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Differences in Emotional Well-Being and Communication Styles Between Mothers and Fathers of Pediatric Cancer Patients

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ABSTRACT. This study investigated 26 pairs of mothers and fathers of pediatric cancer patients to explore the relationship between parental communication patterns and parental psychological well-being as well as the possible differences between the communication styles of mothers and fathers. For mothers, open and frequent communication had a positive effect on emotional well-being, and spousal communication was particularly important. In comparison with fathers, mothers had significantly more positive perceptions of the family's overall emotional climate, evaluated the patient as significantly better adjusted, and communicated significantly more often and openly with the patient.

In the not-so-distant past, a "web of silence" commonly descended on families of chronically ill patients (Turk, 1964). The medical community usually condoned and even encouraged this practice, particularly when a child was affected by a life-threatening disease. More recent clinical evidence and anecdotal observations show that open, direct communication by family members about a serious illness can have a positive effect on the patient's and family's psychological and physical well-being. Increasingly, physicians, nurses, and social workers recommend that families discuss

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the existence and implications of a life-threatening disease in the family openly and honestly.

One common situation in which the issue of communication arises is in dealing with the pediatric oncology patient and his or her family. Medical advances have dramatically improved the five-year survival rate of these patients (*Decade of Discovery*, 1981). At the same time, the protracted and sometimes painful course of treatment, the harrowing cycle of remission and relapse, the continuing stigma associated with physical changes, and the disease itself make it impossible for families and patients to deny the diagnosis (Shumaker & Shapiro, 1982; Vettese, 1976). Consequently, physicians increasingly urge communication about the disease (Schowalter, 1978) and occasionally refuse treatment unless the family agrees to inform the patient of the diagnosis. But how much do we really know about the effect of open communication on the child-patient or on other family members?

Research to substantiate clinical observations of the benefits of open communication for families of pediatric cancer patients is still insufficient, both in focus and specificity. Not surprisingly, the identified patient (in this case, a child with cancer) has been the primary focus of research. As long ago as 1977, Kellerman et al. observed a relationship between disease-related communication and pediatric response to cancer. Their study dispelled assumptions that open communication about topics such as cancer, treatment, and death would be associated with increased psychological dysfunction in the patient. In fact, their data suggested a positive correlation between open communication and successful coping. Research also has shown a positive relationship between levels of family communication about the illness and adaptive psychological functioning in the identified patient (Kaplan et al., 1973; Spinetta & Maloney, 1978). More recently, researchers have examined the impact of communication on the psychological functioning of siblings of children with cancer. Studies show that shielding, avoidance, and lack of communication are common but harmful to siblings (Rosen & Cohen, 1981), whereas open communication with siblings increases their understanding of the illness, dispels their fears, and helps them express their own emotions (Koocher & O'Malley, 1981).

The effect of open communication on the parents of pediatric cancer patients has received the least research attention. Some evidence indicates that good communication between parents and med-

ical staff is related to positive parental adjustment (Stehbens & Lascari, 1974). Other investigators have pointed out that the failure of parents to communicate with one another places a strain on their relationship (Adams, 1979; Kaplan et al., 1973; Pearse, 1977; Sourkes, 1977). Maury (1982) documented differences between what mothers and fathers of pediatric cancer patients did or did not talk about and concluded that death and grief were the subjects least talked about by both parents. Rando (1983) suggested overall poorer adjustment in mothers than in fathers following the death of a child from cancer. Mothers in Rando's study tended to deal with loss through somatization, whereas fathers relied more often on anger.

This article reports on a study of communication patterns in families with a child who has cancer. These patterns relate to parental well-being and differences in perceived well-being and preferred communications between mothers and fathers.

