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The Meanings of ''Open Communication'' Among Couples Coping With a Cardiac Event

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The value placed on open communication is an ideology in U.S. American discourse. It has particular urgency among couples coping with a cardiac event, who are often advised that open communication can enhance recovery, bolster individual coping, and sustain relational satisfaction. Our interpretive analysis of 41 interviews with cardiac patients and partners explored the connection between a widespread ideology of openness and varied ways of enacting it that included apparently contradictory practices. Our findings raise questions about interventions designed to change couples' communication, expand concepts and theories of open communication, and suggest developments in the ideology of openness.

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Many U.S. Americans believe open communication is essential for individual well-being and relational happiness, a view expressed in lay ideals for relationships (Caughlin, 2003; Katriel & Philipsen, 1981) and popular media portrayals (Harnden, Ratchford, Satterlee, Scott, & Walker, 2007; see also Afifi, Caughlin, & Afifi, 2007; Petronio, 2002, for discussion of the open communication ideal). Yet researchers also find close relational partners who endorse the value of openness and believe they achieve it, but who also engage in closed communication (Caughlin, Mikucki-Enyart, Middleton, Stone, & Brown, 2011; Kirkman, Rosenthal, & Feldman, 2005). Kirkman et al. dubbed this pattern, ''being open with your mouth shut'' (p. 49). We observed this phenomenon in another context—couples coping with a cardiac event—and we use the concepts of interpersonal ideology and polysemy to provide an expanded understanding of this persistent, seeming contradiction.

The meaning and value of open communication

Most previous research on openness has sought to understand either the frequency or effects of openness (for a summary, see Goldsmith, Miller, & Caughlin, 2008). This study takes a different but complementary path. We are concerned with how

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people interpret openness. That is, when people say they are open, what do they mean? When they say that openness is valuable, what is it that makes it valuable to them? Although these questions have been asked less often, several studies provide a starting point.

Katriel and Philipsen (1981) analyzed "really communicating" as a cultural term in interpersonal life among some U.S. Americans. In everyday use and in media texts, the terms "open communication," "real communication," "really talking," "supportive communication," and "communication" formed a cluster of synonyms that referred to close, supportive, and flexible conversations. "Communication" involved talk with intimates about important topics and proceeded through a sequence of initiation (such as saying, "we need to sit down and talk"), acknowledgement (stopping other activities to focus on the talk), negotiation (self-disclosure met with nonjudgmental listening and comments), and reaffirmation (which might include a solution or compromise but could also simply affirm the value of having talked). Communication was the "work" required to develop one's self and relationships and engaging in "real communication" had ritual significance, reaffirming the value of unique selves who bridged differences to form healthy relationships. Subsequent ethnographic studies (e.g., Bellah, Madsen, Sullivan, Swidler, & Tipton, 1985; Carbaugh, 1988) reported similar findings.

Parks (1982, 1995) observed that an "ideology of intimacy" (which included valuing open communication) permeated not only lay persons' understandings but also scholarly research and pedagogy. Scholars emphasized the value of openness, portrayed failures to disclose in a negative light, and gave short shrift to the countervailing importance of discretion, deception, and secrecy. In the 30 years since Parks' original essay, communication scholars have responded by examining openness and closedness dialectics (e.g., Baxter & Montgomery, 1996); privacy rules and boundaries (e.g., Petronio, 2002); topic avoidance and secrecy (for review, see Afifi, Caughlin, & Afifi, 2007), equivocation (Bavelas, Black, Chovil, & Mullett, 1990), and multiple goals related to openness and avoidance (e.g., Caughlin, 2010). Nonetheless, scholarly attention to these complexities has not dampened enthusiasm for openness among U.S. Americans. "Open communication" continues to be frequently identified as an attribute of an ideal close relationship (Caughlin, 2003; Parks & Floyd, 1996).

The seeming contradiction between an idealized openness and actual relational behavior has been brought into sharper focus by two recent studies of family communication. Kirkman et al. (2005) asked families how they communicated about sexuality. Respondents almost universally endorsed openness as a criterion for good communication and said that they were open about sexuality, yet also said they rarely talked about it. Openness meant answering questions and having an open-minded attitude, even if sex was not frequently discussed. Indeed, respondents said openness needed to be balanced with privacy and open communication did not require "keeping a spotlight" on the topic (Kirkman et al., 2005, p. 49).

Caughlin et al. (2011) interviewed adult children whose parent died of lung cancer. They found families avoided talking about diagnosis and illness trajectory, decision making, death, and emotions for reasons that included protecting self and others, maintaining hope and optimism, honoring family standards, and concerns for efficacy. Still, participants often articulated the value of open communication. Some were able to reconcile openness and topic avoidance by segmenting (i.e., speaking openly about some topics while avoiding others). Other families chose avoidance, though they saw this as problematic. A third strategy involved "being open while avoiding": asserting that there was nothing they would not talk about, even as they recounted instances of topic avoidance. These families did not report struggling to reconcile a dilemma nor did they perceive their descriptions of communication to be at all contradictory.

Whereas a body of theory and research has developed to explain how individuals wrestle with dilemmas of openness, privacy, secrecy, and the like, being open with your mouth shut poses a different theoretical puzzle. Put simply, how is it that research participants can say that they are open, then say that they are not open, and yet not experience this as a contradiction or problem? Our aim is to explain this phenomenon by examining how polysemous meanings of openness enable speakers to orient to an ideology of openness.

