5-8-2023

Dad Talk: Father-Child Communication When a Parent Has Cancer

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DAD TALK: FATHER-CHILD COMMUNICATION WHEN A PARENT HAS CANCER

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110 Pages

Most individuals are impacted by a cancer diagnosis, in fact 54% of Americans say they or someone in their immediate family has been diagnosed with cancer at some point (CBS Interactive, 2017). While most Americans have a family member with cancer, most research has been done to understand the mother-daughter relationship during such a time. Unfortunately, there is little research regarding father-child communication during a cancer diagnosis, and father-child communication is understudied. The father-child dyad is an important relationship that impacts a child throughout their lives (Fellers & Schrodt, 2021). To further understand these relationships and how cancer may impact it, an online survey was utilized. The survey asked questions regarding father-child closeness, father-child relational satisfaction, and child caregiving. Results suggest that father-child closeness and relational satisfaction were impacted by certain caregiving variables.

KEYWORDS*:* communication; family; father-child communication; cancer; cancer communication; father-child cancer communication

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A Thesis Submitted in Partial
Fulfillment of the Requirements
for the Degree of

MASTER OF SCIENCE

School of Communication

ILLINOIS STATE UNIVERSITY

2023

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ACKNOWLEDGMENTS

To my grandmother, Ruby, and my great aunt, Misty.

Two extremely important women in my life who I know would be so proud of me if they were still here. Much love.

I would like to acknowledge those that have pushed me to be here and have encouraged me to continue to grow and learn. My undergraduate professors prepared me more than I could have imagined for graduate school, and I am forever grateful. Thank you, Cody, Alane, Linda, and Lori. Cody, thank you for talking to me about graduate school and encouraging me to apply as well as continuing to support me by joining my committee. Also, a huge thank you to my other committee members Kevin and Lance. Lance has been nothing but supportive and helpful in this endeavor, providing me with insights I would not have thought of and continuously encouraging me to be the best I can be. Thank you, Kevin, for teaching me quantitative research methods, a class I was afraid to take but ended up loving. I would also like to thank Dr. Steve Hunt for always getting me "fired up" about my projects and showing excitement in my projects as well. I could not be here if it were not for my parents Beth and Will, and my partner Jeffrey. They have provided me with the tough love I have needed at times through this process and never gave up one me. Another huge thank you to my friends I have made during graduate school. Isa, Grace, Tristin, and Haley, I could not have done it without you all, much love. Lastly, a gigantic thank you to my advisor and the chair of my committee, Lindsey Thomas. I could not have done this without your help and guidance and thoroughly enjoyed working with you.

E.A.R

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CHAPTER I: INTRODUCTION

Topic Discovery and Positionality

It is January 2009, and I am 11 years old. My grandmother is my favorite person in the world, and unfortunately, my dad just told me that she was just diagnosed with kidney cancer. I am sad, but I do not really understand the magnitude of what having cancer means. I do not know what the possible affects are that it could have on my grandmother and the rest of my family. My father is my grandmother's main caregiver, and he keeps me updated with what is going on with her health. Again, I do not fully understand what is happening, but I appreciate his attempts to update me. My grandmother is such an important person in my life, I cannot lose her; not this young. I slowly start to cry just thinking about it.

It is now September 2009, and I am at the county fair feeding and taking care of my animals I am showing through 4-H. My parents had an ominous look on their faces as they approach me. They pull me aside and gently tell me that Grandma Ruby was no longer with us. This hit me like a ton of bricks, I immediately start to cry in front of everyone. I know they were trying to do the right thing by telling me, but it did not make it hurt any less. My grandma, my favorite person, is now gone. My parents told me that her kidneys could no longer compete with the invasion of cancer cells throughout her body. This is my first true loss of a close family member, and I am struggling to cope with the grief and confusion of losing a loved one. As I sit at her memorial service, everything starts to truly sink in. I now understand that Grandma Ruby is no longer with us. I feel fortunate that I had the opportunity to visit her the night before her passing. I will always carry her love with me.

It is now 2017, I am a sophomore in college, and I decide to go to doctor with my mom. During the visit, the doctor informed my mom that she has breast cancer. My heart sunk, I was shaking, and my body went numb. There are so many thoughts running through my head. Why does this keep happening to me? What did I do to deserve yet another cancer diagnosis in my immediate family? What can I do to help my mother? I immediately start crying, which made my mother start crying, and we both just continue to cry for several minutes. I just kept thinking about Grandma Ruby and how hard cancer was on her body. This is the first time in my life where I saw my mother look scared due to the uncertainties surrounding her health. My mother is quite literally the strongest person I know, and I feel helpless right now as we sob together. All I can do is pray that someday she will be cancer free.

The diagnosis, surgery, and overall journey with cancer, has disrupted our family system in several different ways. My father has taken over many of my mother's roles as she recovers from surgery and goes through radiation treatments. Thankfully, he was Grandma Ruby's main caregiver, so he knows how to take care of someone diagnosed with cancer. Also, when I am home from school, I help my father with many of the responsibilities around the house. Luckily, my undergraduate college was only one hour and 30-minutes away from my home. This makes it easy to come home to help around the house. Prior to my mother's diagnosis, our relationship felt strained, like many mother-daughter relationships are during the daughter's teenage years. Although, I will say this cancer journey has helped bring me closer to both my mother and father. It is almost like the previous wrench in our family system has been removed.

Fast forward to present day, I still reflect on how the diagnosis, treatment, and tragic loss of my grandmother in 2009 affected me greatly. I think of her often, and always wonder how she would respond to the life I am currently living. Since Grandma Ruby's cancer diagnosis, I have

always been interested in learning more about cancer. Although, I was not interested in exploring how a cancer diagnosis impacts or disrupts a family system until my mother's breast cancer diagnosis in 2017. I experienced this disruption firsthand, but I often wondered if others were impacted like I was. Thankfully, it is now January 2023, and my mother has been cancer free for almost five years. I am thankful that she can walk through the world cancer free now.

As I enter this project, I think it is important to understand how I got here. When I started my undergraduate career, I thought I wanted to become a Physician's Assistant, but I quickly realized that was not the path for me. After taking a public speaking course at Marietta College, I found a passion for communication studies. This passion allowed me to pursue and obtain a Bachelor of Arts in Strategic Communication with a certificate in Health Communication and a minor in Leadership Studies. I made the decision to pursue a graduate degree in communication studies with hopes of conducting research on cancer and family communication. During my first year of my Master of Science degree, I conducted research about mother-child communication with college aged children, and mother-daughter cancer communication. While emersed in this research, I discovered a dearth of literature focusing on father-child communication research, especially from a communication lens. Considering this gap in the communication literature and my personal experiences, the present study addresses father-child communication when a parent has cancer.

Father-Child Communication

Father-child communication plays an important role in the lives of the child and the rest of the family; without healthy father-child relationships and communication, the children could experience lack of skills to build other relationships throughout their lives (Fellers & Schrodt, 2021). Scholars have found that children are more likely to disclose to mothers and given the

cultural emphasis on *mothering* rather than *fathering* or even *parenting*, it is perhaps unsurprising that more extant communication literature focuses on mother-child communication than father-child communication (Barbato et al., 2003). Nevertheless, as illustrated in my previous anecdotal introduction and the literature reviewed in the following subsection, father-child communication is also important. Indeed, many children love to talk to their fathers for numerous reasons: it can be fun, relaxing, affectionate, and stress-reducing. These motivations to have conversations are reciprocated from the father (Martin & Anderson, 1995). Similarly, Barbato and colleagues (2003) found that parents would use relationally oriented motives when communicating with their children; "affection was the most strongly endorsed motive for talking to children, followed by pleasure, relaxation, inclusion, control, and escape" (p. 131). In fact, fathers and mothers reported communicating with their children to show affection, for pleasure, and just for fun (Barbato et al., 2003).

These motivations have a direct tie the culture of fatherhood, which is built on shared norms, values, and beliefs; researchers have found that fathers often have trouble displaying fatherhood and find themselves in a gap between the culture of fatherhood and the action of displaying fatherhood (Braute & Hidir, 2016; Brown et al., 2008; Sunar 2002). The author of a study that explored the mediator role of mothers in father-child communication states that today's fathers should be more nurturing, affectionate, and involved in raising their children (Celik, 2019). Fatherhood is characterized by parenting attributes such as playing an active role in the child's life, expressing love to the child, providing emotional and social support, being available and responsible, being a role model, and offering affectionate communication (Celik 2019; Lamb 2010; Mormon & Floyd, 2006). Father-child communication likely impacts many lives—of children, parents, and others—and continues to evolve.

Masculinity and Fatherhood

Fellers and Schrodt (2021) found that a father's enactment of traditional masculinity may undermine the quality of his relationship with his children regarding the children's satisfaction and closeness. Traditional masculinity, as used by Fellers and Schrodt (2021), is characterized as the expectation of men to be tough, unemotional, dominant, and powerful (Mahalik et al., 2003). However, Fellers and Schrodt (2021) also explore how new masculinity and its enactment affects the father-child relationship. New masculinity is characterized by openness, prioritization of family life, avoidance of physical aggression, and self-awareness (Ratele, 2015).

Proper socialization and modeling of healthy father-child relationships plays an important role in children's lives; without socialization they may lack self-efficacy and communication skills needed to engage in various communication behaviors that enhance relational quality (Fellers & Schrodt, 2021). Those that enact new masculinity are more likely to prioritize expressing affection to their child and view emotional displays and investments in their families as signs of strengths while those that enact traditional masculinity may undermine the quality of father-child relationships from the child's perspective (Fellers & Schrodt, 2021). Indeed, it is the communication that determines the quality of a father-child relationship (Celik, 2019; Floyd & Mormon, 2003, 2005; Mormon & Floyd, 2006). With the consistent turn in communication research toward positive practices, recent fathering literature in the microsystem (the family) "emphasizes the distinctive and constructive relational work contributed by fathers to the family" (Waldron & Socha, 2022, p. 83).

There are several other areas of father-child relationships that have been researched. Waldron and Socha (2022) took a deep dive into communication literature surrounding fathers and found that "fathers' communication can significantly and uniquely affect children's

successful communication and moral development" (p. 79). They state that fathers often struggle to manage inherited remnants of patriarchy, patrimony, and masculinity during quickly changing societal understandings and expectations civilization (Waldron & Socha, 2022). They also discovered that fathers' communication practices have long term consequences in the family and that fathers shape perceptions of children regarding quality and closeness of family life (Waldron & Socha, 2022). Thus, fathers become models for children's family relationships later in life (Waldron & Socha, 2022).

Nontraditional Fathers

Stepfathers and other *nontraditional* fathers often engage in inventive communication as they navigate stubborn policies and manage sometimes unsupportive relationships with families and friends (Waldron & Socha, 2022). Of those nontraditional father roles, stay-at-home-fathers were explored by Medved (2016). Medved found three discourses and practices that push begin to create new understandings gender relations in families: (1) expressions of gender-neutrality, (2) empathizing as a means to gender flexibility, and (3) early negotiations of unconventionality.

Other nontraditional fathers, such as fathers on paternity leave, were found to have a common theme of blurring gender distinctions and roles (Johansson, 2011). Four heterosexual fathers were studied and all of them portrayed having the ambition to live in gender equal relationships. Certain fathers preferred to discuss parenthood as a whole rather than fatherhood specifically while other fathers were not the family breadwinner and stayed home more often than the mother. The cases studied: "show how intimately linked and dependent upon each other work and family are. They also show that it is possible to arrange and rearrange families in different ways, to promote gender equality" (p. 177). For example, one of the fathers from the study was the main caretaker of the children and described himself as the person who takes care

of the ground-service and makes a lot of lists; he discussed how he learned from his child and how these learning procedures were later conveyed to his job. Another father described how he reconstructed his life to be home more and take care of his child; he described how his experiences as a father changed his views towards life, work, and the future (Johansson, 2011).

Stepfathers and fathers on paternity leave are not the only types of nontraditional families. Gay fathers and single fathers have also been studied. While studying gay fathers, Baker (2019) found that the use of discourse of traditional family structure in gay parent families was utilized the parents "perceived the traditional structures and dynamics as relevant, culturally persistent, and, at times, challenging to the couples' family identity" (p. 224). Using the discourse of nontraditional family structure, the participants defined nontraditional identity as othered in comparison to the traditional model due to structural differences (Baker, 2019).

The fathers lacked the indicators of heteronormativity and biological ties consistent with the traditional family makeup. They also "spoke to the existence of alternative family models using the discourse of nontraditional family structure when talking about how they communicate what family means to their kids or how they describe their own families when prompted" (p. 224). Discourse of traditional family structure was often still considered the dominant cultural form of family, but the couples commonly entertained discourse of nontraditional family structure as a worthy and functional approach to their family construction: "participants embraced this normalizing discursive approach to nontraditional family identity communication with each other, their kids, and their communities through the discourse of nontraditional family structure, even when the discourse of traditional family structure was still present in their talk" (Baker, 2019, p. 225).

Fathers from this study indicated that from the instant they decided to become parents, they predicted the possible identity challenges their family may face in the future. Early on in their parental journeys, the parents actively acknowledged and embraced their nontraditional status while committing to regularly communicate the normalcy of their family structure with their children and each other (Baker, 2019).

Further research explores mass media portrayals of single fathers. Thirteen series were selected based on the presence of single fathers who were primary caregivers, full or part time, for their children under 18 years old in the show to research how single fathers are depicted in television shows. Researchers found that most fathers were actively engaged in providing material and emotional support for their children and instances of fathers being tyrannical were not found (Turchi & Bernabo, 2020). Additionally, Turchi and Bernabo found that TV fathers have matured emotionally and suffered less ridicule on television. The parenting choices of the characters have hardly evoked disdain, but rather the fact that some of the characters struggle to act their age.

These scholars concluded "that contemporary television's single fathers provide comfortable home environments and emotional support, while few completely fail at caring for their children" (p. 445). Their results suggest that television's representation of single fathers is evolving as the broader culture around caregiving and gender evolves in the real world. As media's depiction of single fathers has evolved to focus more on parenting rather than fathering, it makes sense that the influence of gender on fathering in real life has shifted towards a more gender-neutral style of parenting that will be discussed in the following section (Turchi & Bernabo, 2020).

Influence of Gender on Fathering

Expressions of gender-neutrality involved when men voiced their roles in ways that seem to disaffirm the influence of gender on their option to be primary caregivers (Medved, 2016). This in turn led to equal eligibility for caring and earning roles and tasks that are associated with being a stay-at-home parent and supports the goal of parenting being degendered (Medved, 2016). The second discursive means of gender transformation is seen using empathy by stay-at-home fathers; men in the study expressed the struggles of being home full time and the demands of caregiving (Medved, 2016). Third, couples that had early marital negotiations regarding their parental roles expressed possibility for gender transformation (Medved, 2016).

Stay-at-home fathers were just one type of examined fatherly role. Stepfathers and their relationships with stepchildren were explored regarding turning points in the relationships. Researchers found 15 different types of turning points in these relationships, with the five most frequent being (1) prosocial actions, (2) quality time, (3) conflict/disagreement, (4) changes in household/family composition, and (5) rituals (Braithwaite et al., 2018).

Prosocial actions were when a stepparent did something out of the ordinary, such as gift-giving or acts of kindness. Quality time signaled a positive relationship was developing with the stepparent and included spending leisure time together and the discussions did not focus on problems. Conflict/disagreement was when there was a struggle between the stepchild and stepparent or another stepfamily member. Changes in household/family composition included when families would move in together, a parent remarrying, or other members moving in or out of the house and rituals referred to events such as holidays, birthdays, graduations, and weddings. These findings show that stepparents and stepchild rely on one another to adjust to the

new family compositions thus allowing healthy growth in the relationship, even with conflict (Braithwaite et al., 2018).

Father-child relationship development is a reciprocal process of interdependent communication practices, shared growth, and mutual benefits (Waldron & Socha, 2022). Fathers also develop communicative strengths for parenting challenges, Waldron and Socha define this as "*fatherspeak,"* which also includes when fathers meet children's needs through communicative tasks. Fatherspeak varies as the family grows and ages but tends to occur in developmental domains such as ethics, relationships, and spirituality benefits (Waldron & Socha, 2022).

