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**IT'S HARD TO TALK WHEN YOUR CHILD HAS A LIFE THREATENING  
ILLNESS: A QUALITATIVE STUDY OF COUPLES WHOSE CHILD IS  
DIAGNOSED WITH CANCER**

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## ABSTRACT

When parents are confronted with something as fundamental as a cancer diagnosis for their child, it is generally assumed that sharing the emotional impact of it, in the form of talking about it with the partner, is helpful and necessary in order to cope as an individual and a couple. However, couple communication in the context of childhood oncology is often challenging. In this qualitative research, we aimed for a better understanding of how partners experience their couple communication during treatment of their child. Thematic coding was done on in-depth interviews with sixteen parents (seven couples interviewed together and two mothers). We found that the circumstances of the treatment period impacted couple communication. In the interviews parents provided three main meanings to their limited talking (1) because of the hospital and treatment context, (2) for self-care/self-protection related to the value of blocking emotions, and (3) because of each other. These findings invite us to rethink equating emotional closeness and frequent or intense emotional communication in couples with a child who has cancer. This research, framed in a dialectic approach, emphasizes the value of both talking and not talking in the tense and challenging couple situation of dealing with a child's cancer diagnosis and treatment. Rather than advocating the general promotion of open communication, our study suggests the value of hesitations to talk at certain points in the process, while also taking into account the degree of marital difficulties in offering interventions aimed at improving couple communication.

## INTRODUCTION

A child's cancer diagnosis and treatment have an impact on all family members (Kazak, Rourke, & Crump, 2003; Rolland, 2005). Families need to adjust to a new reality of an unexpected and life-threatening illness and reorganize family functioning to deal with the increased care needs, hospitalizations and aggressive treatments (Long & Marsland, 2011; Van Schoors et al. 2015). For parents - the most important and present persons in the child's life - having a child with cancer is extremely challenging and emotionally intense. Ample research has demonstrated the effects of childhood cancer on the individual adaptation of parents, their functioning and psychological distress (e.g. Gibbins et al., 2012; Grootenhuis & Last, 1997; Klassen et al., 2007; Van Schoors et al., 2017; Vrijmoet-Wiersma et al., 2008). Although it is clear that the couple relationship of parents becomes strained in this stressful time, research on the impact of pediatric cancer on the subsystem of the couple relationship is rather limited (e.g. Burns et al., 2017; Lavee & Mey-Dan, 2003; Silva-Rodrigues et al., 2016; Steffen & Castoldi, 2006; Wiener, 2016). Mixed results have been found in both quantitative and qualitative studies on the effects on marital satisfaction, emotional closeness, role changes, intimacy and couple communication. In their review, Van Schoors and colleagues (2017) concluded that overall most couples adapt well to the crisis of pediatric cancer in most domains, with the exception of the domain of sexual intimacy.

A recurrently studied domain in the couple relationship, indicated as a critical determinant of the impact of childhood cancer on the relationship, is communication between parental partners (e.g., Da Silva et al., 2010; Hall, 2010; Lavee & Mey-Dan, 2003; Wijnberg-Williams, 2015). Research is sparse and does not allow strong conclusions regarding the changes in couple communication during the child's illness, nor its impact on the couple relationship (Van Schoors et al., 2017). Undoubtedly, being able to talk with one another can

help a couple to connect emotionally, handle stress and know they can cope with difficult situations together (Wiener, 2016). However, communication between partners during the child's treatment can be challenging. This is in part caused by the physical distance between the partners, as one parent typically stays at the hospital and the other goes to work or stays at home to care for other children and to carry out household chores. Moreover, the expression of affect in times of chronic illness may be suppressed, as one may be afraid to exacerbate tense feelings in other family members (Patterson, 1991).

But how do partners react to suppressing or avoiding conversations about their emotions? Manne and colleagues (2003) assumed that avoidance of communication between parents in the context of a child's illness would be detrimental to mothers' psychological adaptation, as it may inhibit the cognitive processing that may derive from talking with others. However, contrary to their predictions, they found that perceived avoidant communication of the partners was associated with decreases in maternal anxiety.