Following Parks (1982, 1995), we propose that many Americans are familiar with an ideology that values open communication. Fitch (1998, p. 186) defines interpersonal ideology as the taken-for-granted ideas about "what is warranted and what is not between people in relationships." These premises become evident in the ways we formulate lines of action and make sense of talk. Using the term "ideology" to describe these premises draws attention to their value-laden nature—some ways of acting and interpreting are preferred—but cultural beliefs about interpersonal relationships do not form an elegant system of orderly premises. Rather, they provide a toolkit of diverse ideas we deploy to make sense of particular situations and to present ourselves and our relationships in a positive light (Fitch, 1994; Swidler, 2001).

Talk therefore shifts as communicators make different selections from among cultural premises but even more importantly for our purposes, talk in any given situation may embody multiple meanings. The rhetorical concept of "polysemy" directs attention to the ways talk can express multiple, potentially divergent meanings and the ways speakers may use strategic ambiguity to address conflicting concerns. Polysemy originates in the speaker's skill at addressing divergent audiences, in an audience's ability to give a resistant reading to a text, and/or in a critic's ability to render a deeper interpretation of a text. Rhetorical analysis of polysemy enables a critic to understand how "different elements of a single text" can develop "two or more meanings for that text" (Ceccarelli, 1998, p. 411). Instead of viewing speakers who use polysemy as dishonest or confused, we may see them as skillfully managing situational demands. If "open communication" is polysemous, then detecting its multiple meanings yields a more nuanced understanding of what occurs in interviews about communication and of what respondents are telling us about their relationships.

Grounding an exploration of "open communication" in the concepts of ideology and polysemy suggests the following explanation for the puzzle raised by "being open with your mouth shut." The ideology of openness provides a powerful tool for formulating and interpreting lines of action in relational life. It provides a ready heuristic for explaining our relationships to ourselves and others in a way that is socially valued. However, our uses of ideology are strategic and situated. We call them up to make sense of specific episodes. Saying "we are open" in one context does not preclude communicating cautiously or showing discretion in another situation. Nonetheless, polysemous meanings are not unlimited, and cultural premises are evident in talk, so it is possible to describe a set of cultural resources for making sense of relational life. In this study, we describe the range of meanings that were invoked when our interviewees said they communicated openly. What do participants mean when they say they communicate openly? How do these statements function in participants' talk to convey their relational experience and also to negotiate particular moments in an interview?

Participants, texts, and analytic process

We examined the meanings and value of open communication among couples (including committed romantic relationships and marriages) coping with one person's recovery from a cardiac event (defined here as a myocardial infarction, MI, commonly known as a heart attack, and/or coronary artery bypass surgery, CABG). These couples are often advised to communicate openly about the physical and emotional challenges they face. For example, the American Heart Association (n.d.) recommends: "Talk openly about your fears, worries, and needs." Under "tips for your successful continued recovery," a New York cardiac surgical practice tells couples, "encourage each other to express and discuss feelings. Open communication can minimize misunderstandings" (Midatlantic Surgical Associates, n.d.). This advice has empirical support from studies that show open communication about recovery facilitates individual and relational well-being (e.g., Ben-Sira & Eliezer, 1990; Coyne & Smith, 1994; Joekes, Maes, & Warrens, 2007; Sebern & Riegel, 2009). Thus, these couples represent a group for whom the ideology of openness is articulated explicitly and for whom important outcomes (physical health, adjustment, and relational satisfaction) may be at stake in how they understand and employ this ideology.

Our 41 participants included 25 patients who had had a MI, CABG, or both in the last year; 15 partners of these same patients and 1 partner of a patient who did not participate. All came from a university in the Midwestern United States community and nearby rural small towns. Most were of European American descent and they ranged in age from 37 to 81, with an average age of 65. They held a variety of occupations and a high school degree was the modal educational attainment. On average, couples had been together 36 years with a range from 3 to 55 years.

Participants engaged in a 60- to 90-minute interview about experiences since the cardiac event. When both members of a couple participated, interviews were

conducted separately and simultaneously by different interviewers, so that participants could speak candidly about couple communication. We began by asking what topics were easy or difficult to discuss and sources of argument. After they listed topics, we asked whether they had experienced some common challenges and, if so, how they handled them, including adherence to diet, physical limitations, concerns about recurrence, changes in roles, sex, talking to others outside the primary relationship, and depression. We concluded by asking them to recall one good and one bad conversation about the heart condition and to give advice for other couples. We transcribed verbatim and then assigned pseudonyms.

We used in-depth interviews because we wanted not only insight into behavior (e.g., expressing thoughts, feelings, or experiences) but also a participants' judgment about whether he/she withheld important thoughts, feelings, or experiences. As it turned out, interviews were also an excellent place to hear ideology. Because interviews ask speakers to give a coherent account of experience, they may articulate ideologies to explain and justify their actions (Swidler, 2001, p. 222). In this respect, interviews resemble other everyday speech events that call forth narratives of experience, reflections on problems, or explanations for action.

We examined each transcript for passages related to open communication and asked of each passage: "What does it mean for them to say what they say in that particular way and at that point in the conversation?" Following Katriel and Philipsen (1981), we identified co-occurring terms and semantic relationships among terms. We emulated Wilkinson and Kitzinger (2000) in noting when statements about open communication occurred and how they functioned in the interview. One of us developed a preliminary taxonomy of the meanings of "openness." We then collaborated to test, refine, and elaborate these categories through consensual coding (Russell, 2000). We met weekly to discuss the meanings of openness in a sample of transcripts, noting key passages that evidenced the categories and developing a profile of meanings for each participant. Our goal was to develop a contextualized profile, rather than a decontextualized application of objective codes; consequently, appropriate standards for evaluating our method are dependability and confirmability (Baxter & Babbie, 2004). We achieved dependability by using systematic procedures and documenting our decisions in meetings. We ensured confirmability by linking each proposed categorization to specific passages and by triangulating our interpretations.