Father communicators and communication itself change over time while exerting significant force on human development. What fathers say today may be different from their own fathers, but their messages will nonetheless influence their own children's future. Today, what fathers say and how they communicate it is stuck somewhere between what their fathers said to them, and their current understanding of their own fatherly role (Waldron & Socha, 2022).

Taken together, father-child communication likely impacts many lives -- of children, parents, and others – and continues to evolve. Yet, the bulk of research has focused on mother-child, especially mother-daughter, communication. In fact, Waldron and Socha (2022) state that fathers are comparatively under-represented in the last 10 years of family communication research. In one meta-analysis of journal publications over the course of a decade, they located fewer than 100 journal articles, or about ten articles per year, featuring fathers; taking a narrower look at only the *Journal of Family Communication*, Waldron and Socha found only 20 articles, about two per year. Continuing father-child research is important to further understand the relationships. Thus, the current study contributes to extant parent-child relationships and

communication literature by focusing on father child communication, particularly in the context of cancer communication.

Cancer as a Family Issue

Although the present study initially grew from events in my own family, I am not unique in my experience of dealing with a loved one's cancer diagnosis and treatment. Indeed, almost everyone has encountered a cancer diagnosis in their social network, and 54% of Americans say they or someone in their immediate family has been diagnosed with cancer at some point (CBS Interactive, 2017). These cancer diagnoses impact families in varied ways. A diagnosis can cause partners to change roles within the family as well as responsibilities, physical needs, and emotional needs (How Cancer Affects Family Life, 2021). Cancer affects children greatly which is why it is important to talk to the children in the family openly about what is going on. It is also important to be aware of the children's behavior as there will most likely be changes in their behavior as they adjust. For example, older children may become angry while younger children may become clingy. It is very important to have good communication when a family member has cancer as a lack of communication may lead to isolation, frustration, and misunderstandings (How Cancer Affects Family Life, 2021). It has been found that families that act openly and express feelings directly when a member of the family has cancer, everyone involved has lower levels of depression and conflict (Edwards & Clarke, 2004).

When it is a child that is diagnosed with cancer, researchers have found several themes that parents experience such as cancer related strains, child strains, and family strains (Patterson et al., 2004). Cancer related strains included treatment affects with five subthemes, all relating to how the cancer treatment had physically affected the child. Parents in this study also reported child and family strains. Child strains included themes such as experiencing strong emotions,

(i.e., fear and anxiety) and the loss of a normal life. Family strains included two main themes strong emotional reactions from parents (i.e., feelings of numbness, loss of control, etc.) and emotions parents currently experience (i.e., worry of relapse, fears about the future, etc.). These findings are important because they demonstrate that cancer affects much more than the physical health of the individual diagnosed. In fact, Patterson and colleagues (2004) also identified community strains in the study, including insensitivity and avoidance from friends of the parents and of the child. However, coworkers and extended family members acted as a positive support system for most of the participants.

Participants reported using several coping mechanisms, which the authors sorted into three domains. Appraisal-focused coping behaviors were the first domain, this included staying positive, focusing on the present and denial. Problem-focused coping behaviors were the second domain, this included planning, being organized, and balancing family needs. Emotion-focused coping behaviors were the third domain and included the use of humor, seeking and giving support, and crying. This data shows that families are affected greatly in many ways by a cancer diagnosis in the family and deal with it in different ways. The fact that cancer can have such affects is a reason why communication about it is so important.

Research Purpose

Parent-child communication is important, as is communication in families with a cancer diagnosis. Yet, given the focus on mother-child communication, little is known about how fathers and children communicate the experiences surrounding a parental cancer diagnosis and its aftermath. Thus, the present study aims to shed light on father-child relationships, particularly communication and sensemaking, in the context of a parental cancer diagnosis. Focusing on how a parental cancer diagnosis impacts the father-child relationship, especially regarding perceived

caregiving. As well as the communicative practices implemented within the father-child relationship.

Theoretical and Pragmatic Contributions

The present thesis project worked to build on and add to the limited research on father-child communication. First, this thesis explored the existing research surrounding father-child communication and the research surround the understanding of cancer. Bowen's family systems theory (FST) was utilized to understand how the interruption of a cancer diagnosis disrupts/impacts the family system in place. FST was chosen because it provided an understanding of the family by focusing on the interplay of members dispositions (Rosenblatt, 1994). FST was created to conceptualize the family as an emotional unit (Kerr & Brown, 1988). Thus, FST was a great framework to provide insights on how a cancer diagnosis disrupts the family system that existed prior to the diagnosis by focusing on the father-child relationship.

This project worked to create insights for those for those that have a parent with cancer, to health care providers to help families cope, and for therapists and counselors to help families in the future. Also, this piece may provide insights for those that have family members with cancer and help them learn more of what to expect and how many families handle the stress of cancer diagnosis.

Organization of Chapters

This thesis is organized in the following manner. Chapter One introduced father-child communication and how I made my way to the current study. Chapter Two examined and unpacked the conceptual framework and literature review for this study, arguing that a parental cancer diagnosis interrupts the current family system in place. Within this chapter the exiting literature surrounding health, family, caregiving, and cancer, as well as the theoretical

framework, family systems theory is explored. Chapter Three explained the chosen methods: Likert-type scales and open-ended questions on an anonymous survey for data collection, and data analysis employing statistical tests, such as correlations and regressions, as well as a thematic analysis. Chapter Four presented the results of the study. Finally, Chapter Five discussed the conclusion, including major findings, applicable implications, limitations, and directions for future research.

CHAPTER II: CONCEPTUAL FRAMEWORK AND LITERATURE REVIEW

Cancer as a Context and the Interruption of Illness

According to the National Cancer Institute (NCI) (n.d.), cancer is a disease of the genes in the cells of bodies. These genes control our cells, and changes to the genes can cause the cells to grow and divide when they should not. It is these abnormal cells that become cancer. These cells grow uncontrollably and spread throughout the body ("Understanding Cancer", n.d.). Typically, human cells grow through cell division to form new cells as the body needs them. Unfortunately, sometimes this process is disrupted, and abnormal cells grow and multiply, forming tumors ("What is Cancer?", n.d.). Tumors, in turn, can be benign (non-cancerous) or malignant (cancerous). Benign tumors typically do not spread and do not grow back after removal, whereas malignant tumors sometimes do. Malignant tumors can develop for many reasons, including errors in cell division, damaged DNA (from UV rays, tobacco smoke, etc.), and genetic predispositions ("What is Cancer?", n.d.).

According to the Centers for Disease Control and Prevention (CDC), cancer was the second most prevalent cause of death in the United States (U.S.) in 2021, killing approximately 599,601 people. Only heart disease was more deadly, killing approximately 659,041 people (CDC, 2022). In the U.S., the rate of new cancer cases is approximately 442.4 per 100,000 individuals per year, and the death rate due to cancer is about 158.3 per 100,000. The cancer mortality rate is higher among men than women, and it is highest in African American men and lowest in Asian/Pacific Islander women ("Cancer Statistics", n.d.).

The National Cancer Institute has stated that about 39.5% of people will face a cancer diagnosis at some point in their lives, with the most common cancers being, in order, breast, lung, prostate, and colon cancers. The NCI discovered that "cancer is among the leading causes

of death worldwide; in 2018, there were 18.1 million new cases and 9.5 million cancer-related deaths worldwide." By 2040 the NCI has estimated that new cancer cases will increase to 29.5 million, and cancer related deaths will increase to 16.4 million ("Cancer Statistics", n.d.). This information demonstrates that cancer, like any chronic illness, is a prevalent issue and plays a huge role in many peoples' lives.

Chronic Illness

Those with chronic illness not only scrutinize the "toll their toil takes" but become subject to scrutiny at work (Charmaz, 2006, p. 29). As employees, they may try to escape the scrutiny of coworkers and supervisors by camouflaging their symptoms. Strategies are developed to avoid such scrutiny (e.g., such as restructuring time, extending the workday by taking it home with them to complete the same amount as others in the office, etc.). Stress becomes a casual explanation that needs no explanation as the meaning of stress remains assumed, thus stress reduction occurs to try to create a comfortable space for individual that minimizes distressing images and maximizes a sense of wholeness (Charmaz, 2006). This is just one-way chronic illness can impact an individual, however it is important to note that illness can have impacts on families as well as the lives of the ill individual.

Charmaz (1995) conducted research on how those with chronic illnesses adapt to their illness and in doing so created a model of identity management. This model has four stages, (1) supernormal identity, (2) restored self, (3) contingent personality self, and (4) salvaged self. The first stage refers to the determination of the individual to be the best version of themself possible. Restored self is when the individual's optimism at the beginning of their journey begins to fade and they deny that the illness has changed them. The third stage is when the individual starts to accept and admit that they may not be able to do all that they used to and confront the changes to

their personal identity. Finally, salvaged self is when the individual develops a transformed identity that incorporates aspects of their former self with the present boundaries of their illness.

Wittenberg and colleagues (2013) explored the spillover effects a chronic illness, such as cancer, can have on a family's health and well-being. The participants in the Wittenberg et al. (2013) study were relatives of people with at least one of five chronic illnesses: arthritis, cancer, Alzheimer's disease/dementia, cerebral palsy, and depression. Four main domains were found to be affected by a relative's illness: (1) somatic health, (2) psychological health, (3) non-health, and (4) scope/duration of the spillover. Further, each domain contained more than one dimension of spillover. For somatic health at least 50% of participants mentioned general physical health and physical pain being affected. Psychological health had seven categories and the most mentioned of those were general mental health (specifically for children), general emotional health, stress/anxiety (specifically for children), and sadness/depression with at least 50% of participants mentioning those affects. The non-health domain's most mentioned spillover effects were general daily activities, caretaking, finances (specifically for spouses), and being confined to the home (specifically for children) (Wittenberg et al., 2013). These findings are notable as the researchers went further than most existing research at the time and looked beyond the caretakers and included multiple familial relationships in the study. This data demonstrates that chronic illnesses, such as cancer, have impacts on the entire family in different ways.

Family Communication and Health

Health—or lack thereof—plays a huge role in everyone's life and can have a major impact on families. For example, perceived confirmation from a family member during health-related conversations has a direct impact on health attitudes and partially accounts for the positive relationship between family conversation orientation and health attitudes (Baiocchi-

Wagner & Talley, 2013). Likewise, frequency of "health-specific communication directly influenced health attitudes, partially accounted for the positive relationship between family conversation orientation and health attitudes and was directly associated with health behaviors" (Baiocchi-Wagner & Talley, 2013, p. 1). Given this information, it is important to understand how different family members impact the family's communication patterns around health, as well as health activities such as caregiving.

Caregiving

The CDC (2022) has defined a caregiver as those that provide care to people who have some degree of ongoing assistance with everyday tasks on a regular or daily basis. Caregivers in families are typically the spouse or adult children; researchers have found that caregivers did not find any of the caregiving task difficult but time consuming (Bakas et al., 2001). The caregiving tasks found in this study include medical or nursing treatments, personal care, mobility, emotional support, monitoring symptoms, transportation, managing finances, household tasks, running errands, planning activities, managing behavior problems, finding care while away, communication services and resources, and communication with healthcare professionals. Bakas and colleagues (2001) found that the overall most time-consuming tasks were providing emotional support, transportation, and monitoring symptoms. The three most time-consuming tasks for adult child were the same. The three least time-consuming tasks overall were finding care while away, providing personal care, and assisting with mobility. The most difficult tasks overall were providing emotional support, managing behavior problems, monitoring symptoms, and household tasks. The overall most difficult task was providing emotional support (Bakas et al., 2001).

Bassi and colleagues (2020) conducted a similar study to the Bakas et al. (2001) study, however Bassi et al. (2020) further explored the relationship between workload and caregivers' wellbeing. On average, participants in their study reported low to moderate levels of perceived workload. Overall findings suggest that different caregiving tasks have different relations with caregivers' psychological well-being (Bassi et al., 2020).

Similar research was conducted by Wittenberg and colleagues (2017). In their study most caregivers described their own personal limitations due to illness or disability and described how communication burden was created by stress from difficult interactions. These stressful interactions impacted feelings of fatigue and mental exhaustion for the caregivers. Helplessness surfaced for the caregiver when the patient had a hard time accepting and/or understanding the severity of their diagnosis and treatment side effects.

On top of feeling hopeless and exhausted caregiving often resulted in role adjustment, changes to relationships, leisure activities, and employment impact social-well-being, sometimes leading to isolation (Wittenberg et al., 2017). In some cases of caregiving family members had to change their work schedule or even give up their jobs (Kumar et al., 2022). Difficultly sharing emotions and feelings added to the communication burden; caregivers described withdrawing from others to avoid communication (Wittenberg et al., 2017). These findings from Wittenberg and colleagues' study confirm that caregiver quality of life is greatly impacted by stress about communication.

Researchers have found negative consequences of being a caregiver are experienced frequently; in a study exploring the burden of caregiving 59% of the participants reported high levels of stress (Lund et al, 2014). Of their sample size of 590 participants, 16% reported negative effects on their own physical health, 20% needed to see a psychologist, 19% reported

that they did not have enough time for their family and friends, 22% reported needing to take a break from practical tasks, and 67% had the need to lead a normal life while being a caregiver. This study demonstrates that being a caregiver is a demanding task and has its costs, as well as benefits. Caregiving can jeopardize the wellbeing of the caregiver but may also bring positive experiences such as increased awareness of the important things in life, positive changes, and valuing relationships (Lund et al., 2014). An example of such a positive experience includes celebrating the victories (Hogstel et al., 2005).

Pristavec (2019) examined burdens and benefits caregivers experience and found that some participants predominantly experienced burdens while others predominantly experienced benefits; however, all participants experienced at least some benefits or burdens. “Burden and benefits co-occur” (p. 1084) and the reasons for a positive, negative, or ambivalent experience is dependent on many factors. A study researching spousal experiences in caregiving when the partner had dementia, researchers found that the caregivers fit into one of three groups, positive, ambivalent, or negative experiences (Shim et al., 2012). Of these groups, ambivalent had the largest group with 12 participants describing both negative and positive experiences while caregiving for their spouse. These participants described satisfaction in caring for their partner along with negative feelings towards the loss of the relationship they had due to the dementia. These participants also reported mixed feelings about their caregiving responsibilities and had a hard time accepting that their partners could no longer reciprocate in the relationship (Shim et al., 2012). Ambivalence of having positive and negative feelings about caregiving was found among other caregiving relationships as well.

While researching ambivalence in relationships of adult child and aging parents, researchers found that in their sample, ambivalence described the experiences of adult children in

over one quarter of their relationships (Wilson et al., 2003). Results indicated that relationships among women were more ambivalent and that women experience more ambivalence as caregivers (Wilson et al., 2003). In the studies previously mentioned, it is clear to see that the caregivers experienced positives and negatives during their time as caregivers. While caregiving may be stressful, it is still rewarding; this study aims to explore the meaning making of the ambivalence in these experiences, such as the positive and negative experiences and feelings they encounter during their time as caregivers. Transitioning to a caregiver requires extensive communication for both parties, leading to conversations about the disease that caused the need for caregiving.

Parent-Child Relationships

Parent-child relationships are extremely impactful on a child's growth and development. Parent-child relationships are typically permanent and involuntary, making these one of the most long-lasting relationships a person will have throughout life (Umberson, 1992). These relationships are constantly changing and evolving as time goes on (Aquilino, 1997). These are one of the first relationships formed in life and help shape people into who they are. Aquilino (1997) found that parents' actions influence their children's activities and relationship skills but does not determine these factors. This section further explored the claims listed above within the context of a cancer diagnosis in the family. This section discussed genetic risk communication as well as how a family is impacted when a child faces a cancer diagnosis.

Generational Approaches and Issues

In addition to family caregiving, cancer communication has also been researched extensively. When researching what factors influence family communication about genetic risk, researchers found that: (a) most families communicated openly about genetic risk; (b)

communication was often inhibited by a diagnosis or bereavement; (c) family cohesion impacts family communication; and (d) young people in the family are influenced by relatives regarding genetic testing for cancer (McCann et al., 2009). On top of genetic testing research there is much research surround specific cancer types.