METHOD

The study was conducted from August 1981 to March 1982. Both parents were eligible for the study, and both were required to be English-speaking; the child had to be 12 years of age or younger at the time of the interview, six months to two years past diagnosis in remission, and without cancer-related severe disfigurements. Sixty-nine families meeting the study criteria were contacted. Of these, 47 were randomly selected from families associated with a pediatric oncology unit at a children's hospital in Los Angeles, California. The remaining 22 families comprised the entire population of families associated with a smaller pediatric oncology unit at a children's hospital in Orange County, California. Data were collected through face-to-face interviews with the mothers and through questionnaires completed by both mothers and fathers. Complete data were obtained from 39 female respondents, 26 from Los Angeles and 13 from Orange County. Complete data also were obtained from 26 matching fathers. Four fathers refused to participate and nine failed to return the questionnaires. Reasons for noninclusion were failure to be interviewed because of staffing problems, drop-out because of the child's illness or other family pressures, and refusal to participate.

In the final sample, the mothers ranged in age from 23 to 45 and the fathers, from 25 to 49. The sample included 8 Hispanic and 18

Caucasian couples. The ages of the sick children ranged from 2 to 12 years, with a mean of 6.5 years. Time since the diagnosis ranged from six months to two years; all the children were in remission during the study. The majority had been diagnosed as having acute lymphoblastic leukemia.

Measures

Current levels of respondents' depression were assessed with the Beck Depression Scale, a standardized measure widely used with nonclinical populations. Psychological and psychosomatic symptoms were measured with Langner's 22-item screening score (Langner, 1962), a commonly used scale for assessing these symptoms in nonclinical populations. Self-esteem was measured with the Janis Personality Inventory (Janis, 1959), which is widely used to assess subjective valuations of self-esteem.

In addition, eight scales were constructed post hoc from interview and questionnaire data. These scales measured marital satisfaction; spousal agreement on disease-related issues; frequency and openness of communication between parents, child, and siblings; coping strategies that relied primarily on communication with friends, relatives, and professionals; respondent's mood in relation to the child's disease; and parental perception of the child's emotional and behavioral adjustment after diagnosis and treatment. The reliability of the scales, as measured by Cronbach's alpha, ranged from .70 to .90, with the majority of reliability coefficients ranging from .80 to .89.

Mothers in the study completed all measures. Fathers completed measures of mood, marital satisfaction, spousal agreement, communication with the spouse, and communication with the child.

Data Analysis

Because of the large number of variables and the relatively small number of subjects, canonical analyses were used. Data analyses investigated the relationship between parental communication patterns and parental psychological well-being as well as possible differences in the communication styles between parents.

RESULTS

Mothers. A canonical analysis was performed on the data subset of mothers only to determine whether a relationship existed between maternal emotional well-being (including levels of depression, self-esteem, presence of psychosomatic symptoms, and marital satisfaction) and the frequency and openness of communication about their child's illness. The multivariate test of significance indicated that the mothers' emotional well-being was positively related to open and frequent communication patterns ($F = 2.15$, $df = 16$, $p < .01$). Analysis of variance revealed two clearly interpretable canonical variables. As shown in Table 1, the first canonical variable, high communication, was highly correlated with self-esteem, few psychosomatic symptoms and marital satisfaction. This variable also was highly correlated with the covariate communication with spouse. The second canonical variable, low communication, correlated with high depression, poor self-esteem, and a high number of psychosomatic symptoms. This relationship also was strongly negatively correlated with the covariate communication with siblings. Further evidence for this inverse relationship between the respondent's well-being and communication with siblings was provided by a within-cells regression analysis in which communication with siblings was significantly correlated with depression, poor self-esteem, and psychosomatic symptoms ($t = -1.99$, $p < .05$; $t = -2.57$, $p < .02$; and $t = -3.00$, $p < .01$, respectively). Marital satisfaction, on the other hand, was positively correlated with both communication with spouse and spousal agreement ($t = 2.3$, $p < .03$, and $t = 2.1$, $p < .05$). Communication with the child was not significantly related to maternal well-being.