Openness as ideology

An ideology of openness persisted among our participants. Sometimes it was stated explicitly but it was also evident in the inferences it took to make sense of an answer to a question or a sequence of exchanges. We found taken-for-granted, value-laden meanings of openness in statements about a lack of problems, openness as healthy, openness as an attribute of a good relationship, or openness as a global positive evaluation.

The value-laden nature of "open communication" was present when participants linked it to a *lack of problems*. Several respondents contrasted "good" or "open" communication with the existence of difficult topics. For example, asked if there were topics that were difficult to discuss, Patrick stated, "I feel comfortable discussing essentially everything with my wife and, no problem. We have very good communication." Why should a question about difficult topics routinely garner responses that deny problems? A puzzle, athletic feat, or career accomplishment can be difficult without being problematic. In other cultures (Philipsen, 1992), and even in previous periods in the United States (Kidd, 1975), it was normal to have topics people would rather not discuss. To assume that difficult topics are a problem makes sense only if open discussion is the ideal. This is why participants answer a slightly different question than the one we meant to ask: Instead of enumerating challenges, they denied problems. Perhaps more surprising were responses to a question about topics that were easy to discuss. This question preceded the difficult topics question, yet participants responded in a code that linked lack of ease with trouble. For example, Cindy stated, "I don't see any problem with discussing anything." Commenting on easy or difficult topics was inseparable from judging individuals and their relationships, creating a discursive need to present oneself and one's relationship as trouble-free.

Throughout the interviews, participants stated or implied that the *right amount of open communication is healthy*. Kathy said, "I think part of healing is being able to talk about it a little bit," and Faith stated, "I personally feel that that's what caused his heart attack, was keeping his feelings inside." The kind of open communication that is preferred entails moderation along a dimension of verbosity-reticence (cf. Hymes, 1972), as revealed through the contrast of openness with unhealthy "denial" or "dwelling." Individuals who did not communicate when they should were said to be "in denial," including patients who did not reveal symptoms or patients and partners who were slow to seek medical help. During recovery, not admitting anxiety could be seen as denying heightened risk. In contrast, those who talked too much risked "dwelling" on their condition. Limiting talk can be a way of staying optimistic, as Lisa explained: "we don't go on and on into that. . . . We don't dwell on the negative." In contrast to denial and dwelling, open communication described a positively valued style of coping, indexed through the right amount of talk. Too little suggested an individual was not coming to terms with reality but too much indicated they had not accepted what happened and moved on.

Whereas participants explicitly articulated that disclosing was healthy, their presumption that open communication constituted a good relationship was more often taken-for-granted. Asked about advice to others who have had a cardiac event, Craig replied: "I would assume . . . that the people had a good relationship before the operation and I would say simply carry on as before . . . continue the communication. If you want to talk about something, talk about it. Out in the open with it. . . ." For Craig, a good relationship entailed open communication. In contrast, Renee acknowledged that she sometimes gave in during a discussion rather than continuing to express herself until the issue was resolved. She said "at times I think it's kind

of a sloppy way of living. . . . We have the basic things all resolved, you know. I mean the foundation is relatively stable. The windows don't shut all the way, but you know what I mean." Renee recognized an ideal of resolving issues through communication though she and her husband did not meet it. Participants also linked open communication with honesty and with sharing, both prosocial, virtuous actions that coincide with a good relationship.

Openness was sometimes simply a global positive evaluation. We noticed this by observing which parts of the interview reliably triggered statements about openness. Early questions about easy and difficult topics of talk prompted characterizations that communication was open and unproblematic. We suspect such general questions at the beginning of the interview made impression management concerns especially salient. Asking about a good or bad conversation also made the evaluative meanings of openness especially relevant. For example, Kathy responded by saying, "I don't know. As a whole, we've been able to talk about it. I don't know. . . . It's, it's all been- we've been very open about the whole thing." Another location for statements about openness was when participants had difficulty recalling specific conversations; at a loss for an example, the ideology of openness provided something acceptable to say.

The last interview question asked if participants had advice for other couples. Advice tells others what they should do for their own good. Having just participated in a lengthy interview about communication with someone who studies it, we were not surprised when participants recommended communication as part of their advice. What was more revealing was that every participant who gave advice about communication emphasized the need to be open. Linda advised, "You've got to be open with each other and just talk it out." Ted offered: "I think the most important thing is just be brutally honest about how you're feeling. Don't hold back." The popularity of this advice showed openness was viewed as a preferred way of relating.[1]

Statements about openness also occurred at those moments when participants appeared to have felt they should be open and needed to defend interaction that was not open (e.g., they were unable to describe open behavior or they recognized that something they said was at odds with an earlier assertion of complete openness). Our interviewers were trained to probe for specific examples of topics, conversations, and behavior patterns. We saw this as a neutral means of getting detailed descriptions; however, Katherine interpreted it as revealing a shortcoming:

ER: Are there topics related to your heart condition that you feel that you can discuss openly with your husband?
EE: Oh I don't think there are any that I can't. No. I mean, I mean there are no, no subjects that I can't discuss with me- with my husband.
ER: What are the things that you can discuss with him?
EE: About the heart attack? Well, I think I told you all the things that happened in the hospital. We talked about those a number of times. And the fact that my memory has failed. And he thinks that's worse than I do and we talked about that. And I don't know, maybe we don't talk enough.