Breast cancer is one of thoroughly researched cancer type. For example, researchers have looked at identifying factors associated with psychological functioning in adolescent children of early breast cancer patients (Edwards et al., 2008). These researchers found high stress rates among adolescents of those with a parent who had breast cancer. Of those participants 33% of the males and 45% of the females experienced increased stress rates. They also found that 30% of adolescents reported psychological problems (Edwards et al., 2008). Thus, young children were not the only ones to experience stress; older children, too, experienced stress when a parent had cancer.

Thastum et al. (2008) found that parents wished that their children would share their emotions more openly with them when one of the parents had a cancer diagnosis. The parents mostly shared information about the cancer. Parents in this study were emotionally closed, however the children still observed and acted upon both of healthy parent's and the sick parent's emotional condition. There were five coping mechanisms the authors found that the children used: helping others, parentification, distraction, keep it in the head, and wishful thinking. Helping others was defined as helping around the house in ways the ill parent could not, such as getting drinks for the parent or helping with younger siblings. The authors defined parentification as "the child's explanation of how it helped the parent had to include that the child in some way concealed or suppressed own needs or emotions" (Thastum et al, 2008, p. 133).

Distraction was defined as something the child did to avoid the negative thoughts and emotions, they felt due to the parent's illness. "Keep it in the head" was defined as children keeping their thoughts about the illness to themselves and not sharing them with anyone. Finally, wishful thinking was the act of thinking positively to comfort themselves that nothing bad would happen. The authors found that the children's use of coping mechanisms and the children's adaptation to the situation was successful depending on communication patterns with the parents (Thastum et al, 2008). Communication between the parent and child about cancer affected how the child coped with the information and how successfully they adjusted to the situation.

While researching parent-child communication about a diagnosis of a life-threatening condition in their parent, Dalton et al. (2019) found that children consistently reported wanting prompt, clear, and simple information about their parent's diagnosis, planned treatment, and prognosis; overall, the researchers found that children wanted more information when their parent became sicker. The anxiety the children had regarding their parent's illness did not outweigh the desire to gain more information; however, some children wanted parents to filter, or soften, the information to process and deal with it better. Children also wanted the information disclosed to them in a more spaced-out manner, to allow time to process the information without becoming overwhelmed, and many children even wanted specific information about parent's care needs so they could help (Dalton et al., 2019).

Overall, in Dalton and colleague's study, the child participants wanted more information to better understand and help their parents. The children wanted information to be direct, honest, and from the doctor or another knowledgeable source. However, it is important to be aware of the language used to inform the children, many children in the study stated that the jargon used created confusion and that descriptive communication was distressing (Dalton et al., 2019).

Furthermore, the children were not the only members of the family who had concerns and wants regarding the parent-child communication patterns during a time like this.

Parents worried about disclosing the cancer diagnosis and became overwhelmed and frightened about sharing the diagnosis with their child(ren) while managing their own emotional reaction. Parents' anxiety was heightened in fear of not telling the children about the diagnosis the right way or at the right time as well as being unable to answer potential questions about the illness. Parents also wanted to create a rapport with their health-care provider to discuss how to communicate the illness with the children as well as gaining guidance to help the children's understanding of death and appropriate language to use. Parents all wanted information about how other families coped and *normal* reactions children may have to better understand what to expect (Dalton et al., 2019).

This literature demonstrates that cancer has an impact on the entire family and that different relationships are impacted whether intended or not. The system of the family faces many difficulties when disrupted in such a manner. It is important to explore these different relationships and the effects such a disruption has on them.

Cancer Communication

When families discuss cancer there are differences between how mothers and fathers handle information exchanges with other family members. First, how mothers discuss cancer will be explored, followed by how fathers discuss cancer. Mothers often withhold cancer diagnosis information from their children (Barnes et al., 2000). This is due to many reasons such as: avoiding questions about death, not expecting the child to understand, to prevent a child's distress, and to preserve holidays. The mothers that did disclose diagnosis information did so because they believed that it was best to communicate with the family, to keep the child's trust,

and to alleviate a child's distress. Researchers also found that women with breast cancer would have appreciated knowing when and how to communicate about cancer to their children, and space and consideration for children during the mother's treatment (Barnes et al., 2000).

When researching the emotional support communication between mothers and daughters coping with breast cancer, Fisher (2010) found that women in all age groups described three themes that consistently helped them adapt during the adjustment to cancer. These themes were listening, being humorous, and showing affection. Listening was simply allowing the woman to vent without interruption or unsolicited advice. This was most important for young-adult and middle-aged women when expressing their emotions. Showing affection included smiling, hugging, kissing, holding hands, snuggling, and frequently saying "I love you." Being humorous was making jokes, teasing, creating funny nicknames for each other, and sharing funny memories (Fisher, 2010).

In comparison with mother-child research, there is little literature focused on father-child cancer communication when a parent has a cancer diagnosis. Much of the existing research focuses on mother-child communication, especially mother-daughter communication related to breast cancer. The other main cancer communication research is focused on parent-child communication when the child has cancer. Considering this dearth of research, there is much opportunity to contribute to father-child cancer communication research.

Existing Cancer Research

Researchers have found that children who have parents with cancer often have misconceptions or guilt related to the parents' illness. This was found to be due to a lack of, or incomplete, information, even though most of the children in their study were well informed of the facts regarding the parents' illness. It was also found that communication regarding

emotional issues was limited between the parents and children. Children reported that their fathers were uncommunicative about their own emotions (Thastum et al., 2008).

In a 2009 study, researchers found that when a mother is diagnosed with breast cancer, the fathers were often a source of reassurance and support for their partners and worked to maintain their normal family life for their children (Forrest et al., 2009). However, the fathers often lacked sufficient information regarding the diagnosis and especially the side effects of the treatments. The fathers in this study struggled to recognize the children's distress and often interpreted it as bad behavior. These fathers frequently expressed a desire to speak with doctors regarding the children but not wanting to monopolize clinical time away from their partner.

When disclosing the diagnosis to children, the mothers were the ones to do so most of the time, but the fathers were present. The researchers found that the fathers believed in open communication about the situation but minimized the reality of the diagnosis. The fathers in the study described three coping mechanisms they used with the children: trying to make sure the children understood the situation, providing opportunities to talk through things, and ensuring the school was aware of situation. When providing reassurance, it was often regarding the mother (not) dying. The fathers felt confident in their abilities to make the children not worried; however, the children reported that they were still worried (Forrest et al., 2009).

Many of the children in the Forrest et al. (2009) study revealed that they were struggling emotionally, but their distress had gone unrecognized, despite the fathers feeling as if the children were coping well. Some of the fathers stated that they did not want professional help for themselves or their children; others said that advice they received from clinical staff helped when discussing the situation with the children. The fathers of teenagers stated that they would have found it helpful if their children would have been able to speak directly with the doctor, and the

teenaged participants stated this in their interviews as well (Forrest et al., 2009). Although research points to reported experiences of (mis)communication issues between fathers and children in the context of a parental cancer diagnosis, little is known about how fathers and children communicate about, and make meaning of, the experiences surrounding a parental cancer diagnosis and its aftermath. In particular, the present study aims to shed light on how a parental cancer diagnosis and the act of a child caregiving affect the father-child relationship.

Relational Satisfaction

Relational satisfaction is directly correlated to quality of communication, which is positive, intimate, and controlled (Emmers-Sommer, 2004). Duck (1994) has posited that meaningful relationships are based on the extent to which those involved deal with the fact that everyone has a personal system of meanings and organized knowledge that the other might gain insight into but never fully acquire. Talk and communication are more than a behavior, talk and communication are a symbolic presentational force that persuades exposes, displays, and informs; it can be managed in a way that allows each person to see it as their own way to express their own personal meanings. Communication serves many other purposes simultaneously: strategic, individual, and relational (Duck, 1994).

Communication quality has been illuminated as a significant predictor of relational satisfaction (Emmers-Sommer, 2004). People have reported high levels of relational satisfaction when communication is not dismissive and deconstructive (Guerrero et al., 2009). Communication quality and relational satisfaction are directly linked through supportive and constructive communication which is formed from shared meaning (Emmers-Sommer, 2004).

Communication is used to compare and construct shared meaning for a relationship (Duck, 1994). The construction of meaning can be seen to have three elements, or components

(1) content (e.g., the meaning of the words generally understood in a culture), (2) individual (e.g., one's habitual modifications of cultural codes and individual adaptations of forms of cultural expression), and (3) context (e.g., an individual's modifications of habitual or cultural codes in a particular relationship). Creating shared meaning is essential to forming meaningful relationships, as it is these various features of communication that indicate that those involved share a view of the relationship and identify with one another (Duck, 1994).

It was found that positive and open communication are relational maintenance tasks that indicate family relational satisfaction (Morr et al., 2007). Self-disclosure and closeness also have impacts on relational satisfaction. Self- disclosure is defined by Verderber and MacGeorge (2016) as, "verbally sharing personal, private information, and feelings" (p. 168). Relatedly, researchers have found that young adults' surface acting and deep acting is likely to undermine their relational quality with both parents, but young adults who are satisfied in their relationships with both parents are less likely to engage in both surface and deep acting with both parents (Schrodt & O'Mara, 2019). Specifically, young adults who feel caught between their parents may be more likely to engage in surface acting to hide or suppress the tension, discomfort, potential anger, and frustration they feel with being placed in-between their parents (Schrodt & O'Mara, 2019). It has also been established that enhanced family conversation orientation produces more satisfaction in parent–child relationships in emerging adulthood due to increased levels of positivity and openness. To add to that finding, creating a climate in which communication interactions are encouraged, parents and children utilize messages that express support and messages that offer self-disclosure. Thus, the quality of parent-child relationships may be explained by positivity and openness rather than family conversation orientation (Aloia, 2019).

Schon (2014) found that communication repertoire size had a positive, but weak, relationship for emerging adults' communication and relational satisfaction with their parents. Communication repertoire size refers to the multiple medium choices that can be used to communicate. The researcher found that communication repertoire size did not predict relationship satisfaction over communication quality and quantity for either parent or communication satisfaction for fathers specifically. Further results suggest that the parent's use of information communication technologies plays a role in maintaining healthy relationships with adult children. This study emphasizes the importance of parents' communication competence regarding communication and relational satisfaction (Schon, 2014).

When researching relational satisfaction and its effects on breast cancer survivors, researchers found that in satisfying romantic relationships, those with cancer felt less stressed and even had lower inflammation throughout cancer treatment (Shrout et al., 2020). In addition, it is evident that communication between parents and children has impacts on the relationship. Relational satisfaction is built on myriad contexts; however, the research mentioned above has shown clearly that communication plays a large part in relational satisfaction, especially in parent-child relationships. It is for this reason that researching how cancer impacts these relationships—as well as how these relationships impact cancer-related experiences—can provide crucial information to help individuals navigate these situations. Thus, it is important to position cancer as occurring withing a *system* of family members, roles, and functions.

Family Systems Theory

Cancer impacts families in several different ways, from the sickness itself to the disruption in can create in a family's typical routine. Cancer has been studied widely from various disciplines. However, father-child relationships remain largely overlooked in cancer

communication research. For that reason, FST is used in the present study. FST offers further evidence that it is important to add experiences of children with their fathers to the literature on parent-child cancer communication. Smith and Hamon (2012) state that "the focus on the systems theory is on the quality of communication among family members" (p. 149). For that reason, FST provides further evidence of the important of bolstering our knowledge of an understudied dyad within the family system: father-child communication.

FST focuses on a mutual interplay of family members dispositions (Rosenblatt, 1994). After observing the interdependence of family relationships while working as a psychiatrist, Dr. Murray Bowen created the FST to conceptualize the family as an emotional unit (Kerr & Brown, 1988). The theory posits that a family is a "network of interlocking relationships that are assumed to be governed by the same counterbalancing life forces that operate in all natural systems" (p. 3). These networks of relationships had an enormous impact on the thinking, feelings, and behavior of family members; each person in the family was strongly influenced by the family relationship system (Kerr & Bowen, 1988).

There are eight basic assumptions of FST (Smith & Hamon, 2012). The first assumption states that "the whole is greater than the sum of the parts" (p. 146). Essentially this assumption positions that family members are different when they are together when compared to being apart. The second assumption states that "the locus of pathology is not with in the person but in a system of dysfunction" (Smith & Hamon, 2012, p. 147). Here, the locus of pathology refers to the location of the issue. For example, a child develops an eating disorder due to having a controlling parent. That parent developed these controlling behaviors because they had an abusive parent, and so one. This demonstrates that the issue is not anyone's fault but rather a dysfunction of the system due to no locus of pathology (Smith & Hamon, 2012).

The third assumption asserts that "circular causality guides behavior" (Smith & Harmon, 2012, p. 147). This means that the subject of an argument is not as important as the repetitive pattern of interaction; it is how the interaction takes place and what can be done about it to make it more functional. The rules a family have are very important, but families do not have an endless amount of brain space to remember every behavioral response for every situation, thus families pick a few and use those over and over. This concept is referred to as the redundancy principle, which is where rules result from, which is the fourth assumption of FST (Smith & Harmon, 2012).

With any system there are rules and with rules comes feedback. The fifth assumption states that feedback loops guide behavior (Smith & Hamon, 2012). A feedback loop in terms of FST can be either positive or negative. A positive feedback loop is a rewarding response for deviation and promoting change in the family and a negative feedback loop occurs when a family member begins to move outside the limits of the family's behavior and other enact in corrective measure to return to homeostasis Essentially, a family utilizes these feedback loops to correct itself or to regain that homeostasis (Smith & Hamon, 2012).

Assumption six discusses how pathological communication can contribute to relationship problems. Pathological communication refers to the different types of unclear and confusing ways of relating that can cause issues in a relationship. The seventh assumption states that family members take on roles and for any one person to change the entire system must change These roles come from recurring patterns of behavior that are developed through interaction that family members use to fulfill functions The eighth, and final, assumption states that family types are based on the rigidity of family boundaries and that there are three differently types of families The first type is considered an open family, where the family acts as a democracy and the rights

of everyone are protected and interactions with people outside the family is permitted. These open families are built on consensus, flexibility, and are bound by love and respect A random family is one with no boundaries, there are little to no rules, family members are disengaged, and commitments to the family are transitory in these random families the children often this *freedom* as a lack of love. The last type of family is closed. These closed families are overinvolved in each other's lives, have no individual identities, and highly value privacy, secretiveness and limit exposure to media or other external influences (Smith & Hamon, 2012).

FST in Practice

FST has been used in several studies throughout the years. More recently it has been used to explore families and how their social media use affects the family system (Procentese et al., 2019). That specific study aimed at expanding the role of parents' perceptions about social media impacts on the family systems and can apply within their family functioning, regarding efficacy and open communication within the family system with adolescents. This shows that FST is appropriate for the present study as it demonstrates the disruption an outside force can have on the system at hand.

Healy and Allen (2019) conducted a case study with transgender minors and how those experiences impacted the family system. The authors for this study utilized a Bowen family systems framework to employ creative strategies clinicians can apply to help families through the transition process. This study explored how transgender minors distress is due to their dysphoria (outside of their control) and how "the family system may experience increased levels of stress resulting from an inability to support a transgender child within a cis-normative world" (p. 1).

A topic everyone has been impacted by in one way or another is COVID-19. The COVID-19 pandemic has impacted so many people in so many ways, and how it has affected family systems has been explored heavily from different perspectives. Prime and colleagues (2020) explored the risks and resilience in family wellbeing during COVID-19. COVID-19 presented several threats to families (financial insecurity, changes to routines, confinement related stress, etc.) and the consequences of these threats may be long-lasting. This could be due to "the ways in which contextual risk permeates the structures and processes of family systems" (p. 1).

Sarvey and Welsh (2021) also investigated how COVID-19 impacted families, specifically how adolescent substance use presented opportunities and challenges to the family. The pandemic strained family systems already but created a potential increase for conflict and relapses, thus leading to the purpose of their study. These COVD-19 studies also demonstrate that FST is appropriate for the present study as it shows another disruption from an outside force can have on an impact on the system at hand.

