking if my partner exhibited extreme anger about the illness and talk to him/her later.	0	-2	0
14.	I would prefer to keep information between my partner and me rather than talk with others about the illness.	-1	0	+2
15.	I would prefer to discuss the finances in detail so that we can then focus on my partner's illness and health.	+1	+3	-2
16.	I would expect my partner to be secretive and withholding of information related to the illness' progression.	-3	+3	-3
17.	I would discuss finances and final preparations with family and friends related to my partner's illness.	0	0	0
18.	I would have minimal discussions with my partner about the illness so that we could just continue to live our lives.	-2	+1	-1
19.	I would keep the lines of communication between my partner and me open regardless of the illness; progression.	+3	-3	+3
20.	I would stop discussing the future and focus on the "now" with my partner since he/she might not be around	-1	+2	+1
21.	I would discuss with my partner ways to prevent future illness-related problems (e.g., altering diet or habits, etc.).	+2	0	0
22.	I would want to talk with doctors about what is going on with my partner's illness progression and care.	+3	-2	+2
23.	I would prefer to discuss all emotions my partner and I are feeling about the outcome of the illness.	+2	+2	+1

Figure 1. Q Sort response matrix used for this investigation.

Most Strongly Disagree -3	**Strongly Disagree -2**	**Disagree -1**	**Neutral 0**	**Agree +1**	**Strongly Agree +2**	**Most Strongly Agree +3**