Her initial description of their communication uses a double negative—there are no subjects they cannot discuss. When asked for an affirmative response—what CAN she discuss with him—her response suggests that if they were open, she ought to be able to give examples, a judgment she acknowledges by saying "maybe we don't talk enough."

In summary, when respondents characterized their communication as open, they often revealed their belief that openness was valuable, healthy, and constitutive of good relationships. Statements about open communication occurred at precisely those spots in the interview that asked for open-ended reflections or evaluation of good, bad, or recommended patterns of interaction. They also occurred when participants might have felt their communication or relationship would be judged negatively. An ideology of openness provided language for making positive statements about one's self and relationship. Statements about open communication expressed cultural ideology and responded to the social dynamics of the interview; they may or may not be summary reports about behavior, an issue to which we now turn.

Openness as polysemic

In contrast to widespread agreement with the ideology of openness, participants differed in how they described conversations about their own or their partner's heart condition. Figure 1 represents the different ways participants oriented to the ideology of openness. A few of our participants did not claim to be open (the upper right parallelogram); some simply did not comment on openness as a relevant aspect of their talk whereas others said they were not open and acknowledged this was problematic (e.g., they wished they were more open or their family had remarked on their lack of openness).

In contrast, the parallelogram on the left represents participants who at some point said they were open (e.g., "we've always been open with each other," "we can talk about everything," or "there's nothing we don't discuss"). To appreciate what this meant to them, we developed descriptive profiles of their talk. What recovery-related issues were of concern? Did they say they had talked about these issues? If so, did they speak freely or did they withhold information or approach conversations with caution? Some participants who said they were open gave no examples to the contrary but nonetheless exhibited patterns that complicated what openness meant in their relationship (denoted by round-cornered boxes). Many participants who said they were open went on to describe examples when a concern had not been discussed freely. We took them at their word, and probed for what it meant to them to be "open" (denoted by ovals).

In other words, as we moved from a widely shared ideology that valued openness, to the specific ways individuals lived out that ideology, we discovered polysemy. Some of the polysemy came from our vantage point as analysts who juxtaposed participant descriptions of behavior with our observations about its context (the rounded boxes); another type of polysemy derived from participants' own multivocal descriptions of

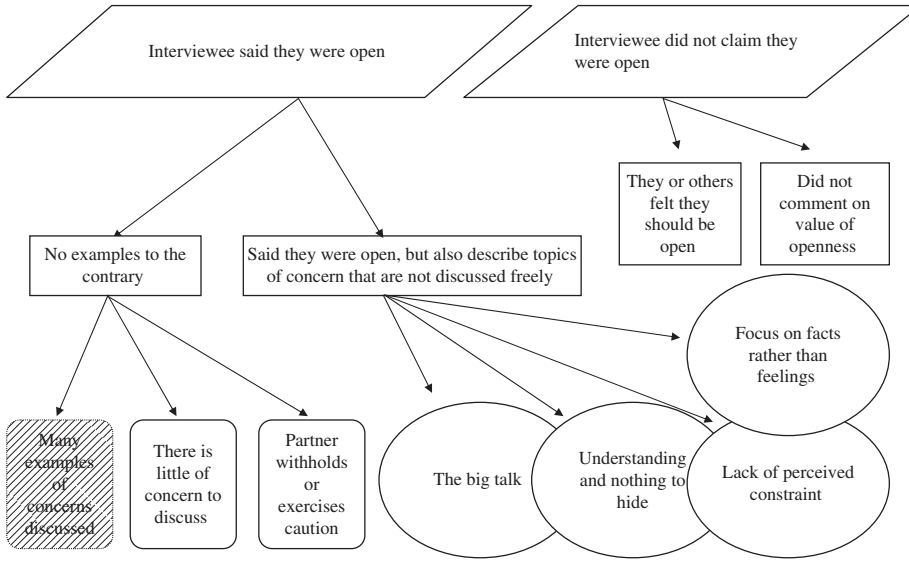

Figure 1 Patterns of open communication among our participants.

their communication (the ovals). We detail here these various meanings of openness, beginning at the far left of Figure 1.

Before describing our participants' meanings of openness, let us address the kind of "open communication" we expected as researchers: *the presence of regular talk without restraint about a range of issues* related to the heart condition (denoted by the shaded rounded box at the far left). This resembles "really communicating" (Katriel & Philipsen, 1981) as well as researchers' measures of "open communication" (Goldsmith & Miller, in press). *None of our participants fit this description*. Perhaps open communication about difficult topics is a rare but valuable thing. Or maybe scholarly conceptualizations of openness fail to correspond to the behavior most couples report.

