Parental Cancer: Catalyst for Positive Growth and Change

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Abstract

Cancer is a disease that affects the entire family, with each member having unique psychological needs. To date, there has been limited research into the effect of parental cancer on adult children. Furthermore, existing research has largely overlooked the possibility of positive psychological growth in the adult offspring of cancer patients. To investigate the perceived benefits arising from parental cancer, 11 interviews were undertaken with adults, whose parents had been diagnosed with cancer, to discuss their experiences of their parent’s illness, and their evaluation of both the positive and negative changes that had arisen. All participants were able to identify positive outcomes in direct response to their parent’s cancer. Frequently suggested changes included improved relationships with their sick parent, an increased emphasis on family, revised life priorities and personal development. The implications of these findings, their link to posttraumatic growth theory, and avenues for future research are discussed.

Keywords

cancer, psychosocial aspects; emotions / emotion work; families; illness and disease, experiences; relationships, parent-child
Cancer is a disease of global significance, with an estimated 12.7 million new cases and 7.6 million cancer-related deaths occurring in 2008 (Cancer Research UK, 2011; World Health Organization, 2011). It is estimated that more than three million new cancer diagnoses were made in Europe in 2006 (Ferlay, Autier, Bonoil, Heanue, Colombet, & Boyle, 2007), 1.5 million new cases in the United States in 2010 (American Cancer Society, 2010), and nearly 180,000 new cases will be diagnosed in Canada in 2011 (Canadian Cancer Society, 2011). Although the number of cancer-related deaths are high (e.g., 156,000, or one in four deaths in the United Kingdom in 2008; Cancer Research UK, 2011), the survival rate has consistently increased with five year survival estimates now ranging from 51% in the United Kingdom to 68% in the United States (American Cancer Society, 2010; Cancer Research UK, 2011). The incidence of cancer in Australia, where this study was conducted, remains high with more than 100,000 new cases diagnosed each year (Australian Institute of Health and Welfare (AIHW), 2008). Cancer was recorded as the main underlying cause of death in Australia for the period of 2002-2004, and it accounts for approximately 28% of deaths each year (Australian Bureau of Statistics, 2006). The five year survival rate has, however, increased. Approximately 63% of cancer patients will reach this survival milestone, thereby resulting in an increased prevalence of the disease in Australian society (Tracey, Chen, Baker, Bishop, & Jelfs, 2006). Consequently, a growing number of patients and their families are living with the disease, its consequences, and the fear of recurrence, for longer periods of time.

Over the last 20 years, it has been recognized that cancer is a disease that affects the entire family, and that family members are “second-order patients” with unique needs (Arnaert, Gabos, Ballenas, & Rutledge, 2010; Rait & Lederberg, 1989). Although there is a growing body of research that has examined the impact of parental cancer on young children and adolescents,
there are very few studies that have focused on the effects of parental cancer on adults. This is a significant void, because many cancers typically occur in people aged more than 50. For example, 85% of prostate cancer cases occur in men aged 65 and above (Cancer Council Australia, 2010), and 76% of breast cancer cases occur in women aged more than 50 (AIHW and National Breast & Ovarian Cancer Centre, 2009). Considering that, in the majority of cancer cases, the patient’s children will be adults; steps must be taken to increase our knowledge and understanding of how cancer affects this cohort to ensure that support agencies are able to develop appropriate services to meet the needs of this group. Although it can be argued that most adult children live independently from their parents, it should not be concluded that the impact of parental cancer is minimized, simply because the dependent child-parent relationship is no longer present. Logan and Spitze (1996) argue that adult children feel a great deal of filial responsibility, when faced with a sick parent. Others have found that caregiving is linked to role strain, increased depression and anxiety among children caring for parents with cancer (Dura, Stukenberg, & Kiecolt-Glaser, 1991; Raveis, Karus, & Seigel, 1998).

The existing research has tended to focus on the identification of psychopathology arising from parental cancer. For example, Kissane, Bloch, Burns, McKenzie, and Postering (1994) examined psychological morbidity in family members of palliative cancer patients, and found that 28% of children met the diagnostic criteria for depression, using the Beck Depression Inventory (Beck, Steer, & Garbin, 1988). An additional finding was that the children reported significantly higher levels of anger compared to their parents (both sick and healthy), potentially indicative of higher levels of anticipatory grief (Kissane et al., 1994). A limitation of the study, however, was that the children in the survey were aged 12 and above, with no information
provided regarding their age breakdown. Therefore, care must be taken in generalizing this result to the adult cohort.