The complexity of couple communication in times of emotional stress has been addressed in the literature on parent grief (Author, Year; Toller, 2005; Toller & Braithwaite, 2009). A dialectic perspective on communication shows promise, as the value of talking and not talking in a couple relationship is emphasized (Baxter, 2011; Baxter & Montgomery, 1996). In previous research related to the communication of parents after the loss of a child to cancer (Author, Year) several meanings of not talking were found. The dialectical process of talking and not talking could partly be understood as an emotional process of attunement on an intrapersonal and interpersonal level. In the same way Author (Year) questioned if simple dichotomies, like talking and not talking, can capture the complexity of family communication.

To our knowledge, no qualitative research has been done to explore the experiences of parents related to their communication with each other in times of a severe illness and treatment of a child. Indeed, more qualitative research is needed “that can enrich our understanding of the complicated context-related factors facilitating or barring successful pediatric cancer communication” (Sobo, 2004, p.150).

Qualitative research methods are particularly useful when data or information is limited, such as is the case for parents confronted with child oncology (Akard et al., 2013). Systematically exploring the phenomenon through qualitative research can result in a rich description of the phenomenon that is grounded in the data, which can then lead to fundamental reflections on conceptual issues. In this study we used thematic analysis to analyze qualitative interview data on communication in couples who are challenged by the cancer of one of their children. We asked parents about their couple communication during cancer treatment of their child. By “communication” we mean the verbal exchanges with one another related to their emotions (f.ex. fears and hopes) and thoughts about the child’s cancer and treatment.

All couples provided informed consent and the research protocol for studying couples and professionals was approved by the Medical Ethics Commission of Leuven University (B322201627096).

## **METHOD**

From a social constructionist perspective (Reznek, 2014), partners construct and interpret their individual social reality in the context of shared realities. Our research can be similarly framed in a social constructionist perspective (Hill, Thompson, & Nutt-Williams, 1997), based on the idea that doing qualitative research is teamwork. In accordance with that

philosophy our analyses were checked by independent external auditors who challenged our interpretations and checked if our interpretations were sufficiently grounded in the data.

### **Participants and Data Collection**

For this study we initially collaborated with the child oncology department of the University Hospital in Leuven, Belgium. The psychologists of the department selectively invited parents whose child was in cancer treatment to participate in our study. Their first concern was with the well-being of their patients and their families, so they only invited couples for whom they thought an interview would not be too disturbing in their process. Other criteria were being Dutch speaking, both biological parents of the child, and living together. They gave the potential candidates a letter from the first author with information about the study. Parents who agreed to participate gave the hospital psychologist permission to share their names and contact information with the first author. Initially we wanted to interview both parents of a child who was in active treatment for a first diagnosis. In addition, we decided that we wanted to do the interviews at least two months after the moment of diagnosis, as to ensure the parents had already had time to reflect on their process. However, in a period of ten months only eight couples were invited by the psychologists and only two couples were willing to participate. Therefore, we changed some of the selection criteria. We also invited parents whose child was not in active treatment anymore, and individual parents whose partner chose not to participate. In addition, we also collaborated with the University Hospital in Brussels, and posted an invitation on a Facebook page (Kikov) for parents whose child had been in cancer treatment. In total nine interviews with 16 parents (seven couples interviewed together and two mothers) were conducted in a period of fifteen months (August 2015-October 2016). See Table 1 for a description of the nine interview cases. All lived in the Flemish part of Belgium and were culturally Flemish. The time since their child's diagnosis

ranged from 2 months to three and a half year. For half of them treatment was still going on; for the other parents, active treatment had stopped, and they were now in a period where their child needed to go only for checkups. Diagnoses included brain tumors, bone tumor, leukemia, and Langerhans cell histiocytosis (LCH). All parents with the exception of one couple and one mother, had other children besides the one that was in treatment. The interviews were planned at the time and place of their choice (8 interviews at their homes, 1 in the hospital), lasted between 1 and 2 hours, and were video recorded. Open-ended questions were asked related to their experiences, and more specifically about their couple communication. Examples include “*How did you talk about your emotions with your partner during that time?*” or “*Can you help us understand why you say you sometimes preferred not to talk about it with your partner?*”