One pattern we observed involved a participant who claimed to be open, and did not describe any behavior that was not open, but also acknowledged there was not much to say. For example, Ken and Rose engaged in fairly regular talk without restraint about various issues but they also emphasized that Ken's heart condition raised few concerns that required much discussion. Each independently said there was nothing they could not discuss, that they talked about everything, and that the experience had brought them closer than before. They each said that Ken was experiencing a good recovery and diet was their only concern. Perhaps, because they perceived few problems, neither recalled any particularly good or difficult conversations. For example, after a long pause, Ken responded to our question about an example of a good conversation by saying, "Well, let's see. I've never been displeased I don't think [little chuckle]. You know, I just haven't had any problems since a few weeks after the surgery, or a couple of months at least." Similarly, Rose explained: "I can't think

of any real discussions about, it was something that we learned about, something that happened. He seemed to recover from it great . . .you just kind of go on and do what needs to be done.'' For this couple, talking was unremarkable. Said Ken, ''Well, I don't think we say, 'Well, we're gonna sit down this evening and talk about changing priorities,' but we do talk about those changes that happen as we go day to day. . . . It may just come up in the conversation and we talk a little bit about it there. . . . '' We could say this couple confirms the merits of open communication: They discussed issues as they arose and this reduced distress and enhanced relational satisfaction. Alternatively, a strong relationship and good recovery made it easy to talk in ways that were not marked as ''sit down and talk openly.''

Another way of being open involved male patients who said they were open and gave no evidence to the contrary, but whose wives withheld disclosure about some topics or exercised caution in speaking. Ron and Cindy illustrate this type of couple. Asked if there were any topics that were difficult to discuss, Ron said:

> I don't know what it'd be. No. Just don't have any--Maybe I'm not sensitive enough [laughs] . . . I just don't have any awareness that there's anything that she wouldn't bring up if it was bothering her, I wouldn't bring up if it was bothering me.

Ron had few heart-related concerns. He felt compliant with his new diet and looked forward to returning to long-distance bicycling. He did not perceive that his life, relationship, or priorities had changed nor was he anxious about his recovery or another cardiac event. He said early on Cindy had expressed concerns about his activity but then his doctor cleared him to return to whatever he felt he could do. He said she occasionally said ''oops'' if he ate something he should not but he had modified his diet successfully and she had accepted it. Overall, he felt they communicated effectively, saying, ''I guess because it's been our lifestyle. We haven't had too many disagreements. She says she could start a sentence and I'll finish it, kind of a thing.''

Cindy agreed that their lives had returned to normal and that no topics were especially difficult to discuss. However, this was largely because she decided to refrain from expressing some of her concerns. Although she wanted to nurse Ron back to health following his surgery, he would not allow it, and so she let that issue drop. She reported that his dietary habits were not as moderate as they should be, yet she did not comment ''because I've learned that I can't change it anyway.'' She said that anxiety about a heart attack was ''that little nagging question'' in her mind but she did not recall telling Ron, because ''he knows the possibility and so I guess there's no talking about it.'' She did not allow herself to worry about the risks of a cut in a cycling accident now that Ron was on blood thinner medication; asked if she had mentioned this to him, she replied, ''No. Why? Why would I? I mean, he would just allay my fears and can't do anything about it anyway.'' Cindy did not disagree with Ron that they communicated well but this was not because she was entirely open with

him. She had learned when it would be unproductive to talk and she felt comfortable refraining from communication about some issues.

What do we make of respondents like Ken, Rose, Cindy, and Ron? Are those who say they are the most open simply those who are least attentive to their communication (as Ron joked)? Are some patients who perceive the most openness those whose partners are most skilled at withholding? Researchers have observed protective buffering among couples coping with a variety of illnesses, a pattern in which one person withholds concerns in an attempt to shield the other from stress (for review, see Berg & Upchurch, 2007). Shall we say a couple is "open" if one person perceives they are but the other person demonstrates withholding and restraint?

The most common communication pattern among our participants resembled "being open with your mouth shut": At some point in the interview, participants said that they were open but they also revealed one or more significant issues of concern about which they had not talked or had talked incompletely or with caution. This seemed contradictory to us, given our scholarly conceptualization of openness, but it did not seem to trouble the participants themselves. We found four ways to interpret "we are open" that were consistent with "keeping your mouth shut." Although many participants leaned toward one of these meanings, these were not mutually exclusive and participants could voice multiple meanings over the course of an interview. Table 1 summarizes these meanings and compares them to the scholarly conceptualization of openness.

Openness sometimes referred to a single big talk in which a couple acknowledged mortality, talked about their life together, or set the record straight about past regrets. Big talks were prompted by a health crisis but focused on what the threat to life meant for self and relationship. After the big talk, these thoughts and feelings did not come up again and were sometimes even avoided so as not to dwell. For these couples, the fact that they had said what they needed to say constituted being open. Often big talks occurred right before surgery, as in this example that Carol described: "[T]hat night we talked more than we ever have in our three years of the possibility of, you know, him not surviving." She said that although it was hard to talk, "we both knew we had to. So we discussed every possibility and what we would have to do if something didn't go right . . . ." Kirby and Linda's big talk concerned mistakes Kirby had made in the past and his desire "to leave no skeletons in no closets." He said it was a "special incident" and described her response as "very open, very loving." Victoria and her husband talked before surgery about "what a wonderful life we've had and [how we] considered ourselves very fortunate to have each other and the years that we shared with each other." Although (or perhaps because) they occurred only once, big talks were significant to participants. They involved emotionally charged talk about past or future events that had not previously been discussed or deep feelings that normally went unspoken. Because these conversations were so memorable, they were accessible examples on which to base a judgment that "we are open" even though they were atypical of the couple's usual interactions.