Mosher and Danoff-Burg (2005) conducted a review of the psychosocial impact of parental cancer, and concluded that anxiety and depression were developed by a “sizeable minority” (p. 365) of adult children. Furthermore, Mosher and Danoff-Burg highlighted that, for some individuals, the diagnosis of a parent with cancer gave rise to symptoms akin to posttraumatic stress disorder (PTSD). This review highlighted that the majority of studies have examined the psychological outcomes of the children (typically daughters) of breast cancer patients, in part, because it is thought that the potential for the genetic heritability of breast cancer might increase the likelihood of PTSD in the daughters of breast cancer patients (e.g., Lindberg & Wellisch, 2004). Smith, Redd, Peyser, and Vogl (1999) conducted a wider examination of the link between cancer and PTSD, and found that clinical PTSD was present in the parents of childhood cancer patients, further suggesting that the stress associated with cancer can significantly impact on individuals other than the patient. Although studies, such as these, provide some insight into the experience of parental cancer, we argue that the narrow focus on psychopathology fails to capture the breadth of the experience. Consequently, there is a lack of knowledge concerning the potentially positive outcomes that might emerge.

Trauma or stress-related growth theory attempts to explain the emergence of positive outcomes from seemingly negative and traumatic events. Affleck and Tennen (1996) have suggested that negative events trigger the need for psychological restructuring, or a reinterpretation of the traumatic event, so that it can be perceived as “beneficial” for the individual. Janoff-Bulman (1992) argued that highly stressful events might lead the individual to question their core beliefs about the world, giving rise to an opportunity for change and growth.
Similarly, Tedeschi and Calhoun (1995, 2004) propose that growth occurs when the individual recognizes that a new reality has arisen from the stressful event. Therefore, posttraumatic growth is not simply a return to pretrauma functioning, but rather is an improvement in some area of the individual’s life (Tedeschi & Calhoun, 2004).

The notion of deriving benefits from cancer has recently emerged in the psychological literature (e.g., Lelorain, Bonnaud-Antignac, & Florin, 2010; Salsman, Segerstrom, Brechtine, Carlson, & Andrykowski, 2009; Schulz & Mohamed, 2004). Thornton (2002) proposes that patients derive a variety of benefits from their illness in three broad areas, including benefits associated with one’s life perspective, interpersonal relationships, and the self. Several researchers have confirmed that such benefits are present in the spouses of cancer patients, suggesting that growth can occur in individuals, other than the patients themselves. For example, Thornton and Perez (2006) examined posttraumatic growth in prostate cancer patients and their spouses, and found that both groups reported modest levels of growth, however, the growth was unrelated to their reported quality of life. Weiss (2002) studied breast cancer spouses and found that 88% of the spouses reported positive changes, typically in the areas of enhanced relationships and an increased appreciation for life. Manne, Ostroff, Winkel, Goldstein, Fox, and Grana (2004) examined the predictors of posttraumatic growth in partners of breast cancer patients over an 18 month period, and found that age, higher levels of intrusive thoughts, a higher use of emotional processing and positive reappraisal, predicted the level of posttraumatic growth.

There have, however, been very few studies conducted to specifically determine whether positive benefits occur among the adult offspring of cancer patients. Mosher, Danoff-Burg, and Brunker (2006) reported that the daughters of breast cancer sufferers do report posttraumatic
growth at levels similar to breast cancer patients. Unfortunately, Mosher et al. did not detail the degree of benefits found in the posttraumatic growth domains, and used a relatively small sample by quantitative standards ($n = 30$). As such, the findings provide very little information other than simply confirming that positive changes are possible in response to parental cancer. Kim, Schultz, and Carver (2007) explored the existence of perceived benefits among cancer carers using a much larger sample. Although the majority of the sample were spouses, 34% ($n = 265$) were other adult family members, such as adult children. In this study, the researchers found that positive outcomes among the adult offspring were possible in the domains of acceptance, empathy, appreciation, family, positive self-view, and reprioritization. Kim et al. (2007) also found that the perceived benefits were higher among carers who had higher levels of social support, and that the various types of benefit might influence their level of depression. Notably, the nature of the family relationship (i.e., spouse vs. other family member) did not significantly predict benefit finding (Kim et al., 2007), which suggested that the level and type of benefits derived from the cancer experience are similar for spouses and adult children. However, additional investigation is needed before firm conclusions can be drawn.

In addition to the two studies outlined above, there is also data from qualitative studies into the general experience of parental cancer and cancer caregiving, which suggest that benefits might be present in the adult children of cancer patients (e.g., Oktay, 2005; Tarkan, 1999; Wong, Ussher, & Perz, 2009). Although benefits have not been the focus of these studies, their data suggested that improvements in relationships, changed life priorities, and personal development are possible outcomes from having a parent with cancer. In the light of the lack of information in the area, the authors aimed to investigate the experience of parental cancer, with a particular focus on identifying the psychosocial benefits that might arise.


