


Family Communication About Cancer in Korea: A Dyadic Analysis of Parent-Adolescent Conversation

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Heeyeon Son¹  and Laura E. Miller¹

Abstract

Parent-adolescent communication is important in the context of childhood cancer. However, we know little about the communication experiences between Korean adolescents and their parents. Here, we conducted a secondary analysis of interview data from a qualitative descriptive study to explore Korean parent-adolescent communication experiences as a unit. Specifically, our dyadic analysis of individual interviews with seven Korean adolescents with cancer and at least one parent included inductive analysis at the individual level and cross-analysis to generate themes. The main theme was “*Experience the same thing, but see it differently*,” along three subthemes: (1) different expectations for parent-adolescent communication, (2) different views on communication challenges, and (3) limited sharing and no progress in the conversation. Overall, our findings provide insights into different communication expectations and preferences between Korean adolescents and parents, and reasons for communication challenges, while emphasizing the individualized assessment of parent-adolescent communication between them.

Keywords

parent-adolescent communication, cancer, dyadic analysis, Korea

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Recent pediatric studies have demonstrated the critical role of effective communication in improving patient outcomes and quality of life (Adduci et al., 2012; Sisk et al., 2022). Parent-adolescent communication, a form of family communication between adolescents and parents, is defined as family members’ ability to share their thoughts, feelings, and concerns with each other without restriction (Haase et al., 2014). Engaging in parent-adolescent communication can help adolescents with cancer to cope with living with a cancer diagnosis, and can facilitate their adjustment (Adduci et al., 2012; Keim et al., 2017) and resilience (Haase et al., 2017). Fostering open and clear communication between adolescents with cancer and their parents is widely recommended to improve their quality of life and treatment-related outcomes (Jalmsell et al., 2015; National Cancer Institute, 2015; Rodriguez et al., 2013). Yet, many families of children and adolescents with cancer struggle to communicate. To develop effective interventions for families to engage in quality communication and produce positive outcomes (such as adaptation and resilience), understanding the current level of parent-adolescent communication and the reasons for communication challenges or barriers is crucial.

Introduction

Parent-Adolescent Communication in Korea

In Korea, over 200,000 new cases of cancer are diagnosed and reported annually, with adolescents and young adults accounting for 7.5% of cases (Jung et al., 2014). A total of 887 adolescents aged 10 to 19 were newly diagnosed with cancer in 2020 (Ministry of Health and Welfare, 2023). Korean adolescents with cancer and their parents may be one of the most representative populations facing challenges in parent-adolescent communication in the Korean family culture. Traditionally, Koreans believe that it is wiser to express their opinions through actions than words (J. Lee & Choi, 2003). A typical tendency is to hope that others will notice hidden messages that are not directly expressed in words. In addition, traditional Korean culture values the goals and

¹University of Tennessee, Knoxville, USA

Corresponding Author:

Heeyeon Son, College of Nursing, University of Tennessee, Knoxville, 1200 Volunteer Blvd, 1412 Circle Drive, Knoxville, TN 37996, USA.
Email: Hson4@utk.edu



optimal function of the group over the individual's autonomy or right to know. Thus, Korean culture might place a different value on truth-telling, thereby inhibiting the discussion of cancer-related topics. The family centered model supports hierarchical relationships, which can disrupt family communication and decision making (S. Kim et al., 2014). In traditional Korean families, caregivers (in this case, parents) are expected to make decisions for their children with severe medical conditions rather than sharing and discussing their thoughts and concerns. Therefore, the practice of parent-child/adolescent communication in Korea has been described as a one-way vertical relationship that allows parents to hide bad news from their children. This can inhibit open and clear communication between Korean adolescents with cancer and their parents (Wiener et al., 2013).

One study has explored the parent-adolescent communication experiences among Korean adolescents with cancer and their parents (Son et al., 2020). It revealed important findings related to the challenges in family communication among Korean adolescents with cancer and their parents from individual perspectives. However, recent evidence indicates possible discrepancies in explaining and interpreting the same experiences among pediatric cancer patients and their parents, and the necessity of listening to both parties (Koutná et al., 2021; Montgomery et al., 2021; Rensen et al., 2020). To the best of our knowledge, no study has focused on the commonalities and divergences in parent-child communication experiences in the context of childhood cancer. By conducting a dyadic analysis of data from the aforementioned study (Son et al., 2020), we hope that our findings expand the literature assessing adolescents' experiences in family communication.