--- Placement Table 1 ---

**Table 1.** Interview Participants.

Interview	Hospital	Time since diagnosis of interview	Treatment phase	Interviewed together/alone	Type of cancer
1	Leuven	6 Months	Active treatment	Together	Bone tumor
2	Leuven	7 Months	Active treatment	Together	Bone tumor
3	Leuven	3.5 Years	Checkups	Alone	Leukemia
4	Brussels	2 Months	Active treatment	Alone	Leukemia
5	Brussels	1.5 Years	Checkups	Together	Brain tumor
6	Leuven	1.5 Years	Active treatment	Together	Langerhans cell histiocytosis
7	Leuven	2.5 Years	Checkups	Together	Leukemia
8	Brussels	1.5 Years	Checkups	Together	Brain tumor
9	Brussels	3 Years	Checkups	Together	Leukemia

## Data Analysis

The interviews were transcribed verbatim in Dutch based on the video-recordings. In preparation for the analyses, the first author watched the video files of the interviews several times in order to be fully immersed in the narratives. Simultaneously the transcripts were completed with notes about nonverbal behavior and silences. We identified and marked all

statements and sentences that seemed essential, revealing and/or surprising regarding the theme of talking and not talking with the partner. Then a thematic line-by-line coding (Charmaz, 2006) was done on each transcript, using MAXqda software Version 2 (2007). Subsequently, for each transcript, codes were grouped into clusters around similar and interrelated ideas or concepts. Hence, we inductively coded the data, rather than testing specific hypotheses. No predetermined themes were used, and all themes emerged out of the data. This resulted in a hierarchical coding structure, with themes and subthemes reflecting participant experiences of couple communication. During the coding process the hierarchical code system became more complex. New codes were created, and themes became more nuanced, resulting in a hierarchical structure with 7 levels of coding/subcoding, 1203 segments and 145 codes. Often, meaning units were assigned with more than one code. For example, a father said, *“At those moments you don’t have the time to be angry at each other, as you hardly see each other.”* This meaning unit was coded with three different codes and subcodes: 1. Our life is on hold, with subcode ‘No time for the partner relationship,’ and 2. Our partner relationship, with subcode ‘No room for conflicts,’ and 3. Our couple communication, with subcode ‘No time to talk, hardly together.’ We achieved theoretical saturation after analyzing the transcripts of seven interviews (five couple interviews and the interview material with one of the two mothers). Two more interviews were coded, but these data did not yield new categories, which confirmed the theoretical saturation (Charmaz, 2006).

The credibility and trustworthiness of the analysis was verified by incorporating an extensive auditing process (Hill et al., 1997; Author, Year). The first author gave a detailed report, made anonymously, to the psychologists of the oncology department in Leuven and Brussels (third, fourth and fifth authors). Independent of each other these auditors read the



report and reviewed the overall category structure for coherence/consistency as well as elegance/nonredundancy. All meaning units were audited for their fit into the category to which they were assigned. All three auditors then provided feedback to the first author, who used this feedback to modify the theme structure and the assignment of meaning units. As an additional validation check the first and last author had a meeting with these psychologists to review the new code system and discussed what they found recognizable or surprising. All themes were agreed upon as fitting what they encounter in their practice.

## **RESULTS**

To be able to understand the couple's communication during the time their child was in cancer treatment, all couples stressed the exceptional situation they were in and how it had an impact on their partner relationship. Therefore, we first provide a general overview of how cancer diagnosis and treatment limits couple communication. Then we show how for these parents, despite the limits of communication, there was still a sense of the couple working together in the situation. Then we focus on what the couples had to say about the communication of emotion, and, following that, on the three main meanings the couples offered related to their limited talking about emotions with each other.

### **A Context That Limits Couple Communication**

We learned that following diagnosis and during treatment for all couples there was little or no room for their relationship, or as a father (2) said, "Our couple relationship was the last thing on my mind." In many ways the partner relationship needed to be put on hold. Most obviously, they were rarely together. Or, as a mother (1) said "You can't take care of a couple

relationship if you're hardly together." Moreover, the couple relationship was not a priority, and energy needed to be saved.

Father (6): "Our couple relationship really was the last thing on my mind. It's a matter of 'battle for survival,' straight focus on him (child), everything else doesn't exist anymore."