In 2010, Harris and colleagues researched cancer risk communication within melanoma families. The authors' goals of this study were to use FST to identify traits "of this sample of families at increased risk of developing melanoma and to relate familial characteristics to the frequency and style of familial risk communication" (p. 1). All the studies mentioned used FST to explore how a specific incident impacted or changed a family system. For that same reason, this study uses FST to explore how a parental cancer diagnosis impacts the father-child relationship and communication. Rather than using FST as a framework, this study uses FST to demonstrate why this study is important.

Strengths and Limitations. As with any theory there are strengths and limitations to FST. A central strength of FST is that it accounts the family that is continuously affected by every part that makes up the whole (Minnich-Sadler, 2005). Priest (2021) even stated that "we can come to a scientific consensus about the best theory for explaining family interactions, and I would argue that we currently have strong evidence for using FST to do so" (p. 106). Priest (2021) argued that the positivist framework of FST can be directly challenged, meaning that it can change and improve based on evidence. Thus, the theory can evolve with the world as it changes allowing it to remain relevant and important for an extended amount of time.

A concern researchers may have regarding FST, is that it is more of a model/flow chart for conceptualizing yet advocates of the theory counter that the worldview most appropriate for FST is the constructivist position. A constructivist researcher is one who works to understand the *experiences* of the participants, meaning that FST is a strong theory to use as a lens to discover participants' perceptions and truths.

Another concern regarding FST is that researchers may forget that FST is a model for understanding and may slip into considering the system to be reality, confusing the model with the thing. It is important to note that FST is no less prone to reification than any other theory (Smith & Hamon, 2012). Essentially people assume that this theory should explain, predict, and control, like most theories rather than to provide an interpretive lens.

While there are limitations there are also strengths to very theory. Broderick and Smith (1979) list the five most productive types of issues for examinations by systems theorists: (1) sequential patterns of interaction, (2) communication and control, (3) goal orientation, (4) boundary maintenance, and (5) complex relationships. Sequential patters of interaction refer to feedback loops and other patterns found in family systems. Communication and control, as well

as goal orientation and boundary maintenance refer to the dynamics and effectiveness of the family system. Complex relationships refer to the fact that life is not linear, and FST recognizes that and includes the fact that there are multiple paths and outcomes, emphasizing branching rather than averaging (Broderick & Smith, 1979). The strengths mentioned were another reason the researcher chose to conduct this study. FST illustrates the need to study families and the under studied father-child dyad. While FST was not utilized as a foundation to the study, it was used as a motivation to study father-child communication.

Present Study

Previous literature related to father-child communication, an important yet understudied link in FST and cancer communication, was explored. There is a plethora of cancer research but very little when it comes to how it affects the family system from a father-child perspective. Cancer communication is an extension of health communication that specifically focuses on communicating about cancer and how cancer affects one's communication. For example, researchers have explored health literacy and cancer communication (Davis et al., 2002), narratives and cancer communication (Green, 2006; Faulkner, 2016), and patient-provider cancer communication (Back et al, 2008).

Other researchers have explored what factors influence family communication about genetic risk (McCann et al., 2009). There is a large amount of communication-focused research surrounding specific types of cancer, especially breast cancer. Researchers have looked at identifying factors associated with psychological functioning in adolescent children of early breast cancer patients (Edwards et al., 2008). This is where this study comes in to play. FST allowed for the focus to be on the communicative process within the family and the impacts it had on the system.

From the previously discussed review of literature, four research questions were created to further expand understanding father-child cancer communication literature and identify gaps in the literature. The research questions that emerged from this review of literature are listed below.

There is a gap in literature and research within father-child communication, especially from the communication field. Without healthy father-child relationships and communication, children could experience a lack of skills to build other healthy relationships throughout their lives (Fellers & Schrodt, 2021). Furthermore, research has illustrated the importance of mother-child communication in the context of a parental cancer diagnosis, yet father-child cancer communication remains largely unstudied. These points led to the first research question.

RQ_1: What themes emerge as salient in talk about father-child communication in the context of a parental cancer diagnosis?

In addition to a need for more father-child cancer communication research in general, although known *motivations* for communication between fathers and children include it being fun, relaxing, and affectionate (Barbato et al., 2003; Martin & Anderson, 1995), little is known about the specific *practices* of father-child relationships. Thus, the second research question seeks to examine what practices children report engaging in with their father while a parent lives with cancer.

RQ_2: What are the communication practices used by the child with their father when a parent is diagnosed with cancer?

Research has shown that caregiving has often resulted in role adjustment and changes to relationships (Wittenberg et al., 2017). The overall most difficult task for caregivers is providing emotional support (Bakas et al., 2001). There are negative and positive experiences when it

comes to caregiving. Many caregivers experience high levels of stress, worsening physical health, and the need to see a psychologist (Lund et al., 2014), yet caregivers also often experience positive aspects such as celebrating the victories (Hogstel et al., 2005) and finding satisfaction in caregiving (Shim et al., 2012). Indeed, it is common to experience ambivalence during caregiving (Pristavec, 2019). Furthermore, scholars have found that experiences of ambivalence might be gendered, with women caregivers tending to experience more ambivalence. This forms the basis of the third and fourth research questions.

RQ_{3a}: Does the child's perceived involvement of caregiving with their parent with cancer positively affect reported relational satisfaction between fathers and children?

RQ_{3b}: Does the child's perceived involvement of caregiving with their parent with cancer positively affect reported closeness between fathers and children?

RQ_4: Does child gender predict level of caregiving?

The research questions listed above frame the methods used in the present study, as described in chapter three.

CHAPTER III: METHODS

The previous chapter summarized the research relevant to relational satisfaction, parent-child communication, and cancer communication. This chapter introduces and explains methods used to gain participants and basic information regarding participants. Chapter three also introduces and explains the procedures, and data analysis of the current study.

Participants

Participants were 18 years or older, lived in the United States and had at least one parent that has been diagnosed with cancer. At the time of the diagnosis participants were at least 15 years old, a requirement that helps to ensure the ability to recall that time-period in the past. The age 15 was chosen because this is an age when children start to transition into young adults. In the United States, 32 states allow 15 year-olds to get their drivers permit thus leading to an increase in responsibility and independence (Highway Loss Data Institute, 2023). Participants must also have had contact with their father during this time. Any parent of the participant may have had cancer to participate in this study, this includes single families, polyamorous families, and traditional families.

Participants were mostly cisgendered men (n = 32; 24.2%), and cisgendered women (n = 92; 69.7%). Three participants identify as nonbinary accounting for .8% of the participants. Three (.8%) participants declined to offer while one (.8%) participant identified as gender nonconforming, and one (.8%) participant self-described as demigirl. Five participants indicated that they identified as Asian or Asian American and Black or African American, both accounting for 3.8% of the participants. Two (1.5%) participants self-described as muti racial, three (2.2%) as Latino/a or Hispanic, and one (.7%) as Arab American, Middle Eastern, or North African.

Most participants identified as White or European American, accounting for 84.8% (n = 112) of the participants.

Participants were also asked to identify the gender identity of their parent with cancer, 77 (58.3%) were indicated to be cisgender men and 51 (38.6%) were identified as cisgender women. Two participants declined to answer. The parents age at time of diagnosis varied starting at 28 years of age and ending at 85 years of age. The most popular ages were 55 (5.3%), 60 (4.5%), 50 (4.5%), 61 (3.8%), and 42 (3.8%).

Participants informed what channel of communication was most frequently used when they communicated with their fathers. Face to face conversations were the most popular at 53 (40.2%) participants indicating this as the most used channel. Phone calls followed at 44 (33.3%), then text at 25 (18.9%), and video call at six (4.5%). Email and Facebook messenger both accounted for one participant each (.8%).

Participants were asked to provide the type of cancer their parent had. Breast cancer was the most common in this study, with 27 (20.1%) participants identifying it as their parent's diagnosis. Breast cancer was followed by lung cancer at 15 (11.2%), colon cancer at 13 (9.7%), prostate cancer at eight (5.9%), leukemia at seven (5.2%), and melanoma at five (3.7%). Four (3.9%) participants identified their parent having pancreatic cancer, and the same for kidney cancer. Uterine, bladder, throat, and thyroid cancer were identified by three (2.2%) participants each. Two (1.5%) participants identified that their parent had stomach, ovarian, nasopharyngeal carcinoma, and colorectal cancer.

There were several diagnoses that were identified by one (.7%) participant each: metastatic cancer, brain cancer, appendicle cancer, carcinoma in the duodenum, cholangiocarcinoma, liver cancer, lymphoma, non-Hodgkin's lymphoma, oral cancer, renal

cancer, renal cancer, skin cancer, testicular cancer, small cell carcinoma, and sarcoma of the nasal cavity. There were also nine (6.7%) participants that noted that their parent had more than one time of cancer at the same time.

Procedures

Convenience sampling was utilized to gain participants from social media, such as Facebook and Reddit, as well as using Illinois State University's School of Communication research announcement board. Convenience sampling is a form of nonprobability sampling in which the researcher announces the study and participants self-select if they wish to participate (Stratton, 2021). A call for participants was sent out in the National Communication Association's COMM Notes and through a university wide email at Illinois State University, including undergraduate students, graduate students, faculty, and staff. All responses were anonymous to ensure participants comfortability in sharing personal topics. Prior to posting the survey on such cites, approval from the Institutional Review Board was obtained. Given a survey asking Likert-type questions the participants were asked to answer regarding closeness, caregiving, and relational satisfaction regarding their relationship with their father. They were then asked to answer open-ended questions to further explore the tone, frequency, content, channel, and differences that the cancer diagnosis had on the communication patterns with their father. There was then an option to write about other aspects in the relationship that were affected but not mentioned in the survey.

Quantitative Methods

Quantitative research has a primary objective to "create, expand, and redefine theory through systematic observation of hypothesized connections among variables" (Allen et al., 2008, p. 4). Data is obtained through surveys and/or experiments in which the researcher's role is

to analyze. The validity of the conclusions and connections drawn during quantitative researcher "is directly dependent on how well the theory, method, and analysis was enacted by the researcher" (p. 5).

This type of research is defined as any approach that uses systematic observations to explain and generalize human behavior. Systematic observation refers to the intent to be able to focus your observations, the ability to replicate findings, the validity of observations, and the researchers account for human behavior. Most quantitative studies use a sample of individuals to draw generalized implications about larger groups or populations. Quantitative methods typically answer what questions (Allen et al., 2008). It is for these reasons that quantitative methods were chosen for this study, to explore what happens to the father-child relationship when a parent has cancer.

Survey

There are two principal research designs for quantitative methods, experiments, and surveys (Allen et al., 2008). This study uses surveys as this design is use tests of associations such as correlations and regression. Surveys are a series of questions; a typical survey used in research is more accurately described as a several surveys put together in a packet. There are many advantages to using surveys such as being able to obtain from large samples, allowing for more full-bodied conclusions. Another advantage is that surveys often take place in naturalistic settings and can provide strong generalizability. This is not to say that there are no disadvantages to surveys. Surveys can help identify relationships between variables, but they are not proficient to identify cause-effect relationships among variables. Several types of questions are used in surveys, this study uses Likert-Scale questions as well as open-ended question (Allen et al., 2008).

The Likert scale was developed to measure attitude in a scientifically accepted and validated manner in 1932 by Likert (Joshi et al., 2015). Originally, the Likert scale was a set of items offered for a situation under study and participants were asked to show their level of agreement. Likert and Likert-type scales are rooted in the aim of research and sometimes the purpose of the research is to understand about perceptions of participants related with a single underlying variable. This underlying variable is expressed by various items in the survey.

These constructed items in a mutually exclusive manner, address a specific element of phenomenon under analysis, and in unity measure the whole phenomena. During the analysis, the scores of items are summed to generate a composite score. The validity of these scales is given by the applicability of the topic concerned and the honest cooperation of the participant (Joshi et al., 2015). If a participant feels they can state their own attitude and not what they think is expected of them, validity can be assumed (Likert, 1932). For this reason, the researcher opted for an anonymous survey to provide a sense of trust and openness to be fully honest for the participants. The topic of the study can elicit an emotional response in the participants which may leading to feelings of being uncomfortable sharing their honest answers if it can be tied back to them.

Open-ended questions are questions that leave the answer open to the participants, on a survey these questions are answered in a text box**.** There are many advantages of open-ended questions such as discovering the responses that individuals give spontaneously and avoiding the bias that may result from suggesting responses to participants that may be found in closed ended questions (Reja et al., 2003). For these reasons the researcher chose to use both methods of data collection to fill any gaps that may arise from the Likert scales.

Measures

Caregiving

A five-point Likert scale was used to determine how perceived caregiving impacted the child. A caregiver is typically an adult child or a spouse that provides care to a person who needs some level of assistance with everyday tasks (Bakas et al., 2001). The Caregiving Reactance Scale (CRS) (O'Malley & Qualls, 2017) was used to explore several dimensions of the caregiving experience in participants of this study. The response choices were slightly modified incase participants did not act as a caregiver or take part in certain parts of caregiving. Response choices ranged from 1 (*not at all*) to 5 (*completely*) with 3 (*neutral*) being added. This scale consisted of seven subscales regarding the participants feelings of themselves, household conflict, financials, and personal losses.

The CRS consisted of seven scales: relational captivity, overload, relational deprivation, competence, personal gain, management of meaning, family beliefs, family conflict, job conflict, and finances. All subscales for the CRS used the responses of 1 (*not at all*) to 5 (*completely*). Relational captivity was a four-item scale, for example, participants were asking if they felt trapped by their relative's illness and if they felt stressed by their relative's illness. Overload was also a four-item scale. For overload participants were asked if they had more to do than they could handle and if they are exhausted when they go to bed at night. Relational derivation was a six-item scale. Example items of this scale included asking the participants to what extent they had lost "being able to confide in their relative" and "having someone who really knew them well."

The 11-item management of meaning scale asked participants how often they used certain coping strategies, such as trying to keep their sense of humor and exercising. Family

beliefs was another four-item scale; this scale asked the participants about the level of disagreement they had with family members due to issues such as the need to watch out for the relative's safety and whether the relative should have been placed in a nursing or assisted living facility. The family beliefs scale was followed by the family conflict scale. The family conflict scale was eight items and asked about the level of disagreement among the family based on variables such as having a lack of patience with the relative and not giving the participant enough help. Finally, the job conflict scale was five items and asked participants how much they agreed with the statements about their work situation. Examples of items from the job conflict scale include "you have less energy for work" and "you have missed too many days" (O'Malley & Qualls, 2017, p. 293).

The CRS displays good psychometric properties and convergent and discriminant validity. This suggests a valid and reliable measure of the "positive and negative aspects of the caregiving experience" (p. 288). Internal reliability was strong according to the Cronbach's alpha analyses that were done on each subscale. Cronbach's alpha coefficient was used to establish internal reliability; the scores of the seven subscales of the CRS showed good to excellent internal consistency $\alpha \geq .82$.

O'Malley and Qualls reported Cronbach's alpha for all subscales. They reported $\alpha = .82$ for role captivity. The current study calculated the final EFA procedure for role captivity and produced an acceptable one-factor solution. Both the KMO measure (.746) and Bartlett's test [$\chi^2 = 132.822(6)$, $p < .001$] were acceptable. The unidimensional solution, consisting of four items, explained 49.7% of the variance. The final single factor solution produced an overall alpha coefficient reliability of .79 for the scale producing respectable reliability. They also reported an alpha coefficient of .82 for overload. Similarly, to role captivity, the current study calculated the

final EFA for overload produced an acceptable one-factor solution. Both the KMO measure (.819) and Bartlett's test [$\chi^2 = 304.922(6)$, $p < .001$] were acceptable. The one-factor solution, consisting of four items, explained 66.8% of the variance. The final unidimensional solution produced an overall alpha coefficient reliability of .88 for the scale producing respectable reliability.