Dyadic Approach

Here, we employed a secondary analysis of the original qualitative data to provide a detailed description of the participants' shared experiences in dyad units by applying a dyadic analysis (Collaço et al., 2021). According to Eisikovits and Koren (2010), dyadic analysis of interview data is useful when a researcher is studying an experience shared by both members of a dyad. Importantly, a dyadic analysis is more than the sum of the individual interviews. It helps researchers identify the overlaps and contrasts between dyadic participants at various levels. It is preferred by researchers studying family communication because it promotes a better understanding of the constitutive nature of family communication (Baxter, 2004), and in observing family communication practices in creating and making meaning across situations and contexts (Manning & Kunkel, 2015). One of the greatest benefits of dyadic analysis is gaining a genuine sense of family members' interactions.

Purpose

We conducted a dyadic analysis of interview data from Korean adolescents with cancer and their parents to show the

commonalities and differences in their perspectives on their communication experiences with each other. Specifically, the aim was to highlight the differences in adolescents' and their parents' views and experiences of communication in the context of pediatric cancer.

Method

Study Design and Participants

We conducted a secondary analysis of interview data from a qualitative descriptive study (Son et al., 2020). A qualitative descriptive design was chosen to provide straightforward descriptions of experiences and perceptions, which have rarely been explored (Sandelowski, 2010). This methodology is widely used in nursing research as it recognizes the subjective nature of the problem and the different experiences of participants, and presents findings in the most practical way based on constructionism and critical theories that use interpretive and naturalistic methods (Doyle et al., 2020).

Participants were recruited between June and August 2018 using convenience sampling. Physicians reviewed medical charts and recommended eligible study participants to the principal investigator. Eligibility criteria for adolescents were: (a) aged between 13 and 19 years; (b) received a diagnosis of cancer, regardless of treatment status; (c) knew that they received a diagnosis of cancer; and (d) did not have any limitations on participating in the interview (e.g., being isolated due to low Absolute Neutrophil Count or a physician's recommendation not to participate because of their condition). Eligibility criteria for parents were (a) aged 20 years or more and (b) if applicable, have a partner's consent to participate. From the 13 dyads of native Korean adolescents with cancer and their parents contacted, three declined to participate. Their specific reasons were psychological stress due to the recent recurrence of cancer, negative experiences from a previous research study, and no reason provided.

Ethical Considerations

Approval from the Institutional Review Board at the study site (Severance Hospital IRB: 420180392) and participating institutions (Duke University IRB: Pro00105744) was obtained before recruitment. All study participants were fully informed of the study purpose, expectations, procedures, potential harm, confidentiality, and no expected disadvantage of dropping out of the study or participation. Prior to data collection, the researchers obtained parental consent and permission from minor adolescents younger than 19 years, as required by the institutions. All study participants (dyads) were compensated approximately \$40 USD. Attending physicians provided post-assessment of psychological distress; when necessary, referral was available to avoid potential harm to the study participants because of answering sensitive

Table 1. Guide for Semi-Structured Interviews With Korean Adolescents and Their Parents.

Please tell me about your relationship with your parents/adolescents before the adolescent received a diagnosis of cancer.
Please tell me about your relationship with your parents/adolescents after the adolescent received a diagnosis of cancer.
Please tell me about your communication with your parents/adolescents
What is good/positive/open communication with your parents/adolescents, in your opinion?
Please tell me about your engagement in good/positive/open communication with your parents/adolescents.
Please tell me about sharing your feelings and emotions with your parents/adolescents
Please tell me anything that you would like to share with adolescents with cancer/parents who are in the similar situation (in terms of family communication).

questions. However, none of the participants reported psychological distress after participating in the study.

Data Collection

One-time, semi-structured interviews using open-ended questions were conducted with 10 dyads of adolescents with cancer and one of their available parents in the original study (Son et al., 2020). All interviews were conducted separately to maintain the privacy and transparency of the shared information. The first author of this study interviewed all participants in Korean. This author was a Korean-speaking PhD candidate with 5 years of clinical experience in working with children with cancer and their families, and had received training in conducting qualitative research. All interviews were conducted in Korean to capture and preserve articulate and fluent responses in their mother tongue. None of the authors of this manuscript have been involved in the treatment or care of the adolescent participants. Most interviews took place in isolated consultation rooms at pediatric hematology-oncology clinics, in study settings, or at the study participants' homes for their convenience. Each interview lasted 30 to 40 min. The interview guidelines were developed based on a literature review and are presented in Table 1. The same questions were asked to both adolescents with cancer and their parents. Based on participants' answers, probes were provided to draw rich descriptions from both. Frequent rest was allowed when needed. Participants could skip answering the questions if they felt uncomfortable. All interviews were audio recorded and transcribed verbatim. Field notes were taken during the interviews to provide cues for non-verbal communication of the study participants and the interview context.