**Method**

We used a qualitative methodology for data collection and analysis in an attempt to gain an insight into the experience of adults having a parent with cancer. We deemed this the most appropriate method because of the limited research conducted with this cohort, and desired to capture the core elements of the experience. We employed an interpretive phenomenological analysis (IPA) approach to enable a detailed examination of the experience, as it is perceived by those who live through it, hence capturing the “human” dimensions of this aspect of health (Thorne, 2011). IPA is grounded in two philosophical schools of thought: phenomenology and symbolic interactionism. Phenomenology focuses on the lived experience of individuals, examining the world as it is perceived by people, and gaining an insight into how people understand their world (Willig, 2001). We aimed for the study to provide both a description of the phenomena of parental cancer, and the articulation of the meaning derived from people’s lived experience (Groenewald, 2004). The second philosophical foundation, symbolic interactionism, aims to understand the lived experience of people through an examination of interactions both within (e.g., thoughts, interpretations) and between individuals and groups (Ephross & Greene, 1991). Symbolic interactionism acknowledges that people experience the world through dynamic social processes, which have the potential to change the individual by altering their interpretation and understanding of the world (Charom, 1995). We believe it was critical to use a philosophical approach, which acknowledged the significant role of interactions in human understanding, because the topic of investigation was how illness in one individual affects the psychological functioning of another, while also considering the broader context of the family unit.

*Participants*
Participants were recruited for involvement in the study through one of two means: the advertisement of the study through Charles Sturt University’s daily electronic news posting, or through regional radio exposure. Participants were eligible for inclusion if they met the following criteria: they were aged over 18 at the time that the diagnosis was made; the diagnosis of parental cancer occurred at least 12 months ago; and, if bereavement had occurred, this took place at least six months prior to their participation in the study. Eighteen volunteers contacted the researchers, however, seven failed to meet the eligibility criteria and were excluded, leaving a final sample of 11 participants.

Nine of the 11 participants were women, and ages ranged from 24 to 52 years, with an average age of 41 years. Forty-six percent of the diagnosed parents were mothers, 36% were fathers and, in 18% of cases, both parents were diagnosed with cancer. The types of parental cancer included breast, prostate, multiple myeloma (two cases of each type), bowel, brain, melanoma, pancreatic, ovarian, chordoma (malignant bone cancer in the skull base and/or spine), and lymphocytic leukemia (one case of each type). Most participants (10 out of 11) had siblings, ranging from one to four, with a modal number of three siblings. Seven of the participants were involved in caring for their parent in some capacity (e.g., they were either a primary carer, part of a family care team, attended medical appointments or involved in treatment decisions).

**Data Collection**

We employed semistructured interviews to collect data. Interviewing is well suited for the exploration of the deeply personal experience of parental cancer, allowing the researcher to gain an insight into “subjectivity, voice and lived experience” (Rapley, 2004, p. 15). Furthermore, semistructured interviewing recognizes that research participants are active meaning makers and the “expert” on the topic under investigation (Smith & Osborn, 2003). The first author conducted
all interviews, and the semistructured approach provided a flexibility that allowed the pursuit of interesting and relevant topics which emerged from the participants’ recounts of their experiences.

The interview schedule was divided into several sections: (a) experiencing parental cancer (e.g., tell me about your parent’s cancer?); (b) familial relationships (e.g., can you describe how you believe parental cancer has changed your family, if at all?); (c) coping (e.g., how did you adjust to your parent’s cancer?); (d) cancer and adjustment related cognitions (e.g., what are some of the cancer-related thoughts or beliefs you used to help you deal with your parent’s cancer?); and (e) personal health behaviors (e.g., do you think that your parent’s diagnosis of cancer has altered the way you look at your own health?). The authors acknowledge that no question was asked that specifically mentioned perceived benefits, despite this being the particular focus of the study. It was the authors’ opinion that the area of investigation was a particularly sensitive subject, and that questions, which implied that the participants could benefit from the suffering of their parent might cause offense. To overcome this, we asked a variety of general questions on the experience of parental cancer and, when positive changes were raised by participants, additional questions were asked to gain insight into, and to determine the meaning that the participants had developed surrounding such changes.

Participants were asked to contact the first author to arrange a time and place for the interview. The participants determined the location of the interviews (e.g., work offices, home). The interviews ranged from 28 minutes to 75 minutes in duration. All interviews were recorded and transcribed verbatim, with all identifying information being removed to protect participant anonymity. The study had the approval of the Charles Sturt University Human Research Ethics Committee. Because of the sensitive nature of the topic, the ethical procedures implemented
prohibited the participation of individuals whose parents had been diagnosed within 12 months, or who were recently bereaved. Additionally, all participants were provided with contact information for two counseling support agencies, one cancer-specific and one available 24 hours a day.