Relational deprivation reported having an alpha coefficient of .85. The final EFA procedure for relational deprivation in the current study produced an acceptable one-factor solution. Both the KMO measure (.877) and Bartlett's test [$\chi^2 = 377.336(15)$, $p < .001$] were acceptable. The one-factor solution, consisting of six items, explained 56.3% of the variance. The final unidimensional solution produced an overall alpha coefficient reliability of .88 for the scale producing very good reliability. Family beliefs was reported to have an alpha coefficient of .87. The current study calculated the final EFA procedure for family beliefs and again produced an acceptable one-factor solution. Both the KMO measure (.723) and Bartlett's test [$\chi^2 = 194.716(6)$, $p < .001$] were acceptable. The one-factor solution, consisting of four items, explained 53.9% of the variance and the final unidimensional solution produced an overall alpha coefficient reliability of .81 for the scale producing very good reliability. Family conflict reported have an alpha coefficient of .92. The final EFA procedure for family conflict produced an acceptable one-factor solution. Both the KMO measure (.882) and Bartlett's test [$\chi^2 = 910.346(28)$, $p < .001$] were acceptable. The one-factor solution, consisting of eight items, explained 68.6% of the variance. The final unidimensional solution produced an overall alpha coefficient reliability of .94 for the scale producing excellent reliability.

Finally, O'Malley and Qualls (2017) reported job conflict having an alpha coefficient of .85 The final EFA procedure for job conflict from the current study produced an acceptable one-

factor solution. Both the KMO measure (.814) and Bartlett's test [$\chi^2 = 250.818(10)$, $p < .001$] were acceptable. The one-factor solution, consisting of four items, explained 52.7% of the variance. The final unidimensional solution produced an overall alpha coefficient reliability of .84 for the scale producing very good reliability. Previous research stated that management of meaning was not considered unified leading the researchers to not calculate or report reliability data for the subscale.

Correlations were run against all subscales and demonstrated that the constructs were related but the amount of variance that did not overlap was substantial enough to document subscale distinctiveness. The authors stated that the "initial psychometrics suggest the CRS offers a reliable and valid assessment of multiple dimensions of the caregiving experience" (O'Malley & Qualls, 2017, p. 281). Moderate positive correlations were found between some of the subscales of the CRS, this suggested that a relationship among burden, competence, and family atmosphere exists.

O'Malley and Qualls (2017) ran correlations with other caregiving scales to test validity of the CRS. They stated that "validation of the CRS against the most commonly used caregiver burden measure yielded the expected positive relationships among subscales tapping similar constructs" (p. 288). The role captivity and job conflict subscales were not significantly correlated with either ZBI subscale or ZBI total score. However, the overload subscale exhibited good convergent validity with the ZBI personal strain, ZBI role strain and ZBI total scores. Similarly, the relational deprivation subscale demonstrated good convergent validity with the ZBI personal strain subscale and the ZBI total score.

Relational Satisfaction

To determine the relational satisfaction affects a parental cancer diagnosis may or may not have on the parent children relationship a parent-child relational satisfaction scale was used. This scale was a 14-item scale and used a five-point Likert scale, responses ranged from very dissatisfied to very satisfied. Participants were asked to use this scale regarding communication and openness, conflicts, and intimacy. The scale used was built off Burns' (1993) Relational Satisfaction Scale (BRSS). The researcher adapted this scale by adding trust and quality time to the scale and deleted the closeness aspect as there is a question in its own regarding closeness. The resolving conflicts and arguments item was also changed to conflict management as not all conflicts can be resolved but can be managed.

Validity and reliability of the BRSS have been proven sound for research as the scale has good internal consistency with a coefficient alpha = .94 (as cited in, Heyman et al., 1994). The BRSS also has a strong correlation with other measures of relationship satisfaction. These measures are those such as the Locke-Wallace MAT (r = .80), the Dyadic Adjustment Scale (r = .89), and Norton's Quality of Marriage Index (r = .91) (as cited in, Heyman et al., 1994). The current study calculated the final EFA procedure for the relational satisfaction scale and produced an acceptable one-factor solution. Both the KMO measure (.965) and Bartlett's test [χ^2 = 1838.606(91), $p < .001$] were acceptable. The one-factor solution, consisting of 14 items, explained 69.7% of the variance. The final unidimensional solution produced an overall alpha coefficient reliability of .96 for the scale producing excellent reliability.

Closeness

Closeness was determined using a 12 item, five-point Likert-type scale. The scale ranged from 1 (*strongly disagree*) to 5 (*strongly agree*). Participants were asked if they felt close with

their father as well as if they felt their father was a priority in their life. Participants were also asked if they feel like they can share problems or intimate issues with their father. The scale used was the Unidimensional Relationship Closeness Scale (URCS) developed by Dibble and Levine (2012). The scale was modified by the researcher to specifically ask about the participants relationship with their father as well as changing it to a five-point scale from a seven-point scale. Reliability and validity were assessed by the original researchers using dating couples. The results indicated that the scale is unidimensional with a high reliability across relationship types (α = .96) (Dibble & Levine, 2012). Validity "included considerable within-couple agreement for the romantic couples (intraclass correlation = .41), substantial friend-stranger discrimination for the female friends (η^2 = .82), and measurement invariance across relationship types" (Dibble & Levine, 2012, p. 569). The Eigenvalues obtained were, in order: 6.89, 1.06, and 0.66.

The final EFA procedure for the closeness scale from the current study produced an acceptable one-factor solution. Both the KMO measure (.925) and Bartlett's test [χ^2 = 1306.393(66), $p < .001$] were acceptable. The one-factor solution, consisting of 12 items, explained 61.3% of the variance. The final unidimensional solution produced an overall alpha coefficient reliability of .95 for the scale producing excellent reliability.

Demographic Items

Questions regarding sex of participants and parents, type(s) of cancer, size of family were asked. Participants were also asked when their parent was diagnosis and what age their parent was at that time, as well as the participants age at the time. A Likert-type scale was used it determine the closeness in the parent-child relationship before and after the cancer diagnosis. Questions about frequency and channel of communication were asked as well as when the parent informed the child of their diagnosis.

Data Analysis

Statistical Analysis

Multiple regression tests and correlations were run for research questions 3a and 3b in SPSS. A correlation helps answer a fundamental question about the relationship of two variables and ranges from +1.00 to -1.00 (Allen et al., 2008). If the variables are not correlated the value will be zero. A positive correlation indicates that as one value increases so does the other, while a negative correlation indicates that as one value increase the other decreases.

A correlation predicts the strength of the relationship between two variables while a simple regression takes it a step further. A regression estimates how much variance in the dependent variable is accounted for by the variance in the independent variable. While calculating a simple regression a researcher will get an unstandardized beta value, telling the researcher how many units of one variable must change to achieve one unit of change in the other variable. The simple regression is useful because it takes the correlation further and provides information that can be useful for prediction. The test run for research question four is different than those used for research question three. An independent samples *t*-test was run for research question three. An independent samples *t*-test examines the mean difference between two groups (Allen et al., 2008). For research questions one and two a thematic analysis was used to analyze the data.

Thematic Analysis

A thematic analysis was utilized to find themes within the data. A thematic analysis was used to systematically identify and organize themes across a data set and allows researchers to make sense of shared meanings found within data (Braun & Clarke, 2012). There are six steps to a thematic analysis: (1) familiarize with the data, (2) generate initial codes, (3) search for themes,

(4) review themes, (5) define and name themes, and (6) produce the report (Braun & Clarke, 2006).

Step one consisted of reading through all the data once before immersion occurred. Immersion consisted of rereading the data activity and searching for patterns. During this step the researcher also took notes and marked ideas for codes. The second step is where initial codes were generated from the notes and markings on the data set. Step three is where themes were developed.

Development of the themes started with the data that had been initially coded and collated. The data consisted of a list of many different specific codes that were then sorted into larger themes. This is where codes began to be analyzed. This was followed by reviewing and refining the themes. Reviewing and refining themes consisted of two levels. Level one was the review at the level of the coded data extracts while level two considered the validity of individual themes in relation to the data set (Braun & Clark, 2006). During this step, open and axial coding were utilized. Open coding refers to going through the data and marking parts with appropriate labels (codes) to be used in further analysis later (Allen, 2017). The researcher used words and short phrases as the unit of analysis during the analysis specifically important for step three of a thematic analysis. Open coding is generally the initial stage of qualitative data analysis; upon completing open coding researchers typically move on to conduct axial coding.

Axial coding was derived from grounded theory and is the process of relating codes of data to each other. Axial coding seeks to identify central phenomena in the data and makes connection between categories to reveal themes new categories, and/or sub-categories. A concern for any type of analysis is the credibility and trustworthiness of the method, “axial coding has proved to be a trustworthy and credible tool for analysis throughout the

communication discipline and others" (Allen, 2017, p. 80). Using axial coding themes can be further identified. Open coding finds the big picture categories while axial coding finds the subthemes that go under the larger umbrella themes found during open coding (Allen, 2017).

Following open and axial coding step five was completed; this step consisted of defining and naming the themes and finally, step six was the production of the report (Braun & Clark, 2006). This can be found in the following chapter.

Triangulation

There are four types of triangulations, however this study used methodologic triangulation (Thurmond, 2001). Methodological triangulation involves using more than one kind of method to study a phenomenon. It has been found to be beneficial in providing confirmation of findings, more comprehensive data, increased validity, and enhanced understanding of studied phenomena. Methodologic triangulation comes in two different types, this study utilized what is called, "between method triangulation." Between method triangulation refers to the use of both qualitative and quantitative data collection methods in the same study.

There are many benefits to triangulation, such as the possibility of increasing confidence in data, revealing unique findings, providing comprehensive data, increasing validity, and providing clearer explanations and understandings of an issue (Thurmond, 2001). Qualitative and quantitative data both seek to understand and explain phenomena, even though some argue that the methods paradigms differ epistemologically (Dzurec & Abraham, 1993), the approaches are similar in their objectives and scope, thus merging these methods allows for further representation (Thurmond, 2001).

Triangulation is also used for completeness purposes, especially with understudied research areas (Hussein, 2009). A benefit of qualitative research is its use to generate rich data

that can help researchers in developing hypotheses and research questions for quantitative research. There are areas that are less researched, therefore coming up with credibly testable hypotheses and research questions for these areas, researchers need to make use of qualitative and quantitative methods (Hussein, 2009).

The use of the methods described above were used in this study to examine the research questions at hand. In the following chapter the results and explanations of said results can be found. Furthermore, implications of the results, practical and theoretical, can be found in chapter five.

CHAPTER IV: RESULTS

The chapter at hand presents the findings of the thematic analysis and quantitative tests described in Chapter III, thus answering the four research questions posed in Chapter II. The findings of this chapter are organized by those research questions, the first section addressed the qualitative findings from questions**,** RQ1 "What themes emerge as salient in talk about father-child communication in the context of a parental cancer diagnosis?" and RQ2 "What are the communication practices used by the child with their father when a parent is diagnosed with cancer?" The second section addressed the quantitative findings of RQ3a "Does the child's perceived involvement of caregiving with their parent with cancer positively affect reported relational satisfaction between fathers and children?," RQ3b "Does the child's perceived involvement of caregiving with their parent with cancer positively affect reported closeness between fathers and children?" and RQ4 "Does child gender predict level of caregiving?" After the findings are presented in this chapter, they are interpreted in the succeeding discussion chapter.

Salient Themes in Father-Child Talk

To answer RQ1, participants were asked about the content of the conversations they had with their fathers during the time of a parental cancer diagnosis and four themes emerged. The first theme was health, followed by phatic talk, family, and hobbies. Each theme was constituted by subthemes, which provide more nuance and understanding for the themes. Thus, each overarching theme, and the subthemes that comprise it, are described and illustrated with exemplars in the following subsections.

Health

The theme of health included discussions that surrounded the cancer diagnosis, prognosis, doctor appointments, and feelings of physical and mental health. Unsurprisingly participants discussed health with their fathers when they had a parent diagnosed with cancer. Most of the health-related conversations revolved around the parent with cancer; however, some did not. Participant 131 stated that she talked about their mental state with their father. This demonstrates that there was concern for the child's wellbeing as well as the parent with cancer's wellbeing.

Participant 119 shared his experience of learning about his parent's cancer diagnosis stating that:

> When it got closer to the time that he was going to be hospitalized and have surgery it was occasional short talk about what was going to happen and what needed to be brought to the hospital. He'd been sick and in and out of the hospital my whole life, so this didn't really mean much to me and there was no big meaningful conversation. It was just another thing he's going to the hospital for.

Participant 85, sharing a similar sentiment with participant 119, stated that her "parents tried to deny that his situation was serious." Although participant 119 stated his parent's cancer-hospitalization was "just another thing," participant 107 shared that she discussed her father's "doctor appointments, his progress in his chemo and how things were looking. He also repeatedly tried to get me and my siblings to not be worried about him." While it appears on the surface that the content of these conversations is about the parent's health, the parents try, in what they think is the best way, to protect their child and their child's mental health. The examples above show that whether directly approached about their mental state or not the

parent's attempted to alleviate stress by either asking about the child's health, denying the seriousness of the situation, or simply telling the children to not worry. This demonstrates that while the children worry about their parents, their parents are still worried about them.

Participant 108 shared that her father "talked about what it (cancer) is and how he is going to try and do better for himself and how we can help out with him during that time." This quote demonstrates that some health conversations were informative and educational, teaching the child in the relationship what was going on and how they can help.

Other participants shared that they discussed their parent's prognosis, general terms about their parent's diagnosis, their parent's treatment, and current symptoms, as well as the parent's feelings. For example, participant 90 shared that they discussed how her "stepmom was doing, how HE was doing, and what the next steps were." Participant 89 even shared that her and her father would discuss "what life will be like from that point on, what we will do when my mother passes, and how I'm feeling." These examples demonstrate that that the fathers worked to inform and educate the children, whether it be about the diagnosis itself or how the child can help. This shows that the fathers were attempting to create a realistic and functional relationship with the children and the change they were facing.

Although some participants had a positive outlook during the diagnosis others did not. Participant 81 shared that their father discussed "how he was going to die soon and I would severely regret not talking to him." Others, like participant 77, were optimistic but their fathers still tried to prepare them for the worst. Participant 77 stated that her father discussed "how she [mother with cancer] will survive, and how I need to mature quickly in case she were to pass away." These demonstrate that not all fathers and children have a great relationship and the

cancer diagnosis exacerbated that. The fathers here were not keen on being emotional with their children.

Participant 62 shared that her dad kept her updated on the diagnosis and treatment plans, as did other fathers. Participants also discussed the next steps in treatment and doctors' visits. Participant 34 even discussed power of attorney and next of kin information with her father. In addition to sometimes in-depth health conversations, participants also talked about the salience of phatic talk, or small talk, with their fathers.

Phatic Talk

Phatic, or small, talk refers to the everyday conversations one may have. These conversations are used to maintain social bonding (Fadhil, 2022). Subthemes for phatic talk included daily life, school and work, and checking in and updates. Many participants were in high school or college when their parents were diagnosed, leading discussions of school grades and school activities with their father, as well as work. Some discussed their fathers work with them such as participants 60, 61, and 126. Others discussed the participant's job. Some even discussed both of their jobs. Participant 57 stated he discussed his new job and how his father was looking forward to retirement as well as how work was going before that retirement. Participant 87 shared that it was her first year as a teacher and they often talked about her new career.

Some participants simply stated that they discussed daily happenings and hassles with their father. Participant 91 stated that he discussed "daily happenings and pet antics" with his father. Participant one mentioned that she discussed "our day, plans for going out, [and] current events" with her father. Participant 31 mentioned that they would discuss "life updates [and] how one another was feeling." Participant 125 disclosed that she was "always checking in on [her]

father as [she was] away at college." Participant 5 stated that they "were often checking in with each other."

While it may not seem that these small everyday conversations hold any significance, it is important to recognize these experiences. These examples demonstrate that even in a tragic and scary time normal, everyday conversations are still taking place. These conversations could have been used to break awkward silences or to transition into a more serious conversation. Either way, it is comforting to learn that there was still a sense of normalcy during these times.

Family

While checking ins happen often between family members and often are the start of conversations, it can lead to conversations of other family members and matters. Theme three consisted of the theme, family. This included subthemes of topics that typically involve families, such as advice, home maintenance, the child's level/need to help, reminiscing, visiting, and money. Some participants, such as participant six, simply stated that they discussed money and family, while others went more in depth.