Translation. Professional bilingual editors conducted forward and backward translations before analyzing the interview transcripts to accurately reflect the content and construction of the original interview transcripts (Lopez et al., 2008; Santos et al., 2015).

Data Analysis

Interview transcripts of 7 of the 10 dyads were selected for this secondary analysis. A dyad's transcripts were selected

based on whether its interview included (1) descriptions of the same event or experiences and (2) either overlapped or contrasted in the description about their parent-child communication practice. Qualitative dyadic analysis was conducted using QSR International's NVivo 12 qualitative data analysis software to identify themes characterizing adolescent-parent communication and their relationship (Eisikovits & Koren, 2010).

Initially, the dyadic analysis involved key qualitative analysis procedures at the individual level. The procedure included: (1) familiarizing oneself with the data; (2) generating initial codes by highlighting significant statements, sentences, and quotes by cross analysis; (3) searching for themes; (4) reviewing themes; (5) defining and naming themes; and (6) reporting findings. The first author initially familiarized herself with all the data by repeatedly reading the transcripts and listening to audio recordings. Next, the researcher highlighted the significant segments and sentences, and coded each transcript. The codes were then reviewed and clustered based on their similarities. The grouped codes were used to create subcategories and categories to generate themes based on individual interview transcripts. The uniqueness of the dyadic analysis was the examination of themes from each individual narrative by assessing the contrasts and overlaps between them. After reviewing them, we divided the tentative themes into four categories to examine the contrasts and overlaps: (1) overlap in description and interpretation, (2) overlap in description but contrast in interpretation, (3) contrast in description but overlap in interpretation, and (4) contrast in both description and interpretation. The dyadic view allowed reconstructions of the existing themes and unique sub-themes reflecting the dyadic views on the parent-child communication experiences.

The second author, a senior researcher experienced in qualitative research and communication scholarship, then reviewed these generated themes. The final theme were generated after several discussions between the authors: "Experience the same thing, but see it differently." This theme was represented by three sub-themes: (1) different expectations for parent-adolescent communication, (2) different views on communication challenges, and (3) limited sharing and no progress in conversation.

Table 2. Participant Characteristics.

Characteristic	<i>n</i>
Adolescents (<i>n</i> = 7; 14–19 years, <i>X</i> = 17.3 years)	
Sex	
Male	4
Female	3
Diagnosis	
Leukemia	1
Brain tumor	3
Rare diagnosis	1
Rhabdomyosarcoma	1
Embryoma	1
Time since diagnosis (<i>n</i> = 10 parents)	
3 months to 1 year	2
2–3 years	4
Over 3 years	1
Treatment status	
On treatment	4
Remission/survivorship	3
Parents (<i>n</i> = 7)	
Sex	
Male	2
Female	5
Economic status	
High	0
Medium	6
Low	1
Education	
Less than 12th grade	0
High school graduate	5
College graduate	2
Graduate or professional degree	0

Note. A high economic status is \$5,758 or greater per month, medium is \$2,578–\$5,757, and low is \$2,577 or less.

Trustworthiness. The trustworthiness of the findings was maintained by taking field notes during the interviews, taking reflective memos on researchers' values and interests that may influence research work, recording memos on coding selections, having a rationale for analytic decisions as part of the audit trail, receiving feedback from healthcare providers in the research setting, and peer examination (Guba, 1981). Member-checking was not conducted to prevent participants from experiencing additional distress (Birt et al., 2016).

Findings

Participant Characteristics

Data from seven dyads of adolescents with cancer and their parents were used in this secondary analysis. The major demographic and clinical characteristics of the study participants are presented in Table 2.

Theme and Subthemes

The main theme that resulted from this dyadic analysis was: "Experience the same thing, but see it differently." Of the seven dyads, six dyads showed some level of discrepancy in their perceptions regarding parent-adolescent communication. These differences in communication experiences were captured by three sub-themes (see Figure 1) and described in the following sections.