Data Analysis

The first author analyzed the transcripts using IPA as outlined by Smith and his colleagues (see Smith, Jarman, & Osborn, 1999; Smith & Osborn, 2003). The analysis began with a single transcript being read several times to identify important points of interest, recurring topics/sentiments, and analytic impressions. The next stage of the analysis involved listing and articulating emerging theme titles, and an examination of the emerging themes for possible connections, which led to the creation of a master list of themes for that transcript. Each transcript was treated as a “new first case,” and the above process was repeated for each case, with efforts being made to minimize the influence of themes identified in prior cases on each analysis. Once each transcript was analyzed, the authors read the master lists together, and noted similarities and differences.

The first author made journal entries throughout all stages of the data analysis process, reflecting her interaction with the text. This diary was used to note possible interpretive options, uncertainties regarding the interpretation of the data, insights into how the first author’s presuppositions might have influenced the data interpretation, her emotional reactions to the data, and points of interest to pursue in additional readings of each transcript. The first author reviewed the diary regularly throughout the data analysis process to ensure that all impressions and interpretations of the data were considered. The reflective journal was one strategy that we employed to enhance the rigor of the research, with additional strategies outlined below.
Rigor

We ensured that several systems were built into the research design to make the procedure rigorous and transparent. Pure phenomenological studies require researchers to suspend their prior knowledge, beliefs and suppositions through the process of bracketing (Laverty, 2003). The authors however argue that the suspension of presuppositions is difficult to achieve, and therefore a more authentic approach is to acknowledge the role that researcher beliefs, values and identity play in the interpretation of data (Denscombe, 2003). As the first author had experienced parental cancer as an adolescent it was essential that she acknowledged her presuppositions. The authors also share Holloway’s view that prior experience of the researcher with the phenomena under study may enhance the research process through the use of common language and data sharing (Holloway & Biley, 2011). Holloway (in Holloway & Biley, 2011) also argues that qualitative research needs the voices of both participant and researcher for the interpretation of meaning. The first author engaged in a process of self-reflection, which involved the articulation of the beliefs and biases that had arisen from her experience, before the commencement of data collection. Throughout the data analysis process, she regularly reviewed these presuppositions, and self-evaluation was conducted to determine whether personal bias had distorted the data interpretation.

The first author and a fellow academic also engaged in regular discussion of cases throughout the data analysis phase to ensure rigor. Both parties independently analyzed several cases, and followed up with a discussion of themes and interpretative concerns. A high degree of similarity in terms of the identified themes was found, and the process allowed an opportunity to discuss ways in which researcher bias might have been present in the interpretation of the data.
This process was viewed as a credibility check (Elliot, Fischer, & Rennie, 1999), rather than an attempt to establish inter-rater reliability.

The final strategy we employed to ensure methodological rigor was the explicit examination of negative cases. Negative cases are sentiments expressed by participants that do not agree with the dominant view of the data set (Willig, 2001). The value of negative cases is that they highlight areas of difference, which assist in evaluating the suitability of data interpretation. The authors identified six negative cases, and these cases are highlighted in the results presented in this article.

**Results**

The analysis of the data revealed that, although perceived benefits were present to some degree in all participants, such benefits were clearly related to the struggle that the individual had traveled through, as a result of having a parent with cancer. The emotional upheaval and life disruption that the illness had on the individual’s life provided the context in which to appraise the benefits that emerged. Therefore, the first theme that emerged was emotional experiences arising from parental cancer. Four benefit themes were identified, which included transforming the relationship with the sick parent, family matters, altered life priorities, and personal development.

*Emotional Experiences Arising From Parental Cancer*

Most participants mentioned the notion of disruptions in one’s normal life caused by their parent’s cancer, and the emotional reactions that accompanied these changes. For some participants, the impact of the diagnosis and treatment was very intense. One participant described the impact of parental cancer as “the biggest thing in my life, especially the last few weeks, they were just dreadful.” Another stated that the experience of having both parents
diagnosed with cancer within 18 months of each other was “really quite traumatic.” Some participants used language that indicated that the impact and ensuing disruption were so intense that their lives became quite enmeshed with their parents to the point where they would refer to themselves as the patient (e.g., “So I am still up to the second last of the hormone needles at the moment”), or use the collective pronoun “we” to describe treatment activities (e.g., “no she has finished her [chemotherapy] session, yeah so that is where we are up to”).

Participants reported a range of emotional reactions, which included shock (e.g., “I didn’t know that it would happen to us”), anger (e.g., “my workplace was very sympathetic and supportive, but people would say things and I would get so angry”), uncertainty (e.g., “. . . for me at different times a sense of when will this end, I wish it would end either way in some ways . . .”), frustration (e.g., “. . . he goes OK for a little although and then the next thing will hit, and yeah you go through that, and it’s just a matter of waiting”), and sadness (e.g., “… I think I am sadder than I used to be, and I am sure a lot of that has to do with saying goodbye to my mum”). The emotional reactions were changeable throughout the disease progression, with often intense reactions experienced at the beginning, followed by longer-term sadness, grief, and loss as the disease progressed. One participant reflected this change in emotional experience when she described the journey as an “emotional rollercoaster.”