Fathers. A canonical analysis was performed on the data subset of fathers only to determine whether a relationship existed between the fathers' emotional well-being, as measured by mood and marital satisfaction, and frequency and openness of their communication. The multivariate test of significance revealed an overall significant effect ($F = 5.23$, $df = 6$, $p < .001$), with emotional well-being significantly related to communication about the child's illness (see Table 1). The first canonical variable showed a strong correlation with marital satisfaction. This variable also was highly correlated with scales of both spousal and child communication. The second canonical variable, low communication, showed a strong correlation with negative mood. It also showed a strong negative correla-

Table 1. Well-being of Mothers and Fathers in Relation to Communicative Coping: Correlations Between Dependent, Covariate, and Canonical Variables

Dependent Variable	Function 1 High Communication	Function 2 Low Communication	Covariate Variables	Function 1 Positive Well-being	Function 2 Negative Well-being
			Mothers		
Depression[a]	.33	-.51	Spousal agreement	.83	.30
Self-esteem[b]	.67	-.55	Communication with spouse	.85	.32
Psychosomatic symptoms[c]	.67	-.44	Communication with siblings	-.22	.80
Marital satisfaction[d]	.86	.43	Communication with child	.07	.11
			Fathers		
Mood[d]	-.34	.94	Spousal agreement	.44	-.84
Marital satisfaction[d]	.91	-.42	Communication with spouse	.93	.20
			Communication with child	.72	-.24

[a]Scores obtained with the Beck Depression Scale.

[b]Scores obtained with the Janis Personality Inventory.

[c]Scores obtained with Langner's Scale for assessing psychiatric and psychosomatic symptoms.

[d]Scores obtained with authors' post-hoc scores.

tion with spousal agreement. Further supporting evidence for these relations was found in the within-cells regression analysis. Fathers who tended to agree with their wives to a high degree about the child's illness tended to have a more positive mood ($t = -2.00$; $p < .05$). Fathers who reported high marital satisfaction communicated with their wives significantly more often and openly than fathers who did not ($t = 2.5$; $p < .02$).

Mothers versus fathers. Mothers were compared with fathers with a repeated measure statistic, comparing their perceptions of the overall emotional climate in the family. This included the health of the marital relationship, the mood of individual respondents, and the parents' perceptions of the child's adjustment. The results of the overall multivariate test of significance were significant ($F = 109.91, df = 3, p < .001$). Fathers had significantly poorer perceptions of the family's overall emotional climate than did mothers, but univariate analysis indicated no significant differences between spouses in their perceptions of the marital relationship or of their individual mood. However, in both cases fathers reported more dissatisfaction and more negative feelings than did mothers. They evaluated the child with cancer as suffering from significantly more behavioral and affective disturbances than their wives did ($p < .001$; see Table 2).

Table 2. Parents' Mean Scores on Scales Measuring Communicative Coping and Perceptions of the Family's Emotional Environment

Scale	Mothers		Fathers	
	Mean	SD	Mean	SD
Communication[a]				
Communicative coping	38.5	8.4	40.2	7.7
Agreement with spouse	10.8	3.5	11.2	2.6
Communication with spouse	11.8	4.3	11.5	4.1
Communication with child	19.8	4.9	12.3	3.1
Perceptions of family's emotional environment[a]				
Marital satisfaction	10.8	3.8	10.4	3.6
Mood	34.6	4.8	36.0	4.4
Perception of child's adjustment	12.8	4.2	30.5	3.0

[a]Scores obtained with authors' post hoc scales.

Differences in the mothers' and fathers' overall reliance on communication as a coping strategy also were investigated. This analysis included scales of communicative coping, communication with spouse, spousal agreement, and communication with child. The results of the overall multivariate test reached significance ($F = 11.82$, $df = 4$, $p < .001$), and univariate analyses indicated no significant differences between spouses in terms of communication with friends and professionals or with each other. However, mothers reported communicating significantly more often and openly with the child than did fathers ($p < .001$; see Table 2).

DISCUSSION

This study, despite the small number of subjects, provides evidence supporting the assertion that open and frequent disease-specific communication, especially within the family, is positively related to enhanced psychological and physical well-being in both parents (see Figure 1). However, the more detailed analyses suggest that the nature and direction of this communication may need to be considered and that injunctions to communicate per se may not be specific enough. According to our analyses, the mother's well-being depended most strongly on supportive communication and exchange with her husband. Anecdotal data suggested that this communication was mutual, with both spouses giving and receiving emotional support, sharing together, and problem solving together. This finding makes intuitive sense and is in line with the principles and theory of family therapy, which stress the importance of a healthy marital dyad in overall family functioning.