Different Expectations for Parent-Adolescent Communication. Adolescents and their parents described how they communicated with each other in terms of topics and frequency in a similar manner. However, they shared different opinions on how they openly communicated. For example, mother (#1), who had a daughter with a brain tumor, explained how she openly communicated with her child without holding back anything. However, her daughter complained that her mother was not being honest with her and learned that her mother was trying to avoid communicating with her regarding her cancer diagnosis.

I mean there's no reason to hide them from each other, she should know what's up so that she could handle things. I don't think there's any need to hide, well, if any, if I really need to hide something, it would be because whatever it won't be of any help to my daughter . . . I tell her that you will need such and such shots, this drops your immunity level so don't eat, and hey you have such and such number of treatments left so hang in there, that sort of things . . . those are the type of plans I share with her. [Mother #1 of a girl #1]

I don't talk about my tumor, I cry when we talk about it . . . but I know they are avoiding talking about my tumor because she (my mom) says I don't have hair, that I should wear a hat every day and everywhere. That's when I felt that she isn't feeling comfortable with my cancer, and she didn't talk about it. I want to know more about what kind of tumor I have something like that . . . [Girl #1]

Her mother did not tell her that she did not want to communicate about her cancer diagnosis; instead, she talked about cancer-related topics, such as treatment plans or future goals, with her daughter. However, the daughter felt that her mother was avoiding communicating with her. She may have wanted to communicate on other topics that her mother perceived as harmful or difficult to discuss. This gave her the impression that her mother was not open to her and avoided communication. This reflects the discrepancies in the communication expectations of adolescents and parents, and their own definitions of open communication.

Similarly, a girl with a brain tumor (#2) and her mother echoed this and showed what happened when their needs were not met. Specifically, both the daughter and her mother reported that they were experiencing challenges communicating with each other. Her mother mainly communicated