Participant 19 shared that he and his father discussed "My new life in California. I had moved the summer before he was diagnosed. My relationship with my girlfriend (now wife), whom I moved to California for. How my mom and brother were doing. How he was doing."

Participants stated that they often discussed family with their father during this time as well as advice and home maintenance with their fathers. Participants nine and 112 simply stated that they discussed life advice and house repairs with their fathers. Participant 24 stated that "often he [her father] offered assistance with fixing things." Participant 102 went most in depth stating they conversed about their "thoughts about road maintenance, the importance of driver's

education, politics, economics, how to read mail, how to write a check, and other house maintenance." House maintenance went hand in hand with the child's need to help.

Other participants stated that they talked to their fathers regarding helping out. Participants 17, 39, 55, and 133 reported simply asking if they (the fathers) needed any help. Participant 101 stated that she and her father discussed chores that needed done and other things she needed to help with when her father could not and participant 104 stated that her and her father would get in "occasional arguments about chores." Participant 115 shared that they discussed "school, things I [the participant] needed him to buy, and his work." Checking in with parents, asking for advice, and arguing about chores also demonstrates a sense of normalcy for the participants. This once again demonstrates that even during a stressful situation, fathers and children can still have a sense of normalcy in their relationships.

On top of advice and house maintenance, some people reported discussing the logistics of visits with their fathers. Participant 137 reported that they often discussed "wanting to see him [their father] more" and participant 112 reported "coordinating quick visits." Visits can lead to many conversations including reminiscing. Reminiscing was chatted about by four participants. Participants four, eight, 51, and 79 reported this topic. Participant four simply stated that they talked about "good memories" and participant eight stated they talked about "the past." Participant 79 reported that they reviewed "his [their father] childhood" and participant 51 reported "childhood and growing up" as a topic of conversation. This demonstrates that some participants truly valued the time they had with their father and used it as a way to strengthen their relationship by seeing him more and talking about his past or the past experiences they had together.

Visits can also lead to talks of finances, especially during a health crisis. Richard et al. (2021) reported that a cancer diagnosis may place a financial burden on patients and families through large and repeated costs of treatment and potential loss of employment. This leads to no surprised that participants also discuss finances with their fathers during their parents' time of diagnosis. Only six participants reported discussing finances whether it be in the form of financial advice (participant five), loans (participant 50), or money for groceries (participant 65). Participants did not go further in depth regarding their financial discussions with their fathers. While serious conversations regarding family life and expectations occurred, so did talk about mutual matters the father and child enjoyed.

Hobbies

The theme of hobbies included the subthemes of sports, news, food, art, and music. Participant two stated that they discussed "sports or the news" and participant six stated they discussed the Ohio State football team. Music was also a hobby discussed. Participant 50 shared that her father would discuss "upcoming concerts the family might want to go to." Other participants simply stated "music." Four participants stated they discussed food with their fathers, three stated they discussed art, and one participant mentioned discussing gardening with their father. The once again demonstrates a sense of normalcy between the fathers and children. On top of that, these results could also demonstrate the use of hobby talk as a distraction. Lacking the ability to ask for further elaboration limits the conclusions that can be made from these results.

Communication Practices

When attempting to answer RQ2 and uncover how a parental cancer diagnosis impacts father-child communication practices, five themes emerged. Those five themes included normal

communication, emotional communication, cautious communication, more communication, and decreased communication. In most themes were subthemes. These subthemes provide more nuance and understanding for the themes.

Normal Communication

The first theme included the responses of the participants who simply noted that they approached the conversations with their fathers the same as they always had. None of these participants went further in depth to inform what that looked like for them. It can only be known that the participants did not perceive any changes in how they communicated with their father in the context of a parental cancer diagnosis. While some participants communication practices with their fathers did not change, others became more emotionally charged.

Emotional Communication

The second theme of emotional communication included the subthemes of empathy sympathy, and supportive. Participants who had responses that fell into this theme stated that they were trying to remain happy and supportive as an effort to limit the stress on their father. Participant 87 shed light on her experience and stated:

> My dad and I have always been pretty open with each other so we would communicate often and easily but we both were carrying a lot of weight due to my mom's diagnosis. I tried to approach communication though with an empathic approach because I knew that he was really struggling.

Some participants mentioned trying to keep a positive atmosphere during this time. Participant 127 stated that she would “stay bubbly” and participant 132 shared that she “tried to stay optimistic and let him know how much I love him.” Participants 68 and 69 responses also fell under this theme. Participant 68 stated that he approached conversations “with sympathy”

while participant 69 stated that she "listened to him and tried to help him take care of my mom as much as possible."

Participant 63 shared that she strived to "be positive and give encouragement" in their conversations. Participant 58 shared that she "tried to be as positive as possible, tried distracting him and talking about things other than cancer." Participant 59 stated that her parent was diagnosed while they were away getting their master's degree, but that did not inhibit their conversations. She stated that prior to the diagnosis she rarely spoke with their father but now she calls every day to "try to keep a positive and happy conversation about anything and everything."

Participant 55 shared a similar sentiment stating that she approached "most communication looking for a way to make him laugh or help him out." Other participants also shared that they approached their conversations respectfully and participant 32 shared that he strived to be "more compassionate in communicating" with his father. Participant five shared that she approached conversations with "lots of love and offering any help or comfort."

Other participants also shared that they worked towards understanding and sticking to the facts to do so. Participants 6, 15, 27, 45, 49, 69, and 113 shared that they mostly listened about what their father had to say about oncologist reports, aspects of treatments that the father needed help with, and other medical details. Discussing sensitive details surrounding the diagnosis and treatment lead others to be more cautious of how they approached their communication with their fathers. The responses show that the child was seriously concerned with their situation at hand and attempted to be a source of light during a dark time. This also shows the compassion that the participants have for their fathers. While some children attempted to be the light during a dark time, others were more wary regarding their communication with their father.

Cautious Communication

Those responses that fell into the cautious theme included the subthemes of being straightforward and inquisitive while the participants reminded careful and honest. Those that were inquisitive such as participant two simply asked if their mom (their parent with cancer) was okay to be okay, others like participant seven asked for details on dates and milestones. Participant 26 asked questions directly about their father's diagnosis but regularly asked their mother too in an effort to not stress their father out. Then there was participant 112 who stated:

> I asked more questions, not just about the past, but I wanted to know his opinions, preferences, experiences, thoughts. I asked about his fears, dreams, regrets. I was just generally more curious and less inhibited, wanting to soak up as much of him as possible in the time we had left together.

This demonstrates that participant 26 truly valued and wanted to continue to learn and grow closer with their father by getting to know him better. It also demonstrates a sense of urgency to do so in the limited time they had left together. This could be due to many reasons, maybe the participant and father dd not have a close relationship in the past and saw this as an opportunity to forget about the years they took for granted and enjoy what they can.

Participant 28 also asked direct question as his father and his father's partner had a low level of health literacy. He stated that he "had to carefully word questions or comments in an effort to obtain proper medical information." Similarly, participants 132 and 106 asked questions for clarity. In response to the prompt, participant 106 stated that she "just asked him questions about exactly what he had and what his treatment would look like, I wanted to know as much as I could because I was so curious as to why he was feeling awful every day."

This demonstrates an issue that many face. According to Lopez and colleagues (2022), 88% of adults living in the United States lack the level of health literacy to adequately navigate the health system. Without proper health literacy, one cannot properly understand the care being given/received, nor can one advocate for themselves or their loved ones during a time of need. It appears that some participants had a higher health literacy level than their fathers, making it difficult to understand what the doctors were informing them of, as the fathers most likely did not fully understand and were thus less able to convey information to the child.

Participant 62 sought the same answers as participants 28, 132, and 106 but had a different experience. She stated that she had "to be very direct in asking questions and seeking answers. This was the wrong approach; I found he doesn't want to be questioned; he just wants to talk about his problems."

Other participants approached communication with their fathers cautiously as to not to be disruptive. An example of this would be participant 64 who said she approached communication "somewhat carefully to not upset him, but he was pretty open." Participant 36 shared that same feeling, stating he was more hesitant to approach/ bother, especially if he wasn't feeling well during his treatments.

These responses demonstrate that many felt they had a strained relationship with their fathers and the diagnosis only exacerbated that. Those that were more straightforward appeared to have a closer, more intimate relationship with their father while those who were more cautious and attempted to "beat around the bush" did so because they feared upsetting their father. Those that were more cautious lacked that emotional aspect that those who were straightforward had with their father.

Some participants, like 57, had other reasons to be cautious. Participant 57 said that he was cautious because he "did not know how to talk about the diagnosis and was scared." Participant 81 was careful to not communicate their doubt. Participant 134 stated that she approached conversations with caution, curiosity, and sadness. She said this was "because I knew everyone else around me was sad so it felt like that's how we should feel around him."

More Communication

Becoming more cautious when communicating with a parent in a time of distress was the reaction some participants had, others used this diagnosis time as an opportunity to talk more with their father. Participant 19 shared that he talked to his father "a little more when he was willing and able." Participant 21 shared that she "checked in" more frequently but her father did not continue long after his diagnosis and their conversations were the father telling the participant "how bad it was and me trying to make things better."

Participant 33 shared that he started to call his father more. He was consistently unsure of what was going to happen and did not want to "take any time for granted." They "went from texting to calling seven times a week." Participant 98 shared a similar outlook but faced a different outcome. She shared that she started calling their mother several times a day because of becoming agitated with their father and that the father "really didn't talk much directly" to her.

Participant 121 shared that they despite living in different states her father's cancer diagnosis led to increased communication on a regular basis via text and email. Participant 122 shared that she moved back home to spend time with their father during the summer. The face-to-face communication increased as they would eat breakfast and "enjoy the day-to-day friendly interactions" with each other. Participant 112 shared:

> We communicated less often through text and phone calls and spent more time talking in person. Our conversations became more poignant and more emotional. We reminisced more. I asked more questions, not just about the past, but I wanted to know his opinions, preferences, experiences, thoughts. I asked about his fears, dreams, regrets. I was just generally more curious and less inhibited, wanting to soak up as much of him as possible in the time we had left together. I also more freely shared my own memories, experiences, thoughts, and perspectives. I made a point to tell him how he had influenced me, the ways I was like him, the things I would carry on because of him. I vocalized my love, care, and affection more explicitly and more tenderly. There were often times, especially in the early days of his diagnosis (we knew he was terminal), where words could not express the depths of emotion, we felt towards each other. In those moments, our communication was entirely non-verbal, expressed only through the silent tears streaming down our faces and the soft caresses of our clasped hands.

These responses demonstrate an effort from the participant to further their relationship with their father and make an active effort to really get to know them better. It is interesting to note that the children were the ones reaching out to initiate the conversations, rather than the fathers. This could be due to many different reasons, maybe the father is the sick parent, maybe the father is busy taking care of the sick parent, and maybe the father was uncomfortable reaching out to have conversations and show intimacy with their children.

Less Communication

Some participants indicated an increase in communication with their fathers and other revealed the exact opposite. Those that reported a decrease in communication simply stated that. There were a few that fell into the subtheme of avoidance. Participant 125 shared that she “made

sure to not talk about the diagnosis too much so as to not stress him out or make my dad emotional." Others, such as participant 111 shared that the communication in general was "rather avoidant."

Participant 102 shared a similar experience as 111. Participant 102 shared that their father "did not speak about it except about occasionally communicating about feeling better or worse (especially about eating). I would avoid conversation about his condition." Participants 74, 75, and 85 disclosed that they talked to their fathers less, mostly to avoid discussing the diagnosis. Participant 80 on the other hand stated that communication with their father decreased because their father "became a worse and worse person."

These results demonstrate that for some, the children even lacked the desire to reach out to their fathers. Some of these participants stated exact reasons why, a few saying it was because they did not want to discuss the diagnosis or because they did not want to upset their father. Perhaps the decrease in communication was due to a lack of intimacy in the relationships. Some stated that they avoided communication with their father because they did not want to upset him or make him become emotional. Thus, demonstrating a lack of emotional availability between the participants and their father.

Child Caregiving and Father-Child Relational Satisfaction

A multiple linear regression procedure investigated if father-child relational satisfaction could be predicted by the linear combination the caregiving aspects of role captivity, overload, relational denervation, management of meaning, family beliefs, family conflict, and job conflict. This multiple linear regression was run to and RQ3a. Missing cases were excluded pairwise. Results of the regression analysis indicated that 32.2% of the variance in father-child relational satisfaction could be predicted by role captivity, overload, relational denervation, management of

meaning, family beliefs, family conflict, and job conflict., R^2_{adj} = .273, $F(7, 96) = 6.53$, $p < .001$. Results of the regression indicated that predictor variables were able to account for a significant amount of variance in the outcome variable.

Analysis of regression coefficients indicated that role captivity, β = -.376, t = -3.36, p < .001, 95% CI [-.63, -.16] and family conflict, β = -.286, t = -2.70, p = .008, 95% CI [-.49, -.07], were a significant individual predictors of father-child relational satisfaction. These findings indicted a negative relationship between role captivity and family conflict with father-child relational satisfaction, meaning that as the child perceives that they are stuck in the role they possessed their perceived level of relational satisfaction with their father decreased. The same is true for the family conflict variable. As family conflict increased the child's perceived level of relational satisfaction with their father decreased.

The other five variables did not indicate significance. Analysis of regression coefficient of, overload, β = .022, t = .17, p = .85, 95% CI [-.20, .23], relational deprivation, β = -.145, t = -1.26, p = .20, 95% CI [-.44, .09], management of meaning, β = .122, t = 1.29, p = .20, 95% CI [-.12, .58], family beliefs, β = .019, t = .17, p = .86, 95% CI [-.21, .25], and job conflict, β = .204, t = 1.78, p = .07, 95% CI [- .02, .46], did not demonstrate significance.

The squared part correlations revealed that role captivity uniquely predicted 7.9% of the variance, family conflict 5.1%, and job conflict uniquely predicted 2.2% of the variance, management of meaning uniquely predicted 1.1% of the variance, relational deprivation uniquely predicted 1.1% of the variance, overload uniquely predicted 0.02% of the variance, and family beliefs uniquely predicted 0.01% of the variance. None of the variables produced Tolerance or Variance Inflation Factor (VIF) statistics indicating collinearity. Beta weights for this are located on Table 1.

The multiple linear regression model for RQ3a demonstrated no support for RQ3a. No positive relationships were found, but two negative relationships were. Role captivity and family conflict both demonstrated negative relationships with father-child relational satisfaction. This means that as role captivity and family conflict increase, father-child relational satisfaction decreases.

Table 1

Beta Weights for Relational Satisfaction Model

Variable	*B*	*SE B*	*β*
Role Captivity	-.398	.118	-0.376**
Overload	.020	.111	0.022
Relational Deprivation	-.174	.137	-0.145
Management of Meaning	.230	.178	0.122
Family Beliefs	.020	.117	0.019
Family Conflict	-.286	.106	-0.286**
Job Conflict	.218	.122	.204
	R^2	.322	
	R^2_{adj}	.273	
	F	6.52	

Note. An * indicates a unique significant predictor variable at $p < .05$. ($n = 125$)

Father-Child Closeness

A multiple linear regression model was calculated to investigate if father-child closeness could be predicted by the linear combination the caregiving aspects of role captivity, overload,

relational deprivation, management of meaning, family beliefs, family conflict, and job conflict. This multiple linear regression was run to answer RQ3b. Missing cases were excluded pairwise. Results of the regression analysis indicated that 17.5% of the variance in the variance in father-child relational satisfaction could be predicted by role captivity, overload, relational denervation, management of meaning, family beliefs, family conflict, and job conflict., R^2_{adj} = .115, $F(7, 97) = 2.93$, p = .008.

Results of the regression indicated that predictor variables were able to account for a significant amount of variance in the outcome variable. Analysis of regression coefficients indicated that role captivity, β = -.359, t = -2.93, p = .004, 95% CI [-.53, -.10], was a significant individual predictor of father-child closeness. This indicted a negative relationship between role captivity and father-child closeness, meaning that as the child perceives that they are stuck in the role they possessed their perceived level of closeness with their father decreased.