Table 1 Conceptual Dimensions that Differentiate Behavioral Meanings of "Openness"

	Presence of Talk	Regular Occurrence	Without Restraint	Range of Issues
Scholarly concept of openness	The couple does talk	All changes associated with cardiac episode should prompt regular talk	Even though some topics may be difficult, couples persevere	Information, feelings, thoughts; both serious and ordinary
The big talk	The couple does talk	It's an unusual, memorable talk that may only happen once	Each overcomes barriers to reveal deep thoughts and feelings	Serious topics, including regrets, fears, positive feelings for one another
Facts not feelings	The couple does talk	Medical concerns associated with cardiac episode prompt regular talk	Depends on the topic	More emphasis on medical information and problem solving, little talk about feelings
Understand with nothing to hide	Not necessary because of understanding, knowing one another well	Knowing one another enables coordination without talk; too much unnecessary talk would be dwelling	Confident; they know how the other thinks and feels and trust the other would say if there is something new to tell; no secrets	Would reveal something serious that is not already known
Lack of constraint	Not necessary but may occur if either one initiates or situation calls for problem solving	No reason to talk	No reason not to talk; no barriers	Could talk about anything

Some participants interpreted our questions about "how you communicate about your/your partner's heart condition" to refer narrowly to talk about medical facts so that openness meant *focusing on facts rather than feelings*. Openness meant they had reviewed their doctor's explanations and recommendations, even though they had not talked about fears for the future, changes to everyday life, or frustrations with lifestyle changes. For example, asked if there are "topics that are related to your heart condition that are difficult for you to discuss with your wife," Bert said, "No I can't think of any. We're very open about that" and said they had talked about "actual physiological things," "the exact medical procedure that was used," and "ancillary matters like diet and exercise." Bert's wife had had a heart attack 4 years earlier and they "talk about our medications a little bit." Later in his interview, Bert expressed some apprehension about having further heart problems and said he worried "quite a lot" about his wife having a recurrence. However, he says talk of his own recurrence "hasn't come up" and they have talked "occasionally, not extensively" about her condition. He mentioned that sometimes when he is alone, he thinks about death, but does not say anything to his wife.

This view of openness emphasizes its instrumental utility. It is akin to the kind of openness we expect of government or recommend to managers, an openness that entails clarity and transparency about decision making and problem solving. Bert felt diet and activity required problem solving but speculation about recurrence or increased risk of death did not. The only reason Bert and his wife talked even briefly about his wife's risk was because she needed to decide whether to have surgery to revascularize an artery in her leg. Nathan provides another example of this orientation. "I say what the doctor told me. That's it. . . . There's no reason to talk about it. I mean as far as I'm concerned, it's something that happened. So, we don't really talk about it. We talk about quitting smoking, maybe." In this view, it is important not to deny one's medical condition; patients and partners should seek relevant information, and be clear about what actions they are to take. Beyond that, talking about how the medical facts intersect with personal or relational issues was dwelling on things you cannot change. Said Nathan, "She's optimistic, I'm optimistic. I think that's the way you have to live your life."

Big talk and focusing on facts each emphasize complementary but incomplete aspects of open communication as it has been defined in previous research. In contrast to ordinary talk about daily experience, big talks concerned the meaning of one's life and relationship in the face of death. Intensely negative feelings could arise from discussing an uncertain future or an imperfect past, yet these talks emphasized a supportive, positive evaluation of self and relationship. Big talks stood out precisely because these types of discussions happened so rarely. In contrast, focusing on facts but not feelings involved regular talk about one's experience but stopped short of exploring how medical events and lifestyle changes implicated one's sense of self or relationship. Neither form of talk fully captures the ethos of open communication, in which regular talk about problems in life becomes an occasion for working on a constantly evolving self and relationship (Katriel & Philipsen, 1981).

The remaining two behavior patterns entail little actual talk, and instead emphasize lack of restraint as constituting openness. The perception that the partners *knew one another well and had nothing to hide* resembled the notion of one's life as an open book. Participants did not talk much about the heart condition, yet they had a high degree of confidence in what the other thought and felt, in who he/she was, and in the strength of their relationship. For example, when asked what topics were easy or difficult to discuss, Marjory stated, "We discuss everything." Probed for specifics, she mentioned that, "if I see him rubbing his chest, or something like that I'll say, 'Are you feeling okay?'" She then reiterated, "we don't have anything from each other. Really. I mean we don't have any trouble talking about things." At the conclusion of the interview, she did not recall any especially good or bad conversations, saying, "Again, I think this goes back to the fact we've been married 50 years and we've always had a very good relationship. And so, no, I can't think of anything there either." Her belief that they communicated openly was based not on regular conversations but on her confidence that, after 50 years of marriage, they had no secrets.

Several partners acknowledged, but then rejected, the possibility that they did not know their partner's thoughts and feelings as well as they assumed. Some spontaneously mentioned that patients might be hiding pain, depression, or worry. Lisa said it was important to trust that her husband was not hiding symptoms because if she suspected he was not telling her things, "my mind can go a hundred different ways. So I just said, 'if you just promise to tell me everything, then I won't keep asking.'" Her openness did not involve revealing to him when she felt worried. Instead, openness involved her working not to dwell on anxiety about another heart attack—either cognitively or communicatively—in exchange for his promise to initiate talk if there was something to report. Her confidence that Simon would tell her if anything serious arose illustrated the notion of openness as a balance that avoids both his denial and her dwelling.