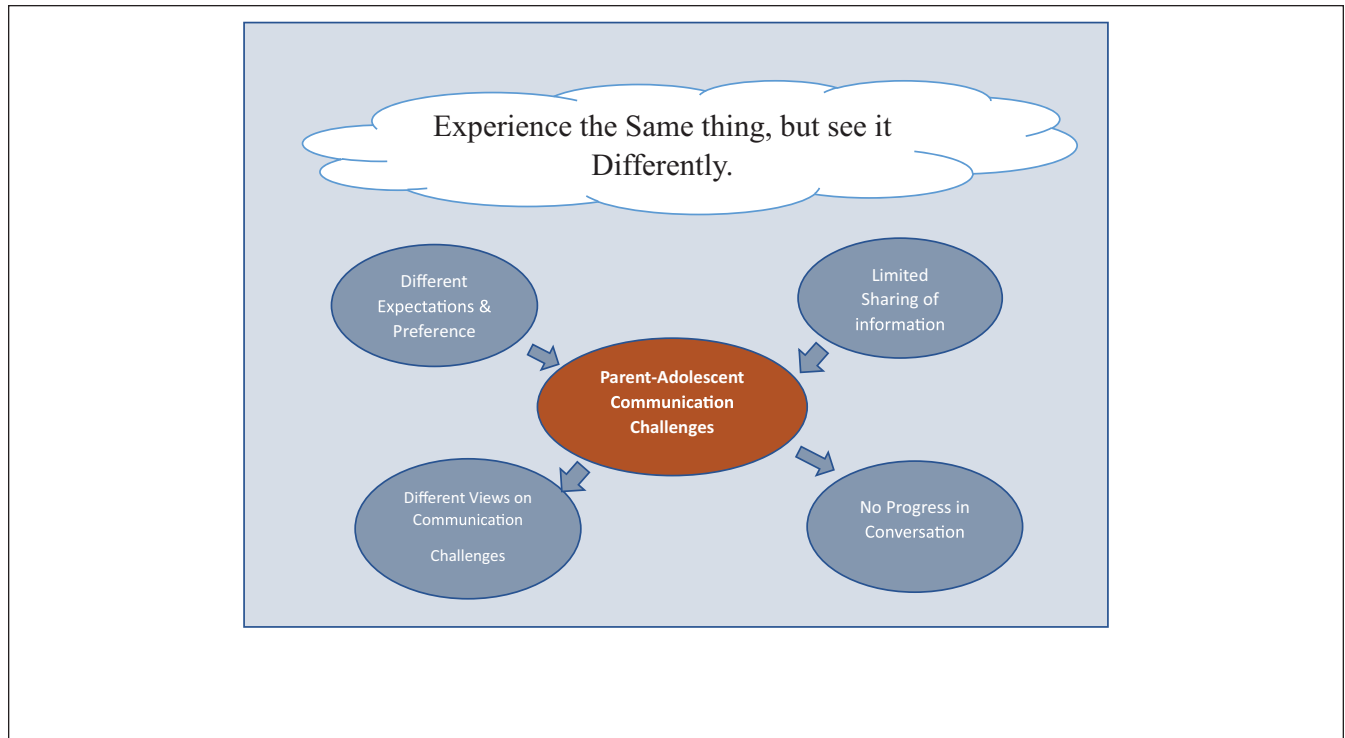


Figure 1. Main theme and sub-themes describing dyadic communication patterns among adolescents with cancer and their parents.

about regular exercise, focused on rehabilitation, and did not allow her daughter to share emotional aspects. The mother firmly believed that sharing emotions made them weak and should be avoided. She explained this:

My daughter says she cries when talking with the therapist and all, but I won't let her cry in front of me because it makes her weak. I tell her "Don't you cry!" flat like that. We don't particularly talk about the matter because you need to be firm and strong, she should be and so should I. She has a long way to go with the therapy and I sensed she was becoming weak mentally. Also, her eagerness seems to fade as therapy continues so I stop her from being sentimental. I tell her to be strong, don't be mentally weak. [Mother#2 of a girl #2]

However, her daughter wanted to share her emotions and hardships. The different expectations of communication discouraged her daughter from communicating with her mother, and consequently, she suffered from loneliness.

No, I haven't shared with my mom that much. Mom took me to this Curves thing (fitness club) and scolded me saying you won't get better if you don't work out, it's not going to come back . . . she used to tell me that . . . [Girl #2]

When her needs were not met, the adolescent reported her thoughts related to suicide, as represented by her quotation, "Sometimes, I regret that I was born and thought about committing suicide . . ."

Further, parents and adolescents may have different expectations for the timing, not just the content, of communication. A boy with rhabdomyosarcoma and his father experienced the following when his father disclosed the cancer diagnosis. The father (#3) explained that despite the difficulties, it took only 1 day for him to disclose his son's cancer diagnosis. However, his son remembered that it took longer than his father thought: 7 days. Essentially, the son and father perceived pertinent communication events differently, which impacted their overall experience of learning about the cancer diagnosis.

When I came to the hospital, the physician didn't tell me at first. My father received a call from the hospital. I noticed it by my sense. He hid the facts for a while, about 7 days. And then later he told me. [Boy # 3]

When I heard the results on the phone, I told the doctor I would say but I couldn't say that on the first day. I didn't know how I should start; I could just say directly but it was hard so skipped a day and told him the next day when my son said that I had a strange face from the day I received a call. It might have been better to just tell him on the same day, but it wasn't that simple, so I did the next day. [Father #3 of a boy #3]

Different Views on Communication Challenges. Most adolescents and their parents agreed that they were experiencing challenges communicating with each other. In the previous study by Son et al. (2020), participants reported that the main

barrier to engagement in parent-adolescent communication was their desire to protect one another from expected emotional suffering. Here, we focused on the different reported reasons. For example, a boy and his parents both realized that the boy had become quiet and introverted despite the parents' efforts to communicate. The father explained that he became reticent after his son's cancer diagnosis:

My son was talkative before his diagnosis. There was an anecdote illustrating how he was talkative before the diagnosis: One day I was summoned to interview with the vice-president of the school because he got penalty points for talking too much in class when he was in his first semester of the first grade. He used to have a lot of friends . . . but after all that happened, he became completely silent . . . [Father #4 of a boy #4]

The father was concerned about his son's shift in communication. After the cancer diagnosis, the father worried about his changes, but his son refused them. The boy explained that he had been reticent since he was born, and nothing changed after his cancer diagnosis. He might not want to accept the fact that he changed and the impact of the cancer diagnosis had on him, or that he really believed that he was reticent in nature. He explained this:

I think there was not much change after I got sick, I am kind of blunt. And, I think we didn't have much conversation regarding my diagnosis . . . we just talked like we always did [Boy #4].

The case of a girl and mother (#2) was similar. The mother stated that she could not communicate effectively with her daughter due to her limited capabilities. For example, she wanted to talk about her daughter's future plans but thought that her daughter could not comprehend them because of complications from several brain surgeries.