The participants expressed a sense of guilt throughout the interviews. Guilt was often multifaceted, and triggered by numerous situational aspects, such as wishing the experience would end, issues of care, or perceived inappropriate reactions on their behalf. One participant, whose father’s leukemia was marked by unpredictable periods of decline, described how this pattern made it difficult to plan her own life, and commented “You get frustrated, then you feel,
sometimes you wish that he wouldn’t get better, that it would just be better if it were all over, and then you feel guilty for feeling like that, I guess helpless.”

The participants raised significant issues of grief and loss, and many of these issues stayed with participants for long periods of time. One participant reflected that “this will be the fourth Christmas without her and it’s like that’s too many, it shouldn’t be that far along, and it is hard to deal with that day to day sometimes.” For some participants the realization that one’s parent was not infallible, and would not live forever, challenged their sense of security and place in the world. For example, one participant stated “I learned that they are human, because when you see your parent, when you are young you see them as being there forever which they are not.” Participants also identified losses (apart from the actual death of a parent), which included changes to the parent’s behavior and cognitive functions (e.g., “She had always been really smart and good with words and she couldn’t communicate properly, she couldn’t get the right words, and that was really distressing for her and us”), and reduced contact with the healthy parent, (e.g., “when he is bad Mum can’t leave him, when he is not bad she is afraid to leave him in case something happens”). It also emerged that the grief which arose from parental cancer continued to impact on the adult child long after the death of the parent. As one participant revealed: “I don’t think I have ever really come to terms with that sort of grief, it is all sort of simmering there in the background.”

Transforming the Relationship with the Sick Parent

One of the strongest themes to emerge from the data was that parental cancer prompted many participants to change their relationships with their sick parent. For some participants, the cancer diagnosis provided an opportunity to resolve old conflicts and grievances and, in doing so, develop an enhanced sense of connection with their sick parent. For example, one participant felt
that his father had disapproved of his career in professional sport; however, he perceived that, after the cancer diagnosis, his father had reevaluated his position, which led to an increased sense of approval and respect. He stated:

He never thought [sports] coaching was a job and now, when I told him about, I had an opportunity to go [overseas], and get a job . . . coaching and he is eager for that now . . . he is much happier for me to go and do things that I want to do . . . now he is more into me making happy decisions I guess so that is the biggest change, or one of. We do things now, we didn’t before, we worked, we talked about working, but we have played golf, we have talked about buying a boat together.

Other changes that were noted by participants included “getting to know each other adult to adult,” the sharing of life stories, and an enhanced understanding between parent and child, so that overt communication was not always needed (e.g., “I know how she is feeling without her saying”). Among participants who already had a good relationship with their sick parent, it was reported that a sense of increased closeness developed, or an open acknowledgement emerged of how significant the relationship was with their parent. One participant described this change as:

The way that I felt about her and wanting to be with her changed . . . I suppose more of an appreciation of her, not a deepening of love or affection, probably more demonstrative in it, and much more in giving to her rather than taking all the time.

The enhanced connection described above has continued for many years after the cancer experience, with the participant and mother currently living together and reporting a strong relationship. This suggested that the changes, which emerged during the intense period of
parental illness, might stand the test of time, and have continued to have positive impacts on the individual.

Another area in which change emerged was in a respect and appreciation of the sick parent, with cancer providing a context, within which the individual was able to evaluate the importance of their parent. One participant described her mother as “the core and the lynch pin and the concrete under flooring of the whole system [of her family].” For some participants, who lost their parent, they developed a respect for the way that their parent had approached their death. One participant described his admiration for his mother in the way that she handled the practical aspects of her death (e.g., disposal of assets, care decisions). Another participant described her admiration of her mother’s behavior, when she commented “whatever she did go through, she did with a lot of dignity.”

*Family Matters*

Participants also acknowledged that living through the experience of parental cancer provided an opportunity to reflect on the importance of their family in their lives, and altered their relationships with other family members. The participants frequently mentioned an increased valuing of their family which, in essence arose, from the recognition that their family played a central role in lives. Participants became increasingly aware of the important permanent connections and love that their family provided. This was accompanied by recognition that the family should not be taken for granted, but rather required attention and devotion. For example, one participant reflected:

I guess it has . . . made me more aware of family and the importance of being, of doing things that you need to with your family, spending the time with your family, telling them that you care about them.
Both men in the study mentioned an increased emphasis on family. One asserted that the meaning that he had taken from his parent’s cancer was “doing better at family stuff,” which he defined as spending time with his brothers, sisters, nieces and nephews. The experience of his mother’s breast cancer led the other man to reflect on his relationship with his wife and children. He described his current relationship with his own family as closer, and said that he spends more time with them, when compared to before the cancer experience. He acknowledged, however, that during his mother’s cancer, there were marital issues and disruption to his family life, because he struggled to balance caring for his mother with his responsibilities to his wife and young children. Therefore, the authors interpreted the data to suggest that, although the cancer experience did lead to an increased awareness of the importance of family, in reality, it also created strain that needed to be reconciled.