Mother (6): "You just know that you need to go to bed and sleep, because otherwise you can't go on the next day."

Even though most parents expressed that the partner relationship was under some kind of tension, there was no room for discussion or questioning the relationship.

Father (7): "If you start a discussion then, it just stops right away. That's impossible, you can't handle that. Because at that time you're working on something together."

Mother (7): "If I would have had a partner saying 'Hello, I'm here too! Do you still love me?' that wouldn't have worked."

### **Couple Working Together**

Although all couples felt their partner relationship was 'on hold,' most couples felt close in another way, as a parental team working towards the same goal. "*We're in this together*" some parents said. This was true in several ways. First and most visibly, in an organizing way, where they tried to help and spare the partner as much as possible.

Father (6): "You just go on and you try to help each other."

Mother (6): "Yes, to make it easier for one another, because you know how hard it is."

In many ways, practically and emotionally most interviewees felt supported by their partner. They were concerned about each other and encouraged one another to hold on and stay hopeful.

Mother (7): “In some way one took care of the other. If he had a bad time, then I tried to make myself stronger, and then I said ‘come on,’ and the other way around.”

Father (7): “That was really necessary, otherwise we wouldn’t have survived.”

Mother (7): “And sometimes we hugged because we wanted to support each other. That’s a very different kind of hug than an ‘I love you’ hug.”

Most couples explained this special relating to each other in terms of the partner being the only one who really could understand what they went through, or as a father (6) framed it, “She actually was the only one who could feel how I felt, because she is the only one with whom I have this child.”

In this period, parents told us that trust was crucial, trusting each other, and trust in the relationship to be able to endure a period of being on hold.

Mother (5): “You have a base and you know we’ll get through this, even though you don’t feel each other, or see each other. I know he’s there for the full 100 percent to take care of our other child, and vice versa.... And when it was crucial, he was there for me.”

### **Couple Communication of Emotion**

The couples were asked about their communication with each other specifically related to the verbal sharing of emotions like fears or ways they each struggled and coped with the stressful time of having a child being treated for cancer. In every couple there was a

sense of communication of emotion being different at different stages in the diagnosis and treatment process.

Most of them said that around the time of diagnosis their conversations were very intense. They cried together and shared their anguish with each other. Or like a father (1) said “I remember those first three, four, five days. I hardly could do my job because there was no way not to talk about it.” In those first days of living with the diagnosis every couple had considerable conversation about decisions and planning that needed to be made about treatment and about the household (particularly care of other children), but also about their fears, the meaning of life and the future. One mother (2) formulated it this way: “Then (around the diagnosis) we talked a lot about ‘How do we see our lives? What does ‘happiness’ mean to us? Where do we see our future going? After the operation was done we had a clear pathway with fewer choices and then it’s more just daily life with a lot less talking.”

Parents whose child was out of treatment spoke about the time after treatment being a time when they talked more with each other about what they went through. For example, in one interview (7) a mother said “During the hardest part, during treatment, we didn’t talk at all; we just kept going on. But now we can talk about it. We can reflect on it, looking at it from a distance.” Interestingly, most of the couples stressed the fact that even in these periods, after diagnosis and treatment, they still were careful not to talk too much or too intensely. Like a mother (2) said, “We try not to talk about it every night, that would be too much. It’s also very exhausting”. They might get into intense interaction when emotions became too overwhelming, or when there was something they needed to share or express. However, some also said that they were only able to talk with their partner when the intensity

of their emotions regarding their child's diagnosis, treatment, prognosis, and recovery had diminished.

A few couples share emotions with each other, even in the most difficult times, as they believed it was important to talk about how they felt so it would not stay suppressed. There were also couples who said that they never have talked a lot about emotions as a couple.

But regardless of those couple differences, all couples we interviewed also talked about the difficulty of talking about their emotions with each other during the period of diagnosis, treatment, and recovery. In the following section we focus on the meanings related to the limited talking. Our analyses revealed three main meanings: 1. Not talking because time together was so limited, 2. Not talking because of self-care/self-protection related to the blocking of emotions, 3. Not talking because of each other.