We don't talk about future plans or prognosis . . . I don't think she can reach that far. I sense she isn't yet capable of thinking about that kind of thing; that's what I see, she can handle simple matters but once you dig into the details . . . There really isn't much she can do although she may think a lot. So, even if we have conversation, she keeps losing her memory so it's hard to keep things going logically. As of now she struggles to talk about what she's thinking; that's how I see it. So, we do the simple talks but without details. She can't seem to handle them. [Mother #2 of a girl #2]

However, the daughter explained that her mother did not listen to her and had a dominating attitude. She reported that this attitude prevented them from advancing and having deeper communication: "I don't think she listens to me (crying)—she sounds forceful. She always told me that 'You need to do this, you must do that' . . ." [Girl #2].

Limited Sharing and No Progress in the Conversation. Differences in engaging in communication also arise from gaps in

knowledge and information related to the cancer diagnosis. Although all adolescent participants were informed about their cancer diagnosis, some were not fully informed about their prognosis or expectations. Specifically, when there was poor prognosis and side effects, parents had difficulty sharing this information with their adolescents. This limited sharing resulted in a knowledge gap between the parents and their children. For example, a boy (#5) was unaware that he would not grow after chemotherapy. He dreamed of becoming taller to be a model and kept talking about this dream. His mother could not comment on this and kept it to herself because she wanted to keep her son from being hurt:

My son doesn't know he stopped growing. I couldn't tell him because I was worried how he would take it being a teenager. He wants to grow as tall as 186 cm and says to himself maybe he should become a model after that. So, I've kept it to myself. [Mother #5 of a boy #5]

The failure to share adolescents' prognoses prevented them from engaging in honest and open parent-adolescent communication, as illustrated in the following case: A girl with a rare cancer diagnosis did not know exactly about her condition, that her disease was rare, and that there were no possible treatment options. Therefore, her mother could not share the truth and gave her daughter false encouragement.

Until March my daughter's condition was not good, was having a hard time, the symptom suddenly showed up, but after that the medical procedure went well so now the treatment is made without pain but it's still in progress it's just (cry). She thinks it will be healed but I can't say all the details, I say yes it will, if you hang in there tight things will get better so we're just holding up for now (cry). [Mother #6 of a girl #6]

Limited information sharing may have caused the girl to suffer alone while experiencing unexpected cancer-related symptoms. Although she reported being aware of her exact diagnosis, she in fact did not know. She also identified limited sharing as a strategy for protecting her mother from further suffering.

At first, my mom was not willing to tell me the diagnosis because I was only 16 years old at that time . . . she thought that I could search all the information related to my diagnosis once I was informed. She might be afraid of that . . . However, I kept asking her my diagnosis and she told me, and she told me not to take it seriously, but focusing on treatment, keep thinking that I can be cured . . . we haven't discussed any details after that . . . So, I was so fearful when I first vomited with blood . . . However, I couldn't tell her because I know that if we talk about it, it will make her suffer. [Girl #6]

Meanwhile, in one case, a parent shared necessary information with her son and they reached a mutual understanding. They showed that they faced fewer challenges in sharing

their thoughts. By sharing everything, they were able to advance and deepen their conversation:

Sometimes I told him more decisively that human beings are gone when God calls them, that you don't know what the future holds . . . I told him all that, and that since he knew about the disease early on it should be fine with good treatment. He's young but I told him so. He has the assurance of his salvation, and he told me that he was fortunate to have this type of cancer.
[Mother #7 of a boy]

Discussion

This secondary analysis study explored the differences in adolescents' and their parents' views and experiences of parent-adolescent communication in the pediatric cancer context. Focusing on adolescent-parent dyads as a unit, we found that adolescents and parents had different perspectives and experiences in communicating with each other, as represented by the overarching theme of "Experience the same thing, but see it differently." First, both had different definitions or expectations for open parent-adolescent communication, as represented by the theme "different expectations for parent-adolescent communication." For instance, one mother believed that she openly communicated about her child's cancer diagnosis while holding back topics that elicited emotional conflict. This finding is consistent with Goldsmith and Domann-Scholz (2013), who focused on a different context of couples' coping with cardiac events. For example, one participant with chronic heart disease reported that he was open to his partner while still hiding his concerns or avoiding discussing cardiac arrest-related topics, whereas his wife considered not holding anything back as open communication. Essentially, the authors found a similar potential disagreement on the definition of "open communication" among participants in the life-threatening, chronic illness context. Different perspectives on desirable communication are also common in childhood cancers. A study examining the communication preferences of clinicians, adolescents, young adults, and their parents reported discrepancies (Srinivas et al., 2022). For instance, adolescents and young adults reported the importance of tone, non-verbal communication, and attitude, while their parents emphasized content alone. This finding implies a potential gap in defining open or desirable parent-adolescent communication, and supports the necessity of individualized assessment.