Participants also reflected on beneficial changes in their relationship with other family members, such as the healthy parent, their siblings, and extended family members. Changes to the relationship between healthy parent and adult child often involved an increase in the care for or worry about the healthy parent, however, it was also marked by enhanced communication and increased affection. One participant stated “I think I can tell her [healthy parent] I love her more than I used to be able to and she can say that to me . . . we can talk about stuff, about Dad too.” Another participant described the increased affection between herself and her father, identified as a startling change in their pattern of interaction:

I am even shocked when sometimes he leans in for a kiss, you know he has never been that type of man, and when he shows affection like he puts his hand on my knee or a hand on the shoulder ... or he does cuddle me, he does stand there and cuddle me . . .
The participants also reported other improvements related to an increased frequency of contact with the healthy parent, and an increased sense of closeness with that parent. It is noted that positive changes in the relationship between the healthy parent and child were not universal, with evidence to suggest that strain and resentment might increase. Specifically, one participant expressed anger and resentment toward her father in relation to his care for his wife. As she put it, he “wasn’t giving his best to mum,” and without her mother to “act as a buffer,” the tension had continued beyond her death. Another participant echoes this notion of the healthy parent not doing what the adult child perceived as right when he described his disapproval of his father’s behavior toward his mother, and that consequently “I don’t make the same effort as I would have done before for him.” It therefore seemed evident to the authors that changes in the relational dynamics between a healthy parent and a child, in response to parental cancer, might occur in both positive and negative ways.

Participants also reported improvements in sibling relationships, because the experience of parental cancer often increased contact and opened communication between them. One participant reflected that “my relationship with my siblings is a lot stronger, it was never fraught but it wasn’t particularly close and we did a lot of talking during mum’s illness and then after.” For some participants it was however noted that the changes in relationships with other family members were at times problematic, and marked by increased conflict and resentment, especially in relation to care issues. For example, one participant felt that her brother and sisters should have been more involved with their mother’s care. Their refusal to help had placed her in the role of primary carer, a role that she adopted to support her mother, but which she did not enjoy, as is evidenced by her statement:
I don’t like it [being the main carer], I don’t like it and I have said to [my siblings] look I’m the baby, you’re all older, . . . but they just don’t help, they are now considering that she is better but when she was in her worst stages none of them came near her, they thought it would be best if they just stayed away cause I’m there but I didn’t go in there blazing and say I’m going to do it all.

*Altered Life Priorities*

The participants used a variety of phrases to express how parental cancer had, in some way, changed their outlook on life. Participants used expressions such as “don’t put things off,” “live for the day,” “I don’t care what people say,” and “I don’t take life so seriously;” sentiments that were cited as being positive changes that had arisen. One participant, who experienced having both parents with cancer, had become quite philosophical, and recognized the illness as a learning opportunity. She commented:

> If anything is sent to you like an illness like that in the family, that you can learn so much from it. You can either be very negative about it and see the worst side of it or you can see the better side and what you have learnt from it.

Some participants had made concrete changes to their career paths, or altered the pattern of their work. The most significant change was observed in one participant who, after the loss of her father, decided to become a “pioneer” and fulfill a long-held dream to develop a rural property. In doing so, both she and her husband left secure employment. When asked to reflect on that time, however, she did not mention the loss of career, but rather reflected that “it was a great thing because we created something together as a family that we had and that was new.”
Notably, the two men in the study made changes to their work patterns, with one turning down employment opportunities to allow him to continue to care for his father, and the second stated that “I . . . don’t work with the same rabid ferocity that I used to.”

The participants reported other changes to their outlook on life which included a greater willingness to try new experiences, travel, and a general slowing of the pace of their lives. From these recollections, it was clear to the authors that parental cancer might motivate some individuals to reassess both their vocational and personal goals, and to realign their behaviors to a path that better suited their new insights into life.

**Personal Development**

The participants also reported some beneficial changes in their views of self, however, this was to a substantially lesser degree (i.e., mentioned less frequently, with less emphasis placed on such changes, or less detail provided by the participants). The most commonly discussed changes were a sense of increased compassion (e.g., “I think probably a much greater awareness of what it means to other people when someone dies”), emotional maturity (e.g., “I don’t want to think about growing up and it just made me”), and the development of experiential wisdom (e.g., “[now] I always see life as a huge learning curve”).