### **Not talking because time together was limited.**

During the time of hospitalizations and treatment there was limited time for parents to be together or talk with each other. In the sparse moments they were together, a lot of organizational or factual things about the treatment or related to the other children at home had conversational priority. The times in between hospitalizations, when the child with cancer was at home, gave more space for the spouses to talk. Then, only sparsely, they sometimes shared how they felt. Or like a mother (9) said when the interviewer specifically asked for these moments, "*...mainly when we were in our bed, when we finally could sleep together after so many weeks, then we started to talk, when the lights were out.*" This was different for couples whose only child was in treatment and both parents decided to spend most of the time together, put their jobs on hold or worked from the hospital or home setting. These couples

found more time together during hospitalization, but then the hospital setting was not conducive to talk in private. However, at home or in the hospital, all parents wanted to spend as much time as possible with their ill child, and in the presence of that child they found it inappropriate to talk about their own emotions, partly not to worry the child.

Mother (3): “I was always with her.... I did not want to show that I was afraid. I did not want her (child) to see that.”

### **Not talking because of self-care/protection and blocking emotions.**

Most parents told us that they needed to block their own emotions in this period, to be able to stay strong and function for the sake of their ill child. Their own emotions were subordinate to their parental role. Some parents said they did not feel their emotions, as if they were functioning in an automatic mode because their emotions were not useful in that time.

Mother (9): “I didn’t really have a lot of emotions. They were not going to help me. Afterwards I realized that I just functioned on automatic pilot....Now I know that back then I parked the emotions that were not helpful at the time.”

Mother (1): “You just try to push them away, because what’s the point of crying all day?”

Father (1): “I think we moved our fears in front of us....We did not want to think about it.”

Others said they were afraid that if they would allow their own feelings to come, they might not stand up again, and it would undermine their functioning. Related to this, statements like “Not being able to move forward,” “getting stuck,” or “then it’s impossible to function” were frequently expressed by all parents.

For some, their anguish and sadness was clearly present at times, but then it was too hard to express it in words, out loud, or share it verbally with their partner.

Mother (8): “I just couldn’t say anything about it....Then you called me and I started to cry. I could not say one sentence.”

Father (8) (smiled): “Yes, two words, and then it stopped, she just couldn’t.”

**Not talking because of each other.**

*Because we wanted to spare each other.*

For some partners, not sharing what they felt, had to do with taking the well-being of the other into account. They knew how hard it was for the partner, and they did not want to burden him or her with their own emotions. A mother (3) who was mostly in the hospital with her child told us she tried not to call her partner at difficult moments, “because I didn’t want to make him feel bad too.” Knowing their partner, some adjusted their words about how they really felt,

Father (5): “When I was afraid...I tried to stay positive when we talked, because I know she is more pessimistic than I am.”

Some partners shared their sadness or fears only after it passed. In one interview a couple talked about how he told her about the moments he had been very anxious only a long time after he felt that way, when the child was back home and treatment had stopped

Mother (5): “You only told me afterwards. There you spared me, right? (partner nodded). Because we coped with it in a different way.”

Interestingly, in no interview did partners openly act surprised to hear the protectiveness of their partner. Most of the time they created a story together by finishing each others sentences or adding to what was just said by the partner. Sometimes they asked for confirmation of what they said, saying things like “Don’t you think?”, or “What would you say about that?”, or directly asking something to their partner, like in the above quote (“there you spared me, right?”)

***Because we have different ways of coping.***

In most interviews parents talked about their different ways of coping with their emotions while their child was in treatment. Some told about how this difference resulted in limited talking.

Father (2): “Sometimes we felt we were in a different phase or so. In the beginning she searched for information about treatments, and then I said ‘I just don’t want to know.’ And the other way around, then I asked her ‘What if this ends bad?’ and then she said ‘I don’t want to think about it.’ So sometimes you can’t talk.”

This different coping was most explicit in the two interviews where only the mothers were present (3,4). Both mothers explained how their husbands were very different than they. Both men were described as listening, but never saying a word. “He lets me talk, and he listens, but he won’t react.”

***Because no words are needed between us.***

Although our focus in the interviews was on the verbal communication in these couples, many emphasized how they often did not need words to share how they felt.