As Lisa and Simon illustrate, having nothing to hide did not necessarily mean that couples talked. Asked if he "fills his wife in" on what his doctor has told him, Craig said, "Oh, if she asks me, I'll tell her. I don't have anything to hide from her. . . . If she doesn't ask, I don't. If she wants to know, she'll ask." For Craig openness did not entail initiating discussion of information, thoughts, or feelings but, rather, being willing to respond to his partner's inquiries honestly. He was open to discussion, though it might not happen. Understanding with nothing to hide shows consideration for the other's wishes, which may involve talk but may also entail silence about Craig's heart condition or Lisa's anxieties.

A final pattern of openness involved a perceived lack of constraint. This is "openness" as an open door or road: One need not enter or travel, but one is free to do so. Those who spoke of openness in this way did not perceive barriers to talking if they wished, even though they did not wish to talk very often or very much. For example, Mike told us, "I'm pretty sure we're pretty easily talking about things that relate to the heart problem I've had but I can't think of any particular time when we really got involved with worry about talking like that." Perceiving no constraint

involved a lack of effort to talk or not, which we distinguished from having nothing to hide when the other already knows everything important. One involves having no secrets, the other involves having no barriers. When asked about a good conversation, Mike paused for a long time before saying:

> I can't honestly think of any time. I know she's glad that I'm coming along as good as I am, but whether she's surprised about it or not, I don't know, and, and we really never talk about, as far as this heart condition's concerned, it's mine and [chuckle] and if something else happens, then she gets concerned you know, but other than that we've never really discussed something like that.

Mike was confident that Rita was relieved by his recovery, and would be concerned if he had another heart attack, feelings one would expect from a wife of 54 years. However, he admitted not knowing what else she thought or felt about the matter and felt little need to talk about a condition he defined as "mine." A lack of constraint defined openness by potential rather than occurrence so it may matter whether a participant says "there's nothing we can't talk about" rather than "we talk about everything."

None of the four types of openness we reported in Table 1 has all of the attributes of the scholarly definition; instead, each uses the presence of one or two attributes as evidence that openness occurs. The big talk involves presence of unrestrained talk on especially deep issues. Facts not feelings involve presence of talk but only about medical facts and daily problem solving. Understanding with nothing to hide emphasizes that talk could occur (without restraint) if anything important changed. Lack of restraint believes talk could occur about anything, even though it does not. An idealized notion of openness requires that all attributes are necessary to claim that one is open; in contrast, our participants drew on these attributes as a toolkit. As they recalled specific situations, they emphasized different attributes and the presence of any one in a particular case was sufficient to conclude that communication was open.

Conclusions

Participants in our study had multiple, nuanced meanings for "open communication." Saying one is open revealed what a speaker valued, an ideology in which open communication is what healthy individuals do in satisfying relationships. Those who valued openness went on to describe a varied repertoire of behaviors. Openness looked different for different participants and even the same participant might describe varied ways of talking across situations. Some who said they were open had few concerns to discuss and some men who reported they could talk about anything had wives who had decided not to bring up difficult topics. Some of our open participants talked infrequently or talked only about medical facts and not feelings. Some did not talk much at all, though they emphasized that they had no secrets or

barriers to talking. This polysemy is significant for those who wish to understand the particular circumstance of couples coping with a cardiac event, and it also has conceptual and theoretical implications for the study of open communication more generally.

Implications for couples coping with a cardiac event

Previous research suggested open communication facilitated recovery for the patient and adjustment and relational satisfaction for both partners. This has been the basis for interventions that admonished couples to speak openly. If unrestrained talk is indeed beneficial, then our findings make clear that it is insufficient simply to advise couples to "be open." They may believe they are open, though their behavior is not what health professionals have in mind. If interventions seek to train couples to engage in regular talk without restraint about a range of issues associated with recovery, it would be useful to assess with couples the degree to which this is happening, make them aware that what they may consider "open" could be improved upon, and then support them in developing new patterns of relating.

Alternatively, interventions that impose researchers' definition of open behavior may be premature. Maybe the couples in our study had already found ways to balance dwelling and denial and construct self and relationship in difficult times. The rationale for telling couples to change how they talk is based on research that usually measures "open communication" by asking participants to agree or disagree with global, abstract statements about openness (cf. Goldsmith & Miller, in press). The similarity between those survey items and our respondents' statements (e.g., "we can talk about anything") raises the possibility that when respondents endorsed those items, they were saying, "I am well-adjusted and have a good relationship" rather than "I engaged in regular unrestrained talk about a variety of issues." Consequently, studies interpreted as evidence for the benefits of open communication might instead be documenting that self-reported adjustment or marital quality is associated with good outcomes (cf. Coyne, Rohrbaugh, Shoham, Sonnega, Nicklas, & Cranford, 2001, who demonstrated that marital quality predicted recovery). Another method for studying open communication brings couples to a laboratory, asks them to identify significant concerns, and then studies their conversation. That couples can engage in a Big Talk when so instructed does not mean that they have before or will do so again. By shedding light on what open communication items or experiments mean to participants, our findings suggest we should re-evaluate the empirical foundation for telling couples coping with a cardiac event that they should engage in a particular kind of talk.

Implications for theories of open communication

Whereas previous research on open communication has usually focused on developing general models of its frequency or effects, this study examined the meanings of openness in a particular context. The resulting description is essential for understanding couples coping with a cardiac event but do our findings generalize beyond this

context and beyond the particular Midwestern, middle-class, middle-age-plus participants with whom we spoke? Whether and to what extent these same meanings occur in other contexts is an empirical question, but the merit of a qualitative study such as this lies less in generalizability than in potential extrapolations and transferability (Patton, 2002, pp. 581–584). Specifically, our findings (1) refine conceptualizations of "openness," (2) suggest when and why being open with your mouth shut occurs, and (3) raise questions about the current status of the ideology of openness.