The participants’ contact with the medical system was increased by having a parent with cancer. Some participants reported that this presented great challenges for them, especially in the perceived need to advocate for better care. Consequently, some participants felt that they developed increased confidence and assertiveness to deal with a system, which they perceived had failed in its duty of care. One participant described it in this way:

I think in some ways I have a greater confidence in some things . . . confidence in not letting a health system run itself so to speak, in being able to say well hang on a minute,
what is this? Why are you doing this? And challenging things, and that challenge may simply mean getting more information and that is all I need or having the care better, better quality of care.

The participant recounts also provided evidence which suggested that parental cancer increased their awareness of their own cancer risk, and several participants mentioned changes to their health behaviors. Specifically, participants described being more aware of preventative measures for sun exposure (e.g., hat, sunscreen), the need for regular medical checks, dietary changes, and changes to their medication usage. The participants also displayed some understanding of how lifestyle factors might have contributed to the development of their parent’s cancer (i.e., stress, drinking, and smoking). Typically, participants also identified similar behaviors in themselves, but reported that they had made no attempt to alter those behaviors. For example, one participant perceived that her parent developed pancreatic cancer “because he was too dependent on alcohol” and “he drank like a fish.” She later reported that she had questioned whether she had similar tendencies, and whether that meant that she would develop pancreatic cancer, but confessed that “it doesn’t stop me from having wine but it makes you wonder.”

Discussion

In conducting this study, we sought to gain an insight into the types of benefits that adults reported from the experience of having a parent with cancer. Four distinct benefit themes emerged, including positive changes in the relationship with a sick parent, an increased valuing of the family, altered life priorities, and personal development. However, we found that the emergence of such benefits cannot fully be examined and appreciated, unless one understands the emotional turmoil that accompanied this experience. The stories that were shared suggested
that, although some positive outcomes had emerged, it remained a time of intense struggle, emotional upheaval, and change. The stories recounted by the participants provided great insight into both the positive and negative aspects of what it was like to live through parental cancer.

The narratives detailed how parental cancer triggered a range of emotions that had the potential to overwhelm, and were considered traumatic. The language used by some participants indicated that they had evaluated the impact of their parent’s illness against other significant events in their lives, and often rated it among the most stressful. There is some discussion in the cancer literature regarding whether life-threatening illnesses, such as cancer, constitute trauma for family members. The Diagnostic and Statistical Manual of Mental Disorders IV-TR (American Psychological Association, 2000) now includes learning about the threat of death in a family member as a potential trigger of PTSD. Research evidence also supports the notion that PTSD can arise in family members of cancer patients. Smith et al. (1999) reviewed research that examined PTSD in cancer, and found that cases of PTSD were present in the parents of childhood cancer patients, which supports the suggestion that, in some circumstances, the stress of having a family member with cancer might give rise to clinical PTSD. Lindberg and Wellisch (2004) have suggested that the risk of PTSD might be increased for family members, who perceived themselves to be at an increased risk of cancer because of a possible genetic heritability (e.g., breast cancer). Although we did not examine the clinical symptoms of PTSD in the present study, the language used by the participants provided some insight into the magnitude of the impact that this experience had on them. Furthermore, the reported emotional upheavals, and the studies cited above, strengthen the argument that we must increase our understanding of how parental cancer impacts on adult children to ensure that we meet both the short and long-term adjustment needs of all family members.
Another important pattern that emerged from the data was that those participants, who appeared to have experienced a high degree of emotional turmoil and disruption to their regular routine, also reported a higher level of perceived benefits. For example, one participant described a strong emotional reaction to his father’s diagnosis, accompanied by a high degree of disruption, because he struggled to balance his care responsibilities with his work commitments. This participant also identified more areas of perceived benefit than any other participant. In contrast, another participant, who reported that her life had not changed that much because of her father’s cancer, reported minimal beneficial change. This pattern supports the underlying premise of theories which propose that growth is an outcome of negative life events (see Janoff-Bulman, 1992; Tedeschi & Calhoun, 1995, 2004). Indeed, such theories argue that an event must be stressful enough to disrupt one’s psychological equilibrium, and it is through the struggle to reestablish core psychological assumptions that positive change occurs. The data we obtained in this study seemed to support this theoretical contention; however, firm conclusions cannot be drawn because of the nature of the data. It is suggested that additional research examining this pattern should be conducted.