Sometimes there was nothing that could be said, or as a father (6) said after their child drastically weakened, “Then we were lying on our couch, in each other’s arms, and I think that at that time there just wasn’t anything to say.” Moreover, many couples told us that they often observed each other and knew how their partner was feeling, or they just assumed they knew.

Mother (7): “We’ve known each other for years already; that’s a long enough time to read each other’s faces. When I look at him, or he looks at me, then I can see what he’s thinking. We don’t need words for that.”

## **DISCUSSION**

We aimed for a better understanding of what a child’s cancer diagnosis and treatment means for communication between the child’s parents. Can they share their fears and hopes with each other, as a couple? If so, how do they experience their talking? And how can we better understand possible hesitations or barriers to talk with one another?

In our interviews, inquiring about their experiences related to their couple relationship and more specifically their communication with each other, they all first explained the circumstances of this period, as a background needed to understand the context of their couple communication. All parents described how their partner relationship was put on hold because they were rarely together and because at that time it was not a priority. For these parents it felt as if their main identity was reduced to parenthood, while being marital partners became subordinate. Similarly, Van Schoors and colleagues (2017) pointed to the difference between parenthood and partnership as an important distinction, as the two imply different roles, responsibilities and behaviors. Others have reported that the demands of cancer tend to push families toward augmented cohesion (Rolland, 2005), with an increased emotional closeness

(Van Schoors et al., 2017). In our study we also found that most parents felt closely connected to the partner, because they were “in this together.” Nevertheless, most of our interviewees said that following diagnosis and during treatment there was very limited talking with each other about their emotions and thoughts related to their child’s cancer. Our analysis revealed three main meanings: not talking (1) because they were in a context that limited couple communication, (2) for self-care/self-protection related to the blocking of emotions, and (3) because of each other, to spare one another (3a), a different coping (3b) and because no words are needed between them (3c).

The context of the child being treated in a hospital setting makes it hard for parents to talk to one another. There is hardly any time together, and the oncology department is not well suited for emotional conversations in private. In addition, these parents experienced this time period as an acute phase in which they were in a survival mode where emotions were blocked. Talking about their own emotions or difficulties could make things worse while they needed to stay strong and function for the sake of the child. Finally, because the partner is going through the same experiences, talking with each other was often more difficult. Although some said that the partner was really the only one who could understand how they felt, these parents often prioritized not burdening each other even more than was already the case. They observed each other and saw how their partner struggled, sometimes in a different way or with different timing, and tried not to add to his or her struggle.

Our study invites us to rethink equating emotional closeness and frequent or intense emotional communication in couples. Indeed, our findings suggest that a limited talking can sometimes serve the couples’ cohesion and closeness. Or to put it differently, how not talking can be part of good couple communication. Not talking about their own emotions and thoughts is a way to attune with oneself and stay focused on the child in order to survive. On

an intrapersonal level, attunement is a process of emotional regulation in which each partner tries to hold their head up and focus on daily chores and treatment procedures while blocking emotions of fear or sadness. As both partners are in the same situation, they also need to attune with one another, not to undermine but support and respect the intrapersonal attunement of the partner. Moreover, the limited talking is also a way to protect their partner relationship, trying not to argue or fight, or putting relational issues on hold. In this period of time there seems to be little or no room for the couple relationship. Framed in a dialectic perspective on communication in which the value of talking and not talking in a relationship is emphasized, our study contributes to the understanding of couple communication as an emotional process of attunement on an intrapersonal, interpersonal and contextual level (Author, Year).

In a previous study in which we also inquired with the professionals of child oncology departments (Author, Year), we found that there was a similar process of attunement between hospital staff and the parents. Often staff attention to the parents or the partner relationship can usefully be minimal in order to support the parents, not intruding in the complex process of attunement these parents are in. However, an attuned response from the staff towards the parents was crucial at times when emotions spilled over or relationship issues surfaced.