One value of context-specific case studies is to reveal variability and range in some concept. Couples coping with a cardiac event do not represent all people and situations; but neither do the healthy young people who are the dominant subject population in many studies of open communication. We offer the categories of talk we discovered not as universals, but as part of the range of possibilities that need to be encompassed by a general theory of open communication. For example, our study suggests couples vary not only in how open they are, but also in how salient openness is to them. In Figure 1, we find that some couples say they are open and that this is valuable and others say they are not open and this is problematic—in other words, variability on a dimension of more or less open (with the expected beliefs that this is good or bad). However, to this variability in open/not open we add a dimension of personal and circumstantial salience. Some participants did not describe themselves as open or not open, suggesting this is not an important dimension of evaluation for them. Other couples had life circumstances in which openness seemed less urgent to them. Should we expect openness to have the same impact when personal orientation or circumstances make it less salient?

Our findings also reveal that previous conceptualizations of openness have conflated what can be distinct features. Table 1 suggests three defining attributes of openness: frequency (regular occurrence), difficulty (without restraint), and topical focus (range of issues). Whereas the cultural ideal (and scholarly conceptualization) presumed all of these attributes must be present, our findings show different versions of openness derive from these multiple facets: infrequent talk about difficult issues, frequent talk about a restricted range, infrequent talk that is not due to difficulty, and so on (cf. Goldsmith & Miller, in press). Each of these different modes of openness merits further exploration. For example, are there particular feelings that are excluded from talk about facts and which types of feelings are particularly appropriate for big talks? What kind of new information would obligate one to initiate conversation if you knew and understood one another and had nothing to hide?

Similarly, general theories must expand to account not only for instances when individuals respond strategically to a felt tension between openness and closedness, but also for instances when individuals do not experience being open with your mouth shut as a contradiction in need of management, a phenomenon that has now been observed across a range of situations. We propose an explanation for how participants can enact this pattern without viewing it as contradictory: Speakers felt they *needed* to say they were open because of ideology and they were *able* to say it because of polysemy. What is common to the situations in which this phenomenon

has been observed that makes ideology and polysemy especially salient? In each of the three studies—parents and teens adjusting to adolescent sexuality (Kirkman et al., 2005), adult children caring for a parent who dies (Caughlin 2010), and couples surviving a life threatening illness—participants are in the midst of a life stage change that could redefine one's self. Swidler (2001) proposed that cultural tools become especially salient in just these types of situations: "For most people, major life transformations . . . inspire some cultural rethinking, although people also continue to rely on their existing repertoire of personal and social capacities" (p. 93). Being open with your mouth shut appears to occur among participants making sense of new experiences and formulating new lines of action. The ideology of openness may become particularly salient as a justification for what we do and who we are doing it with while polysemic meanings of openness help us use familiar practices and habits in new situations.

This analysis might prompt us to re-examine the contemporary status of the ideology of intimacy Parks described in 1982 and the communication ritual Katriel and Philipsen detailed in 1981. Swidler (2001) differentiated between ideologies, which tend to provide strong guidance over specific lines of action, and common sense, which "tolerates a wide range of observations, ideas, and experiences. . . without demanding rigor or pursuing contradictions" (p. 98). During periods of social ferment, ideologies hold great power, albeit for a restricted range of adherents and situations; over time, however, ideologies can become established common sense with a broader range of acceptance and a more diffuse connection to action (p. 101). We discovered polysemic meanings of openness and a lack of perceived contradiction between ideological statements and varied modes of practice. This might signal that the ideological fervor of the 1960s and 1970s has given way to a common sense acceptance of openness. Now, mature couples in a rural Midwestern U.S. community articulate an ideology once associated with the counterculture and, correspondingly, there is a weaker connection to a specific ritualized behavior. It may be no coincidence that the metaphor "open" has emerged as the key term for describing this form of communication. As metaphor, "open" allows for contextually specific, strategically ambiguous referents.

Cecarrelli (1998, p. 397) suggested that we ask of polysemous texts: "Who does it benefit? And how should we judge it?" Our microstructural approach would be usefully complemented by asking macrostructural questions about the dominance of a therapeutic model as an authority for the conduct of personal relationships. In the context of couples coping with heart disease, the ideology of openness is consistent with individualizing the causes of and care for illness, rather than attending to the ways that social conditions and institutions are also implicated. For example, does encouraging couples to talk openly about the challenges of recovery detract from asking questions about the burdens of caregiving (Corbin & Strauss, 1988) or the ways in which lifestyle change recommendations deflect attention from the social and political sources of health risks (Lowenberg, 1995)?

We have treated ideology as a flexible, multivocal system of taken-for-granted premises that enabled participants to present themselves and their relationships in a positive light—to themselves, as well as to an interviewer. From this perspective, we learn something important about how couples communicate in the face of a life-threatening health condition. They take comfort in endorsing openness because they believe it is associated with individual and relational health; and yet they may presume they understand their partner without talking or speak infrequently or about a circumscribed range of topics. Openness, or at least one of its particular definitions, may not after all be a matter of life and death.

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Note

1 Every participant who advised open communication also described one or more instances in which an important concern had not been discussed or had been discussed cautiously, indirectly, or incompletely. This suggests their advice reflected a shared ideology rather than a summary of personal experience.

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