In terms of the types of benefits reported, the authors’ interpretation of the data suggested that they are similar to the types of benefits reported by cancer patients and their spouses. For example, Thornton’s (2002) framework of the benefits for cancer patients and their spouses classified these benefits into three areas: benefits associated with interpersonal relationships, life perspective, and the self. The adult children in this study clearly reported similar categories of benefits as those found by Thornton. Furthermore, there are some similarities in the types of benefits reported in this study and in the research by Kim et al. (2007), as the authors of both studies have reported benefits in the areas of appreciation, family, empathy, and reprioritization.
Thornton (2002) also investigated the frequency of benefits within each category, and found that, for the majority of people, cancer positively transforms familial relationships. A similar result was obtained in the present study, with the themes of transformed relationship with the sick parent, and an increased emphasis on the family strongly represented in the data. Similarly, Dumont, Dumont, and Mongeau (2008) reported that the relational context in family caregiving situations has the potential to enhance the existing ties between family members. Oktay (2005) and Tarkan (1999) also present cases in which enhanced parental relationships are clearly evident, adding additional support to the contention that parental cancer can have a positive impact on the individual’s family relationships. Although positive changes did arise, it is acknowledged that some participants also reported negative changes in their relationships with their siblings and the healthy parent. Although negative changes were mentioned less frequently, they are consistent with the findings of Curbow, Legro, Baker, Wingard, and Sommerfield (1993), who found that approximately 8% of their sample of bone marrow transplant patients reported declines in their familial relationships.

Although the authors acknowledge the similarities between the data presented in this study and the review by Thornton (2002), there are also notable differences. For example, Thornton identified benefits relating to self, such as taking time for oneself and higher levels of satisfaction with life accomplishments. These benefits are notably absent from the present data. There are several possible explanations of why minimal benefit finding emerged in the area of personal development. It is possible that, because the illness was in another person, the adult child’s attention was directed externally toward others, and therefore introspective self-reflection was reduced. Another alternative explanation is that parental cancer added to the workload of the child and, consequently, they were squeezed between their responsibilities to their parents,
career, and their own family. Consequently, they were “time poor” and therefore did not have the opportunity to engage in activities that might have enhanced their personal development.

Alternatively, the finding of different benefits associated with the self in the present study might be a by-product of the small sample size, and therefore an investigation with a larger sample is warranted.

Limitations

This study is to some degree limited by the characteristics of the sample, and the methodology employed. To be eligible for participation, individuals needed to have had a parent with cancer at some point in their adult lives (i.e., post 18 years). This gives rise to two problems, first, the period between the experience and the interview, and second, the broad range of cancer types that were discussed. The length of time between the experience of parental cancer and the interview varied greatly, the longest period being 25 years, the shortest just 12 months. It might be argued that the detail of recall can be affected with the passage of time, and the types of positive changes discussed might have been influenced by other life events in the interim period. Therefore, it is suggested that future studies of this nature provide some time frame in the eligibility criteria (e.g., within 2 years of diagnosis).

The second limitation in regards to the sample relates to the range of cancers present. In planning this study, the authors decided not to limit participation to a specific cancer type in an attempt to address the imbalance in the existing literature, which predominantly focuses on breast cancer. The range of cancer types, combined with the small sample size, might however have reduced the possibility of discovering important insights into the experience of parental cancer. For instance, it is conceivable that parental brain cancer, with the associated cognitive changes, is more traumatic than other cancer types, and that this might give rise to different
patterns of perceived benefits. An investigation with larger samples into particular cancer types might provide a fruitful avenue for future investigation.

A third limitation is the relatively small, heterogeneous sample. Data saturation was achieved in this study; however, the inclusion of other varied participants (e.g., a greater number of men, and people of alternate races and cultures) would offer the potential of finding additional themes missing from the data presented. However, Smith and Osborn (2003) argue that IPA studies typically involve small samples, because of the volume of data generated and the intensive analysis undertaken. Indeed, Smith and Osborn (2003) propose that a sample size of five to six is reasonable for interpretative phenomenological studies, and therefore the current sample is large by such standards.

The authors aimed to examine the type of benefits arising from parental cancer and, as such, the participants were interviewed once. Because of the cross-sectional methodology employed, it is unknown whether the type and level of benefits reported changed over time, both during the illness experience and after successful treatment or the death of the parent. This is an area that potentially deserves attention, especially if the ability to derive benefit from parental cancer assists the individual to find meaning in the losses that they experienced. However, Funk and Stajduhar (2009) argue that drawing conclusions about the family caregiving experience from interview data alone is fraught with problems, because the data represents both the individuals’ description of the experience and their coping efforts. It is argued that interview data be supplemented with longitudinal methods and observational techniques to enhance the depth of our understanding (Funk & Stajduhar, 2009). The inclusion of such methodological enhancements would allow for more detailed examination of the phenomenon of finding benefits within the adult child cohort, and therefore should be considered in the design of future research.
**Implications for Practice**

The findings we have presented indicated that the experience of parental cancer was emotionally distressing for adult children, and therefore programs, which support these family members, are essential. An important finding was that adult children were able to derive a range of benefits from the experience of parental cancer, but that this positive growth seemed to go hand in hand with the experience of distress and disruption. This finding needs to be acknowledged by those who have contact with the adult children of cancer patients, and it should not be assumed that, just because they have been able to “see the bright side” of the situation, they do not require support. Indeed, the suggestion that greater benefits arise from greater distress and disruption suggests that additional attention and support might be needed for such individuals.

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