### **Study Limitations**

In this study we encountered many recruitment challenges. We interviewed sixteen parents about their couple communication during the oncology treatment of their child. These couples were invited by the psychologists of the oncology department based on their assessment related to the emotional and relational strength of the couple to take part in these interviews. In doing 'sensitive' research, like involving parents in pediatric care, this is generally referred to as 'gatekeeping' (e.g., Melville & Hincks, 2016; Stevens et al., 2010;

Tomlinson et al., 2007). Possibly the parents who were invited and willing to participate in our interviews had fewer couple issues than average and were more ‘talkative.’ Given our interest in understanding not talking, it would have been interesting if we could have been able to interview those couples who were not invited or who chose not to participate.

Although this study does not aspire to generalize our findings to all couples confronted with a cancer diagnosis of their child, maybe in a sense our selection bias even validates our findings. Indeed, the ones who did not participate taught us important things, as they helped us to better understand ‘not talking.’ This was possible because the psychologists reported on some of the reasons parents chose not to participate. Reasons mentioned for not participating were similar to what we found in our study: the limited time these parents were together (and thus the chance to talk with one another) and not wanting to reflect on their own emotions to protect themselves and their partner relationship. These parents did not want to talk about their child with a researcher to keep their child’s story alive, but instead tried to put their own emotions on hold to be able to function for the sake of the child. For couples who had more difficulties or had to try harder not to let their couple conflicts intrude in this challenging time, participating in an interview about their couple communication might be too disturbing. This was also confirmed in our meeting with the psychologists of the oncology department (Leuven and Brussels) where we discussed our findings. All affirmed that what we found was highly recognizable in their experiences with parents, but some couples don’t manage to regulate their emotions or attune with each other or put relational issues aside during treatment. These couples were not invited, as a way to protect them, or they did not participate, possibly as a way to protect themselves and their partner relationship.

### **Clinical Implications**

Some scholars have advocated for healthcare that attends to the psychosocial needs of all family members, or family centered care (f.ex. Campbell, 2003; Kazak, 1989; King et al., 1999; Meyler et al., 2010; Rolland & Walsh, 2005). However, most often little is specified related to what this entails, or how this should be translated to, for example, the psychosocial or therapeutic interventions related to couple dynamics or couple communication during childhood treatment. It seems that often a clinical guideline stimulating couple communication is advocated. Or like Patterson (1991) put it, "In the resilient family, open expression is associated with better child and family outcomes. This includes the opportunity to express anger about the impact the illness is having on family life, fears about the future, resolving conflicts about role allocation with other family members, and sharing positive feelings of caring and commitment" (p 495). However, rather than unilaterally advocating the general promotion of open communication, our findings point to the complexity of couple communication for parents whose child is in cancer treatment. Indeed, it might be useful to consider possible hesitations to talk at certain time points in the process.

Probably the timing for couple interventions is important for these couples. In the process of data collection, we noticed that it was a lot easier for parents to participate in the interviews once treatment had ended. Then, most of them could reflect and talk about the process they went through as a couple. Some couples even made it explicit that they would never have participated in an interview in the time their child was still in active treatment, when their focus was exclusively directed to things that would benefit the child's recovery. Talking about their relationship in that time was contextually, emotionally and relationally not feasible for these parents. Even more, they experienced their limited talking not as a subject of strain, nor subject of their attention, but rather as helpful to be able to go on, as parents and as a couple.

Therefore, it could be useful to consider the degree of marital difficulties in offering interventions aimed at improving couple communication. To what extent do their difficulties have an impact on their ability to care for their ill child and maybe other children? Some couples, like the ones we interviewed, might consider their partner relationship solid enough to be put on hold in the interest of parenting the ill child. Or as one of the fathers (2) in our interviews put it metaphorically, “It’s like food and sports: the care for our child is like food, it’s a daily necessity. Our couple relationship is like doing sports, in times of crisis you can put that on hold for a while.” But what about those couples who experience relational issues that cannot be put aside? Interventions have been studied aimed at distressed couples with chronically ill children (Cloutier et al., 2002; Walker et al., 1996) with significant results at two year follow up. Based on their results, these researchers advocated for referring couples who encounter marital and/or psychological difficulties, helping them to enhance their ability to parent their chronically ill child.

Taken together, a better understanding of the possible risks associated with couple communication, and the relational value of not talking, might better aim interventions in terms of timing, and in selecting those parents who are in need and are in a place to make use of an intervention. In that way we can better attune to what specific parents need at specific times in their process.

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