Analysis of regression coefficients indicated that overload, β = .008, t = .05, p = .95, 95% CI [-.19, .20], relational deprivation, β = - .026, t = -.208, p = .83, 95% CI [-.27, .22], management of meaning, β = .128, t = 1.23, p = .21, 95% CI [-.12, .52], family beliefs, β = -.014, t = -.11, p = .90, 95% CI [-.22, .19], family conflict, β = -.126, t = -1.08, p = .28, 95% CI [-.29, .08], and job conflict, β = .106, t = .84, p = .39, 95% CI [-.12, .31] did not demonstrate significance.

Squared part correlations revealed that role captivity uniquely predicted 7.2% of the variance, management of meaning uniquely predicted 1.2% of the variance, family conflict 1.0%, job conflict uniquely predicted 0.60% of the variance, relational deprivation uniquely predicted 0.03% of the variance, family beliefs uniquely predicted 0.01%, and overload uniquely

predicted 0.002% of the variance. None of the variables produced Tolerance or VIF statistics indicating collinearity. Beta weights for this are located on Table 2.

The multiple linear regression model for RQ3b demonstrated no support for RQ3b. No positive relationships were found, but one negative relationship was. Role captivity demonstrated a negative relationship with father-child relational satisfaction. This means that as role captivity increases, father-child relational satisfaction decreases.

Table 2

Beta Weights for Closeness Model

Variable	*B*	*SE B*	*β*
Role Captivity	.316	.108	-.359**
Overload	.006	.101	.008
Relational Deprivation	-.026	.125	-.026
Management of Meaning	.201	.162	.128
Family Beliefs	-.013	.106	.014
Family Conflict	-.104	.096	-.126
Job Conflict	.094	.111	.106
R^2		.175	
R^2_{adj}		.115	
F		2.93	

Note. An * indicates a unique significant predictor variable at $p < .05$. ($n = 132$)

Child Gender and Caregiving

An independent samples *t*-test was conducted to determine if child gender affected one's level of caregiving for their parent with cancer. This test was run to answer RQ4. Seven independent samples *t*-tests were run to assess each aspect of caregiving. The Levene's test for equality of variances was not significant ($F = .04$, $p = .85$), so equality of variance was assumed. Significant results did not emerge, $t(98) = 1.86$, $p = .06$, 95% CI [-.93, .03] . Male participants' ($M = 2.03$; $SD = .97$) scores of role captivity did statistically significantly differ from female participants' ($M = 2.48$; $SD = 1.01$) scores of role captivity.

The Levene's test for equality of variances was not significant ($F = .04$, $p = .85$), so equality of variance was assumed. Significant results did emerge here, $t(115) = 1.94$, $p = .05$, 95% CI [-1.02, .009]. Male participants' ($M = 2.14$; $SD = 1.03$) scores of overload did statistically significantly differ from female participants' ($M = 2.65$; $SD = 1.21$) scores of overload. These results indicate that female participants experienced higher levels of overload than the male participants.

While overload had significant findings, the remainder of the variables did not. The Levene's test for equality of variances of was not significant ($F = .02$, $p = .90$), so equality of variance was assumed. Significant results did not emerge, $t(113) = .19$, $p = .85$, 95% CI [-.42, .35]. Male participants' ($M = 1.80$; $SD = .87$) scores of relational deprivation did not statistically significantly differ from female participants' ($M = 1.84$; $SD = .87$) scores of relational deprivation.

The Levene's test for equality of variances was not significant ($F = .74$, $p = .39$), so equality of variance was assumed. Significant results did not emerge, $t(111) = .07$, $p = .94$, 95% CI [-.27, .25]. Male participants' ($M = 2.95$; $SD = .74$) scores of management of meaning did not

statistically significantly differ from female participants' (*M* = 2.96; *SD* = .54) scores of management of meaning.

The Levene's test for equality of variances was not significant (*F* = .12, *p* = .73), so equality of variance was assumed. Significant results did not emerge, *t(*112) = .63, *p* = .53, 95% CI [-.59, .31]. Male participants' (*M* = 1.86; *SD* = .99) scores of family beliefs did not statistically significantly differ from female participants' (*M* = 1.99; *SD* = 1.01) scores of family beliefs.

The Levene's test for equality of variances was not significant (*F* = .005, *p* = .85), so equality of variance was assumed. Significant results did not emerge, *t*(110) = .82, *p* = .42, 95% CI [-.67, .28]. Male participants' (*M* = 1.78; *SD* = 1.02) scores of family conflict did not statistically significantly differ from female participants' (*M* = 1.97; *SD* = 1.08) scores of family conflict.

The Levene's test for equality of variances was not significant (*F* = .05, *p* = .83), so equality of variance was assumed. Significant results did not emerge, *t*(109) = 1.59, *p* = .12, 95% CI [-.81, .09]. Male participants' (*M* = 2.51; *SD* = .95) scores of job conflict did not statistically significantly differ from female participants' (*M* = 2.51; *SD* = 1.03) scores of job conflict. To summarize, one variable of caregiving was affected by child gender. Overload results indicated that female participants experienced higher levels of overload than the male participants, thus, there was partial support of research question four. Role captivity, relational deprivation, management of meaning, family beliefs, family conflict, and job conflict were not impacted by child gender.

Correlations among Scales

A bivariate correlation was run to assess the relationship between relational satisfaction, closeness, and caregiving. Relational satisfaction demonstrated a very strong, positive relationship, $r(123) = .77$, $p < .001$, significant at the .01 level, with closeness. When analyzing the association between relational satisfaction and caregiving, it was found that the association differed based on the different aspects of caregiving.

The correlation test for relational satisfaction and caregiving uncovered five significant relationships. Relational satisfaction demonstrated a moderate, negative association with role captivity, $r(102) = .37$, $p < .001$, relational deprivation, $r(121) = .32$, $p < .001$, and family conflict, $r(119) = .39$, $p < .001$. Relational satisfaction demonstrated a weak, negative association with overload, $r(122) = .25$, $p = .006$. Two variables demonstrated insignificant correlations, management of meaning, $r(120) = .05$, $p = .57$ and job conflict, $r(119) = .04$, $p = .67$.

The same was true with closeness, where the association with caregiving differed based on the different caregiving aspects. Four variables indicated a significant association with closeness. Closeness demonstrated a moderate, negative association with role captivity, $r(111) = .37$, $p < .001$. Closeness also demonstrated a weak, negative association with overload, $r(131) = .20$, $p = .02$ and relational deprivation, $r(127) = .20$, $p = .02$. Insignificant findings occurred between closeness and management of meaning, $r(125) = .08$, $p = .40$, family beliefs, $r(126) = .16$, $p = .07$, and job conflict, $r(123) = .03$, $p = .74$.

A bivariate correlation was also run to assess the relationship between frequency of communication and closeness as well as quality of conversations and closeness. Closeness demonstrated a weak, positive association with frequency of conversations between fathers and children, $r(127) = .23$, $p = .009$. However, closeness demonstrated a strong, positive

association with the quality of conversations between fathers and children, $r(130) = .57$, $p = .001$.

Results indicated that RQ3a and RQ3b were not supported. The results of RQ3a exhibited a negative relationship between role captivity and family conflict with father-child relational satisfaction. This indicates the participants who experienced high levels of feeling captive in their roles and those that experienced high levels of family conflict had lower levels of father-child relational satisfaction. Similarly, the results of RQ3b demonstrated a negative relationship between role captivity and father-child closeness. This means that the participants who experience more feelings of captivity within their role feel less close to their fathers. The results of RQ4 revealed that child gender did impact levels of caregiving when it came to overload. Female participants reported higher levels of overload when acting as a caregiver, compared to the male participants, thus, a partial support of RQ4.

Table 3

Correlations among Scales

Scale	*N*	*M*	*SD*	1	2	3	4	5	6	7	8
Closeness	132	3.72	.89	-							
Relational Satisfaction	125	3.55	1.08	.76**	-						
Role Captivity	111	2.43	1.02	-.32**	-.47	-					
Overload	131	2.54	1.18	-.19*	-.22**	.53**	-				
Relational Deprivation	129	1.86	.90	-.19*	-.32**	.55**	.47**	-			
Management of Meaning	127	2.93	.57	.07	.05	.16	.02	.22**	-		
Family Beliefs	128	1.99	1.00	-.15	-.23**	.36**	.45**	.47**	.20*	-	
Family Conflict	125	1.95	1.08	-.23**	-.38**	.42**	.42**	.39*	.17	.53**	-
Job Conflict	125	2.39	1.01	.03	-.03	.32**	.54**	.49**	.34**	.34**	.37**

** Correlation is significant at the 0.01 level (2-tailed)

* Correlation is significant at the 0.05 level (2-tailed)

In the fifth and final chapter that follows a discussion regarding the implications of the results will be provided. The following chapter will provide an explanation of the results. It will also provide reasoning of how the present study adds to communication literature, implications of the results, limitations of the study, and areas for future research.

CHAPTER V: DISCUSSION AND CONCLUSION

Throughout the present study, participants provided insights regarding what fathers and children discuss when a parent has cancer and how they approach communication in such a situation. Participants also provided information regarding how child caregiving may impact relational satisfaction and closeness. The qualitative data analysis for RQ1 revealed four overarching themes about salient themes in father-child talk when a parent has cancer: health, phatic talk, family, and hobbies. A continuation of qualitative analysis for RQ2, examining communication practices, identified five overarching themes: normal communication, emotional communication, cautious communication, more communication, and less communication.

The quantitative analysis for RQ3a indicated that two caregiving variables (role captivity and family conflict) had a negative effect on father-child relational satisfaction. The remainder of the variables did not result in significant findings. To directly answer the research question, "Does child caregiving positively affect father-child relational satisfaction?" the findings indicted it did not.

Similarly, the quantitative analysis for RQ3b indicated that one caregiving variable (role captivity) had a negative effect on father-child closeness. This research question was not supported by the findings. The findings indicated that as a child feels stuck in their role their perceived level of closeness with their father decreased. The quantitative analysis for RQ4 explored if caregiving was impacted by child gender. Results indicated that none of the caregiving variables differed significantly between males and females.

Overall, the findings of this study suggest that a child acting as a caregiver negatively impacts the father-child relationship and even more so for female participants. This could be due to a plethora of reasons, that were further explored in this chapter.

The final chapter continued to discuss the ways in which the present study's findings contribute to the extant literature previously discussed. Specifically, the study's contribution to literature will be addressed and followed with practical implications. Finally, limitations of the present study were dissected and possible directions for future research in the interrelated areas of family and cancer.

Contributions to Communication Literature

Most notably, the present study adds to the limited research on father-child communication. In gathering and analyzing the experiences of the participants, the present study offers insights into father-child communication during a parental cancer diagnosis. As discussed in chapter one, father-child communication research is quite limited, thus the present study adds to the literature. The same is true regarding cancer communication, as discussed in chapter two most cancer communication is researched on mothers and daughters or when a child has a cancer diagnosis. The present study adds to the cancer communication literature the exploration of a dyad that has previously not been studied.

Cancer Communication

Previous researchers, as discussed in chapter two, discovered that when a parent had a cancer diagnosis, communication regarding emotional issues was limited between the parents and children. The children reported that their fathers were uncommunicative about their own emotions (Thastum et al., 2008). Findings from the present study support Thastum et al.'s findings. Participant 85 shared that they would avoid talking their father's cancer as he became more irritable and disliked discussing his feelings.

Forrest and colleagues (2009) discovered that fathers often lacked adequate information regarding the diagnosis and treatment side effects. This finding was also supported by the present

study. Participant 28 shared that their father and their father's partner had low levels of health literacy. This led to the participant being very careful and intentional to obtain correct medical information from their family. This information demonstrated how the present study's focus on health and father created an additur to the literature. Further father and family communication contributions continue in the following subsection.

Family

While it was unsurprising that health and cancer were topics of conversations between parents and child when a parent had cancer, it is important to note that participants maintained a healthy family relationship by talking about other things. The salient topics of conversation for the participants were the everyday discussions. These kinds of everyday discussions are known as phatic talk/communication. Phatic communication can refer to utterances that are used to maintain or create social bonding and to maintain a friendly atmosphere (Fadhil, 2022). According to Fadhil (2022), phatic communication "is language that binds the hearer to the speaker by a tie of some social sentiment or other" (p. 63). It is also language that conveys information about the needs and wishes of the conversation participants.

For these reasons it makes sense that participants discussed how other family members were doing and what the pets were up to. These everyday conversations helped maintain the family system that was in place before the diagnosis and might have aided in the transitions that were necessary to make within the systems given the circumstances. Interestingly, this phatic talk paired nicely with the results from RQ2, especially the theme of normal communication. The theme of normal communication and phatic talk go hand in hand together. The phatic talk allowed for a sense of normalcy in everyday life. The same goes with the theme of family, hobbies, and normal communication. Families often engage in small talk to begin conversations

and often talk about other members of the family; this demonstrates that even during a tragic time a sense of normalcy is still there. This is important as it demonstrates that while change occurs within the family system, not everything has to change drastically. Further theoretical implications, specifically regarding FST are in the following section.

Theoretical Implications

Chapter one introduced FST as another reason to study a specific dyad in a system. The present thesis project worked to build on and add to the limited research on father-child communication. Bowen's FST was utilized to understand how the interruption of a cancer diagnosis disrupts/impacts the family system in place. FST was chosen because it provided an understanding of the family by focusing on the interplay of members dispositions (Rosenblatt, 1994). The present study focused on an understudied dyad, father-child relationship.

Results indicated that one of the caregiving roles that negatively impacted females, role captivity, was the same as the role that negatively impacted father-child closeness and relational satisfaction. This finding implies that the father-daughter relationship is more important than may be realized. Thus, while father-child relationships are understudied, father-daughter studies need to be addressed as well.

Results from the present study also indicated that father-child relational satisfaction was negatively impacted when there was family conflict. This indicates that internal conflicts (i.e., conflicts within the family) negatively impact the relationship. One possible explanation for these results may lie in traditional gender roles. Most of the participants were female and based on traditional gender roles and the qualitative results of participants trying to maintain positive and enacting as caregiver supports that.

In many Western societies women are believed to be more nurturing and enact in nurturing roles (Blackstone, 2003). An example of a traditional gender role a woman might engage in would be staying home to care for the family rather than having employment outside of the home. On the other hand, Blackstone states that men are expected to enact in traditional masculine roles such as being head of the household, provide for the family financially, and focus on other such tasks. This could be a potential explanation for the responses provided and the demographics of the participants. These implications demonstrate that the present study added to the existing FST literature and even left questions for further research that were addressed in the directions for future research section.

Toxic Masculinity

Toxic masculinity has been defined as a set of behaviors and beliefs such as suppressing emotions or masking distress, maintaining an appearance of hardness, and violence as an indicator of power (Salam, 2019). Essentially, toxic masculinity is "what can come from teaching boys that they can't express emotion openly; that they must be 'tough all the time'; that anything other than that makes them 'feminine' or weak" (Salam, 2019, para. 8). Harrington (2021) stated that emotionally distant father-son relationships result in *toxically* masculine men.

Throughout the study toxic masculinity has appeared, although it was not directly named. For example, the results of RQ1 identified four themes that emerged as salient in father-child talk. These themes were health, phatic talk, family, and hobbies. Notice that these are not emotionally charged topics. Health and family at times could be, however no participants mentioned those themes being emotional, but rather informational. Results of RQ2 share a similar sentiment. One of the themes from RQ2 was emotional communication, however for every participant that mentioned that it was the child reaching out and approaching the

conversation in an emotional manner. Some participants were even cautious when they approached communication with their father. Some participants mentioned going through their mother instead, to not disrupt or bother their father. Some also mentioned walking on eggshells and being careful as to what they discuss to avoid angering their father.

These results demonstrated that many participants had a strained relationship with their father and lacked the emotional intimacy in that relationship as well. It is likely that these father-child relationships are those with fathers who lacked an emotionally open father as well. Men who lack adequate fathering pursue unrealistic cultural images of masculinity and feel a constant need to prove their manhood, this often translate into their actions of fatherhood (Harrington, 2021). The lack of adequate fathering in turn leads to more inadequate fathering creating a perpetuating cycle of toxic masculinity in new generations.