Second, adolescents and their parents had different expectations of communicating with each other. Parents sometimes preferred to share their practical issues, whereas adolescents preferred to share their feelings and concerns. Therefore, parents sometimes discouraged the sharing of emotional aspects and encouraged adolescents to focus on practical issues. However, sharing emotions is important because it is critically related to coping and adjustment (Adduci et al., 2012; Keim et al., 2017; Son et al., 2020).

Adolescents with cancer are a unique population that faces numerous physical and psychological challenges during their transition period, which manifest as fear, worry, sadness, anger, loneliness, and uncertainty (Chien et al., 2020). If they have no opportunity to relieve their negative emotions, they may experience unexpected negative outcomes (Y. J. Kim & Kwon, 2013; Seth, 2010). However, the opposite can also be true. In general, adolescence is a developmental stage characterized by striving to achieve autonomy and control over life. Worsened parent-adolescent relationships and difficulties in communication are common (Lennon et al., 2015). As one boy mentioned, they may not want to talk. These findings were also reported in a study on children's preferences for participating in treatment decision-making in the pediatric cancer context (Kelly et al., 2017). Therefore, we need an assessment of expectations and preferences for engagement in parent-child communication.

Third, adolescents and parents had different views on communication challenges. As described in the literature, the main barrier to parent-adolescent communication was the desire to protect one another. This is closely related to the fear that sharing negative emotions and sensitive topics would emotionally hurt each other (Son et al., 2020). Adolescents with cancer and their parents reported additional reasons too. For example, one parent reported her daughter's cognitive impairment as a barrier, while the girl cited her mother's dominating attitude. Another parent reported that the cancer diagnosis had made his son reticent, while the boy reported no changes. Healthcare providers need to pay attention to the differences in adolescents and parents' views on communication barriers without assuming that the will to protect is the only reason for communication challenges.

Furthermore, this case highlights the urgent need to provide psychological interventions for those parent-adolescent dyads to restore their relationships and adaptive communication. Many studies have demonstrated the effect of parental psychological status on communication practices. For example, Rodriguez et al. (2016) found that mothers' depressive symptoms predicted their subsequent harsh and withdrawn communication about cancer, which was also closely related to children's coping. The empirically tested model of the biobehavioral family posits that family emotional climate, quality of a parent-child relationship, and parent-child relational security influence a child's health through biobehavioral reactivity, which describes the degree or intensity of an individual's physiologic, emotional, and behavioral responses to emotional challenges (Wood, 1993; Wood et al., 2008). Adolescents with cancer and their parents may benefit from theory-based interventions that reduce parental psychological distress.

In particular, we must pay attention to the cases with differences caused by the gaps in shared information, which were presented under the theme of "limited sharing and no progress in the conversation." Apparently, the adolescents and their parents communicated well without difficulty.

However, parents often gave them false encouragement and/or could not correct their mistaken beliefs or advance into further communication. Limited sharing produced discrepancies in the perception of reality and disrupted further communication. Historically, disclosing a poor diagnosis of cancer in children and adolescents has been a challenging task for clinicians and parents; we have no absolute guidelines on how to disclose these facts (Sisk et al., 2016). However, failure to share critical information results in negative psychological outcomes, as described by a girl with a rare diagnosis who could not share the fearful moment of vomiting blood with her mother. Research shows that limited sharing causes children and adolescents with cancer to feel isolated and disrespected (Zebrack et al., 2010). Further research is needed to help parents engage in challenging communication regarding the prognosis and complications after treatment.

Notably, one case showed how a mother engaged in challenging communication with her son while presenting the benefit of parent-adolescent communication: having a common understanding of the situation and shared experience. A shared understanding would encourage adolescents to be well-prepared to manage their disease during the cancer journey and gain the necessary support from their families. Effective parent-child communication allows children to be actively involved in shared decision-making (Committee on Bioethics and Committee on Hospital Care, 2000), as recommended by the American Academy of Pediatrics. In addition, open and clear parent-child communication can help children gain a sense of accomplishment and their meaning to their families, people around them, and society at large (Armstrong-Dailey & Zarbock, 2001).