However, a less obvious finding is that mothers with greater depression, lower self-esteem, and many psychosomatic symptoms appeared to communicate more frequently with the ill child's siblings about the child's disease than did more psychologically intact mothers. This counterintuitive finding suggests a potentially significant qualification of the concept of open communication. This finding becomes even more perplexing when viewed in the context of existing research documenting that open communication with siblings about their brother or sister's cancer *is* positively correlated with improved psychological adjustment, behavior, and school attendance.

The anecdotal data revealed that families scoring high on the communication with siblings scale might be viewed in family ther-

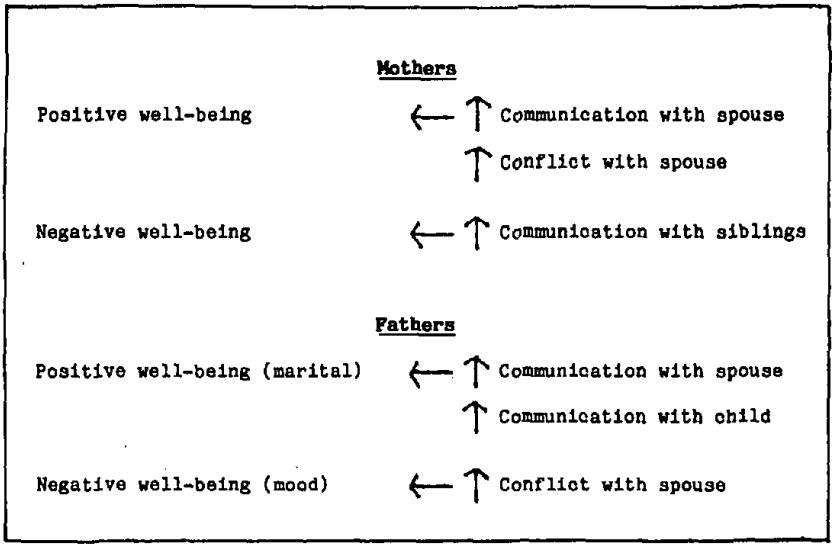

FIGURE 1. A Comparison of Communicative Factors Related to Maternal and Paternal Well-being. (Up arrow = positive sense of well-being; down arrow = negative sense of well-being.)

apy terms as having a parental child or hero child in the household. These families were characterized by an emotionally distant or isolated father who participated little in the family's day-to-day life. Thus, the mothers who reported a high degree of communication with the patient's siblings may have been compensating for the absence of an accessible husband, which may have enhanced their own psychological and physical distress. This explanation is bolstered further by examining the content of the communications between these mothers and the patient's siblings. In a large number of these exchanges, the mother is asking for emotional support and for help, sharing her own worries and negative feelings, and discussing problem-solving logistics or medical expenses. Although this openness, to a certain extent, may be healthy, there is a sense in these families that the mother is abrogating the parental role and appearing (and perhaps feeling) at least as helpless and confused as the patient's siblings.

The fathers' feelings of well-being, like those of the mothers, also appeared to be related to open and frequent communication with their wives. On the other hand, the strongest negative influ-

ence on the well-being of both parents was the presence of chronic unresolved conflict between them about perceptions of the meaning, seriousness, and treatment of the child's illness.

Fathers perceived the overall family environment more negatively than did their wives. The greatest area of perceived difference concerned their perception of the ill child's emotional and behavioral adjustment. Fathers felt that the child was significantly less well adjusted than their wives did, and they also communicated less openly and frequently with the ill child. This pattern of communication with the patient lends partial confirmation to family models of chronic illness, which identify the father as at risk for isolation from the family unit. In the majority of cases, day-to-day care is the mother's responsibility, which increases her natural opportunities to communicate with the child. This frequent, natural communication may give the mother a healthier attitude toward the child—she may perceive the child as a basically normal, functioning person who is simultaneously struggling with a life-threatening illness. A father who has a more remote relationship with the child may focus on the devastating effects of cancer on his child's life in an abstract sense, which in turn may lead him to perceive the child as more decompensated than the child actually is. In the absence of objective data evaluating the child, however, it is impossible to determine whether the mother's or the father's view of the child would conform more closely to an independently validated judgment.

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