Family Communication Patterns Theory

Adding more theoretical framing could answer some gaps in the current study. Further exploring this concept using family communication patterns theory could add to further explanation of the father-child relationship and how a parental cancer diagnosis impacts those relationships. Family communication patterns theory is used to "describe family's tendencies to develop fairly stable and predictable ways of communicating with one another" (Koerner & Fitzpatrick, 2006, p. 51). Within family communication patterns theory there are two dimensions, conversations orientation and conformity orientation. Conversation orientation is defined as "the degree to which families create a climate in which all family members are encouraged to participate in unrestrained interaction about a wide array of topics" (p. 54). These families spend much of their time interacting with each other and sharing their own activities, thoughts, and feelings. Those that are on the high end of the conversation orientation dimension

interact freely and spontaneously with one another without limitations regarding the topic discussed or the time spent in the interaction. On the other side, families that are on the low end of the conversation orientation dimension do not place high value on open and frequent conversations, deeming them unnecessary.

The second dimension is the conformity orientation. This dimension "refers to the degree to which family communication stresses a climate of homogeneity of attitudes, values, and beliefs" (Koerner & Fitzpatrick, 2006, p.55). Families on the high end of this dimension hold high value in interactions that emphasize uniformity of beliefs and attitudes, often associated with a traditional family structure. Those families that are on the low end of this dimension believe in a less cohesive and hierarchical family; they believe that relationships outside the family are equally as important as the relationships within the family. Families on the low end of conformity orientation encourage personal growth of individuals even if it results in a weakened family structure.

Based on these dimensions Koerner and Fitzpatrick (2006) list four different types of families, consensual, pluralistic, protective, and Laissez-Faire. Consensual families land high on both conformity and conversation orientations. Pluralistic families are high in conversation orientation and low in conformity orientation. Protective families are low on conversation orientation and high on conformity orientation. The last family type is Laissez-Faire. Laissez-Faire families are low in both conversation orientation and conformity orientation (Koerner & Fitzpatrick, 2006).

Understanding these family types and researching them in this context could have provided many insights on how different family types handle such a stressful situation. Going through the data and searching for hints as to which family type participants belong could have

provided many results and explanations we did not have before. For example, RQ2 explored communication approaches between fathers and children and understanding what family type the participants came from could provide valuable explanatory power. The same goes for RQ1, different family types probably played a role in what these families discuss with their children. It would also be interesting to see how family type impacts RQ3a and RQ3b. Relational satisfaction and closeness are most likely impacted by the family type as well. Understanding how family types of impact relational satisfaction and closeness could then lead to explanations for the topics of conversations and the approaches to communication.

Expectancy Violation Theory

The results from the quantitative research were not what was expected, expectancy violation theory could help further explain the disconnect between the expected and the actual. Based on what mother-child communication research has found, it was expected that results from this study would be similar to those previous findings. Expectancy violations theory explores how people respond to unanticipated violations of social norms and expectations (Burgoon, 2015). Further analyzing the data and continuing to research this area using expectancy violations theory could provide many explanations and insights on the differences between father-child and mother-child relationships. While there is much more nuance to expectancy violations theory research of this nature could provide practical applications to families, therapists, and counselors.

Practical Implications

The findings of the present study bring forth possible practical implications that may help those that have a parent with cancer. As mentioned in chapter one, this project worked to create insights for those for those that have a parent with cancer, to health care providers to help

families cope, and for therapists and counselors to help families in the future. Also, this piece may provide insights for those that have family members with cancer and help them learn more of what to expect and how many families handle the stress of cancer diagnosis.

The findings regarding how children approach communication with their fathers during a parental cancer diagnosis had mixed findings, but many participants mentioned avoidant communication practices as to not upset their father. This is a part of treatment and recovery that medical professionals may not have accounted for during the process. Medical professionals may be more focused on saving the patient's life and avoiding remission, making it easy to overlook how one may be emotional. Thus, having a therapist or counselor as part of the treatment plan may help to create an open environment or to even help the patient and family adjust to this new journey.

For those that have a parent with cancer, the findings of the present study may help prepare them for possible experiences. Having a small understanding of what may occur can be helpful and in turn can allow participants to be actions into plan. For example, depending on how the relationship with one's father may be, the child probably has some idea of how a cancer diagnosis may change or exacerbate their qualities. Thus, allowing the opportunity to incorporate preventive measures. These measures could be for the child or the parents, such as going to therapy or setting up a strong support system to help get through a difficult time.

Limitations

While the present study offers insights for many, it is not without limitations. While the study employed mix methods the open-ended questions on the survey lacked nuances and did not provide as much information as an interview. An interview would have elucidated the opportunity for elaboration. Another limitation regarding the qualitative data is the lack of

generalizability. While that was not the goal of the study, it is important to note. Also, the study was not as diverse as it could have been. Of all the participants, 69.7% were cisgendered woman and 24.2% were cisgendered men. An overwhelming number of participants, 84.8%, identified as White or European American.

This study also asked most participants to recall back to the time their parent had cancer, while only two participants were experiencing a parental cancer diagnosis at the time of the study. This could have been the reason for many of the limited and short responses on the open-ended questions. The study was also limited by age. Participants were supposed to be at least 15 years-old when their parent was diagnosed which left some not able to qualify for the study.

Another limitation of the present study was participant confusion. Participants were confused on which parent to answer questions to. For example, if a participant's mom had cancer, they often mentioned that it did not make sense that they were to answer the question regarding their relationship with their father. This can be prevented in future research by providing more clear instructions and directions.

Directions for Future Research

While the current participants may have been a bit confused, there is plenty of research that they could participate in the future, with more clear instructions and direction. Many of the participants mentioned discussing money with their fathers. Further exploring the financial impact cancer can have on a family is a topic that could be explored from two points of view: when a parent has cancer and when a child has cancer. To further the research done in this study adding factors such as age and longevity could provide interesting insights.

Given that there is still little research on father-child communication and father-child cancer communication there are several opportunities for further research, such as how father-

child relationships are impacted when the father has cancer and how father-child relationships are impacted when the other parent has cancer. Father-child communication in general could explore specifically father-daughter communication, father-child financial communication, father-child educational communication, father-child sex communication, father-daughter cancer communication, and father-child cancer communication when a child has cancer, specifically from the father's perspective. In addition to exploring father-child communication, examining the emotional communication of sons could provide many insights for parents and counselors. Another opportunity could be how a parental cancer diagnosis impacts sibling communication. An important topic that should be studied is toxic masculinity and parenting, specifically from a communication lens. There could be many practical applications from a study of that nature and could provide many insights on how that affects children and even spouses.

Conclusion

Overall, the present study contributes to the body of communication, cancer, and family literature, specifically father-child communication literature adding the much need voices of those that have experienced a parent with cancer. The lack of previous research in father-child relationships was the main reason for this study and continuing to study these relationships are important as they may be more impactful than given credit for, especially as we see a shift in traditional masculinity and fatherhood. Throughout the study examples of toxic masculinity could be found. These examples show that toxic masculinity is an issue that continues to materialize in the father-child relationship and needs to be further researched.

Through this research process I learned so much. Unlike many others, I have become closer with my father and my mother. My dad and I have always been close so to me it makes sense that we became closer during a scary time. My mother becoming sick affected us all more

than we probably realize. I know from my experiences that my mother's cancer diagnosis created a bond within my family and between us all that those that have not experienced this would understand. I am so lucky to have my father and the relationship we have. It saddens me to see from my results that others have had the opposite experience as me.

Being able to share our emotions with each other has never been an issue for any one of my family members. I am so incredibly lucky to have that and a parental system that encourages that as well. Being emotional is just a part of life and is more than okay, especially during tragic times. While I am so lucky to have been positively impacted by this experience, many have not. I see the barriers those experience and hope that continued research in this area can bring light to and educate everyone about these experiences and toxic masculinity. I am glad to have experienced positive outcomes from such a tragic occurrence, and I am grateful that I get to continue to spend time with my parents.

Present Day

It is April 2023, I pack my car with my belongings and my pets, preparing to embark on the six-hour drive to my parents' home, and I begin to envision what this day will bring. I rush as I am excited to get home to see my parents and my cat, Spot. I know I will beat both parents home from their days at work. After I get home, my dad will arrive about an hour or two later, depending on traffic, of course. The first thing he will do is greet my dog and ask me how school has been going. We will either cook dinner together or go pick up Chinese food. I love Chinese food. While we wait for my mom to get home, my father and I will sit out on the deck and talk for a few hours, or we will watch a movie in the living room in companionate silence.

After a couple hours of spending time with my dad, my mother will come home from work. The first thing she will do is grab whatever my dog brought her and play for a little while.

Then, I will get a huge hug. I will never get tired of her hugs. Then, we will all stand around the kitchen and catch up, talking about the most annoying things that happened to us that day.

Finally, we will end the night watching either infomercials or a show on the couch together. I may be 25, but I will never be too old to lay on the couch with my parents and watch nonsense television with them. As we all head to bed, I cannot help but to think of the days when my mom was sick with cancer, and how lucky I am we are all still here together. It is hard to believe that only five years ago our lives were interrupted with my mother's cancer diagnosis. Luckily, I get to go home and see my parents happy, healthy, and carefree. Not having to worry about the status of their health is a blessing in itself right now.

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APPENDIX A: SURVEY INSTRUMENT

Parent must have had cancer when you were no younger than 15 years old and you must have had contact with your father during the time of the parent's cancer diagnosis to participate in this study.

Please remember to not disclose any identifying information in your open-ended question responses.

Open Ended Questions

Answer regarding your relationship with your father during the time of your parent's cancer diagnosis.

1. Describe the overall tone of your everyday conversations with your father when your parent had cancer in terms of the following:
    a. On average, how would you rate the quality of the conversation from 0 (negative) to 100 (positive). (Number slider)
        i. Why did you choose this rating?
    b. Content of the conversations: What sorts of things did you commonly communicate about?
2. How do you approach communication with your father after your parent's cancer diagnosis? (When your parent had cancer)
3. What communication differences have you noticed since your parent's cancer diagnosis?
4. How do you feel about these differences?
5. Is there anything else you'd like to share about your communication with your father?

Demographic Questions

1. How do you describe your gender identity?
    a. Drop down box:
        i. Cisgender man
        ii. Cisgender woman
        iii. Transgender man
        iv. Transgender woman

v. Gender nonconforming

vi. Nonbinary

vii. Two-spirit

viii. Prefer not to answer

ix. Prefer to self-describe—text box

2. How do you identify?

    a. Drop down box

        i. American Indian, Alaska Native, Indigenous

        ii. Arab American, Middle Eastern, North African

        iii. Asian, Asian American

        iv. Black, African American

        v. Native Hawaiian, Pacific Islander

        vi. Southeast Asian

        vii. White, European American

        viii. Prefer not to answer

        ix. Prefer to self-describe—text box

3. What is the gender identity of your parent with cancer?

    a. Drop down box

        i. Cisgender man

        ii. Cisgender woman

        iii. Transgender man

        iv. Transgender woman

        v. Gender nonconforming

vi. Nonbinary

vii. Two-spirit

viii. Prefer not to answer

ix. Prefer to self-describe—text box

4. What type of cancer did/does your parent have? (Text box)
5. How many years ago was your parent diagnosed? (Number slider, 0-20)
    a. What was their age during this time? (Number slider, 0-100)
6. How old were you when your parent was diagnosed? (Number slider, 0-100)
7. On average, how frequently do you talk with your father on a weekly basis? (Number slider, 0-50)
8. What channel of communication do you use most frequently when communicating with your father? (Drop down box: phone call, text, face to face, video calls, email)
9. Describe the makeup of your immediate family, specifically your parent(s)? (Ex: Single parent father, mother-father, father-father, etc)
    a. Text box answer

The Unidimensional Relationship Closeness Scale (URCS) (Dibble & Levine, 2012)

For the purpose of this question please keep this definition of closeness in mind while answering the following questions.

Closeness is defined as "the degree to which individuals affect and are affected by each other" (Laursen & Collins, 2003, p. 337).

Please think about your relationship with your father when responding to the following questions. Please respond to the following statements using this scale:

Strongly disagree (1), disagree (2), neutral (3), agree (4), strongly agree (5)

1. My relationship with my father is close.
2. When we are apart, I miss my father a great deal.
3. My father and I disclose important personal things to each other.
4. My father and I have a strong connection.
5. My father and I want to spend time together.
6. I'm sure of my relationship with my father
7. My father is a priority in my life.
8. My father and I do a lot of things together.
9. When I have free time, I choose to spend it alone with my father
10. I think about my father a lot.
11. My relationship with my father is important in my life.
12. I consider my father when making important decisions.

Caregiving Reaction Scale (O'Malley & Qualls, 2017)

Please think about your relationship with your father when responding to the following questions. Please respond to the following statements using this scale:

Not at all (1), somewhat at all (2), neutral (3), quite a bit (4), completely (5)

Here are some thoughts and feelings that people sometimes have about themselves as caregivers. How much does each statement describe your thoughts about your caregiving?

A) Here are some thoughts and feelings that people sometimes have about themselves as caregivers. How much does each statement describe your thoughts about your caregiving?

1. Wish you were free to lead a life of your own.

2. Feel trapped by your relative's illness.
3. Wish you could just run away.
4. Feel stressed by your relative's illness and needs.

B) How much does each statement describe you?

1. You are exhausted when you go to bed at night
2. You have more to do than you can handle
3. You don't have time just for yourself
4. You work hard as a caregiver but never seem to make any progress

C) Caregivers sometimes feel that they lose important things in life because of their relative's illness. To what extent have you personally lost the following:

1. Being able to confide in your relative
2. The person whom you used to know
3. Having someone who really knew you well
4. A chance to do some of the things you planned
5. Contact with other people
6. A sense of who you are lost an important part of yourself

D) People can often learn things about themselves from taking care of a relative. How much do you:

1. Believe you've learned how to deal with this very difficult situation
2. Feel that, all in all, you're a good caregiver
3. In general, feel competent as a caregiver
4. Feel self-confident as a caregiver

E) Since becoming a caregiver, how much have you

1. Become more aware of your inner strengths
2. Become more self-confident
3. Grown as a person
4. Learned to do things you didn't do before

F) There are many different ways of coping with the stress of caregiving. How often do you:

1. Try to accept your relative as he/she is, not how you wish he/she could be
2. Try to think about the present rather than the future
3. Try to keep your sense of humor
4. Spend time alone
5. Eat
6. Smoke
7. Get some exercise
8. Watch TV
9. Read
10. Take some medication to calm you down
11. Drink some alcohol

G) Family members don't always see eye-to-eye when it comes to dealing with a relative who is ill. How much disagreement have you had with anyone in your family about the following issues:

1. The seriousness of your relative's memory problems
2. The need to watch out for your relative's safety
3. What things your relative is able to do for him/herself

4. Whether your relative should be placed in a nursing home or assisted living

H) How much disagreement have you had with people in your family because they:

1. Don't spend enough time with your relative
2. Don't do their share in caring for your relative
3. Don't show enough respect for your relative
4. Lack patience with your relative
5. Don't visit or telephone you enough
6. Don't give you enough help
7. Don't show enough appreciation for your work as a caregiver
8. Give you unwanted advice

I) How much do you agree with the following statements about your present work situation?

1. You have less energy for your work
2. You have missed too many days
3. You have been dissatisfied with the quality of your work
4. You worry about your relative while you're at work
5. Phone calls about or from your relative interrupt your work

J) These questions ask about your household expenses and your standard of living. Compared with just before you began to take care of your relative how much would you agree, with the following statements:

1. Total household income has decreased
2. Total monthly expenses have increased
3. In general, family finances work out at the end of the month

Parent-Child Relational Satisfaction Scale (Burns, 1993)

Answer regarding your relationship with your father.

Very Dissatisfied (1), Slightly Dissatisfied (2), Neutral (3), Moderately Satisfied (4), Very Satisfied (5)

1. Communication and openness
2. Conflict management
3. Supportive Communication
4. Constructive Communication
5. Channel of Communication
6. Communication quality
7. Communication quantity
8. Degree of affection and caring
9. Intimacy
10. Trust
11. Quality time
12. Satisfaction with your role in the relationship
13. Satisfaction with your parent's role in the relationship
14. Overall satisfaction with your parent-child relationship