Limitations

This secondary analysis has strength in that it analyzed the data in dyadic units by comparing and contrasting, and presented overlaps or discrepancies between adolescents with cancer and their parents. Still, several limitations provide directions for future research. Due to the secondary analysis design, we were limited in our ability to determine whether we had achieved redundancy in our analysis. In addition, we have relatively small sample size. However, the dyadic units included provided important insights into parent-adolescent communication patterns in the context of pediatric cancer. Second, due to the small sample size, we failed to reveal any potential gender influences on parent-adolescent communication. Future research with larger and more diverse samples may be helpful. In addition, employing a qualitative descriptive design without providing a deep theoretical context may be considered atheoretical. However, this allowed us to identify the potential use of theory to explain these findings (Doyle et al., 2020). Finally, the study population comprised Korean adolescents living in Korea. Some cultural aspects may also affect their communication practices

(J. S. Lee et al., 2010). Therefore, this conclusion should not be generalized to other populations in the context of pediatric cancer.

Implications

Our findings have several research and clinical implications. First, assessing diverse reasons for communication challenges is critical; the desire to protect one another should not be assumed to be the number one reason for parent-adolescent communication challenges. We found that adolescents with cancer sometimes have different expectations and a desirable level of openness than their parents. These discrepancies can cause conflicts and challenges in communication. Furthermore, adolescents with cancer and their parents reported different views on communication challenges. Therefore, assessing adolescents' preferences, expectations, and challenges in communicating with their parents is required, along with an assessment of daily parent-adolescent communication (Coyne et al., 2016). For example, if adolescents are pressed to communicate their emotions when they do not want to, the gap in communication preferences may result in adverse outcomes. However, when adolescents experience challenges in sharing their emotions when they would like to because of parents' unavailability, healthcare providers can provide necessary interventions for adolescents to share their feelings and emotions to prevent further psychological distress. When applicable, educating parents about the importance of encouraging their children to engage in emotional talk and providing effective parent-adolescent communication interventions is important.

Besides emotional communication, parents may find it difficult to disclose a cancer diagnosis or poor prognosis. They need more support so that they do not bear the entire burden. In particular, parents should be provided with sufficient information while ensuring that they understand all necessary information, as parents cited a lack of knowledge and skills regarding disclosure as one of the main reasons for their challenges (Badarau et al., 2015). In the healthcare setting, nurses were selected as the most trusted healthcare professionals in the United States (Saad, 2022). Indeed, they may be well positioned to help adolescents with cancer and their families engage in communication by assessing their needs. Finally, appropriate practices must consider family culture and the overall cultural influence on family communication practices. Western families may show different communication practices than families from Eastern cultures.

An important topic for future research is examining the outcomes of parent-adolescent communication challenges, especially in relation to different expectations and preferences. For instance, studies can explore the expected positive outcomes when parents' and adolescents' communication needs and expectations are met. Another area is identifying modifiable factors in communication challenges to develop

future interventions. Finally, further research is required to extend the applicability of these findings to additional populations with life-threatening chronic conditions, including Type 1 Diabetes Mellitus and asthma. Existing evidence underscores the significance of parent-child/adolescent communication in enhancing self-management behaviors among adolescents and young adults with chronic illnesses.

Conclusion

This study contributed new knowledge on parent-adolescent communication by exploring the commonalities and divergence in parent-child communication experiences among Korean adolescents with cancer and their parents. Our findings emphasized the potential gap in both set of actors' preference and expectations in parent-adolescent communication. This gap emphasizes the necessity of assessing the definition of desirable open communication, expectations, and preferences for adolescents with cancer and parents so that an individualized approach can be provided. Healthcare providers can play a critical role in facilitating quality parent-adolescent communication. Finally, further studies conducted in dyadic units are necessary to understand the shared experiences of adolescents with cancer and their parents in the context of childhood cancer. This approach will be useful in expanding our understanding of the dyadic and communicative experiences of these actors.

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ORCID iD

Heeyeon Son  <https://orcid.org/0000-0003-3144-7107>

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Author Biographies

Heeyeon Son, PhD, MSN, RN is an Assistant Professor at the University of Tennessee, Knoxville, College of Nursing, Knoxville, Tennessee, United States.

Laura E. Miller, PhD is an Associate Professor at the University of Tennessee, School of Communication Studies, Knoxville, Tennessee, United States.