

Commentary

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Commentary: Association between coping of the primary caregiver and the adolescent patient with cancer

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Abstract

In this commentary, I synthesize and clinically contextualize findings from our recent study on coping interdependence in adolescent patient–primary caregiver dyads, “Association between coping of the primary caregiver and the adolescent patient with cancer”¹. The study demonstrated that coping in adolescent patients with cancer and their primary caregivers operates as an interdependent and compensatory emotional system rather than as two parallel individual processes. This perspective challenges traditional clinical assumptions and supports a paradigm shift toward dyad-centered care. Here, I offer a critical synthesis of the study, discuss its implications for psycho-oncology practice, and outline concrete directions for developing brief, culturally sensitive interventions focused on the adolescent patient–primary caregiver dyadic relationship.

Introduction

Cancer during adolescence represents a profound disruption in psychological, emotional, and social development. Unlike other chronic diseases, its association with the possibility of death leads to an abrupt restructuring of identity, autonomy, future plans, and family roles². Adolescent patients frequently undergo invasive procedures, prolonged hospitalizations, academic interruption, altered self-image, and persistent prognostic uncertainty^{3,4}.

Primary caregivers—most often mothers—experience emotional exhaustion, financial strain, increased responsibilities, and the ongoing fear of losing their child⁵. In the original article, the primary caregiver was defined as the family member responsible for the adolescent patient’s care during cancer treatment. According to Lazarus and Folkman, coping involves cognitive and behavioral efforts to manage demands perceived as overwhelming⁶; yet most research has examined patient and caregiver coping separately^{1,13}.

The meaning attributed to cancer and the perceived proximity to death strongly shape emotional responses. In Western contexts, construing cancer as a threat elicits anxiety; as injustice and anger; as failure and guilt; and as harm, depressive reactions⁷.

In this commentary, I reframe adolescent patient–primary caregiver coping as a dyadic regulatory process rather than two parallel individual responses. Building on the original findings, I translate the observed coping patterns into practical assessment and intervention decision points for psycho-oncology, integrating complementary literature to propose brief, culturally responsive dyad-focused targets.

Synthesis of the Original Study

In our study, several central findings emerged¹. First, we observed low concordance between adolescent patient and primary caregiver coping styles ($Kappa = 0.15$). Second, a compensatory pattern was evident: when one dyad member used passive coping, the other tended to adopt active strategies. Only 14% of dyads showed simultaneous passive coping, a pattern associated with: (a) primary caregivers without a partner, (b) frequent hospitalizations, (c) younger primary caregiver age, and (d) adolescent patients unaware of their diagnosis. The multinomial model explained 61% of total variance, underscoring the value of a dyadic approach for understanding clinical vulnerability.

Overall, the results indicate that coping does not function as two independent processes but as a dynamic, adaptive, relational system.

Taken together, these findings suggest that clinical risk and resilience are organized at the dyad level rather than within either individual alone. The next section translates these empirical patterns into clinically interpretable mechanisms and actionable targets for assessment and intervention.

Clinical Interpretation

Dyadic coping as a regulatory system

Primary caregiver coping did not automatically predict adolescent patients coping, challenging long-held clinical assumptions. Instead, the dyad behaved as a compensatory system in which each member adjusted emotional responses to buffer the other's vulnerability⁸. This mechanism can be understood as joint regulation, mutual protection, or a shared effort to maintain balance under extreme stress.

Lack of diagnostic disclosure promotes passive coping

Not informing adolescent patients of their diagnosis was consistently associated with passive coping⁹. Limited disclosure:

- reduces personal agency
- restricts the development of resilience
- undermines self-care
- heightens uncertainty

These findings reinforce the need for developmentally appropriate, gradual, and sensitive communication protocols¹⁵⁻¹⁶.

The caregiver as an emotional anchor

Primary caregivers with limited support networks, multiple burdens, or psychiatric symptoms demonstrated higher likelihood of passive coping¹⁰. The literature

confirms that these profiles require early detection and specialized follow-up¹⁴. When caregivers are overwhelmed, the emotional stability of the entire dyad weakens.

Toward a dyad-centered intervention paradigm

Although some family-based interventions exist in pediatric oncology, most approaches still separate strategies for adolescent patients and primary caregivers. Our findings—and growing contemporary evidence^{11,12}—indicate that directly targeting the relationship strengthens shared resources, reduces silence-based dynamics, and promotes more adaptive joint coping.

Clinical Recommendations

Dyadic assessment as a standard in psycho-oncology

Clinical models should incorporate tools that evaluate both members simultaneously¹³. Assessment should include stress intensity, available resources, and both individual and joint coping capacity¹⁴.

Monitoring risk factors

Reducing conditions that heighten passive coping requires early identification of dyads characterized by:

- lack of social support
- frequent hospitalizations
- younger caregiver age
- unrealistic prognostic perceptions
- absence of a partner or emotional support

Structured diagnostic communication protocols

Communication should be honest and progressive, and allow space for questions. Directly involving adolescents helps prevent conspiracy-of-silence dynamics. Clinicians trained in delivering serious news can facilitate adaptation, reduce fear, and support shared decision-making^{15,16}.

Integrating mental health as a core component

Early detection of psychiatric symptoms in primary caregivers and adolescent patients must be part of standard care¹⁴. A dyadic mental-health approach supports emotional expression, reduces distress, and facilitates communication.

Brief dyad-focused coping interventions

Based on the literature^{11,17,18}, I recommend incorporating:

- Open and effective communication to reduce emotional isolation
- Joint emotional regulation, recognizing each member's affective responses

- Shared decision-making, decreasing individual burden
- Shared meaning-making regarding the illness experience
- Collaborative problem-solving training
- Dyadic psychoeducation on grief and resilience
- Fostering shared hope, grounded in relevant spiritual or cultural beliefs
- Gradual reintegration into routine activities
- Reducing emotional distancing, promoting healthy expressions of affection
- Collaborative parenting, avoiding overly paternalistic or patient-centered patterns

These strategies strengthen mutual agency and help the dyad engage with the illness from a more integrated relational stance.

Future Research Directions

To move dyad-centered coping from an explanatory model to a clinically actionable standard, future research should prioritize mechanistic, comparative, and implementation-relevant evidence:

- Longitudinal models to identify critical transition points in dyadic coping
- Randomized trials comparing dyad-centered vs. individual-centered interventions
- Validation of dyadic coping profiles based on psychosocial risk
- Evaluating the impact of joint coping on treatment adherence
- Developing family resilience indices tailored to pediatric oncology

Conclusion

Coping in adolescent patients with cancer should be understood as a relational rather than an individual process. Our findings¹ show that compensatory adjustment is common and that the emotional bond within the dyad serves as a stabilizing axis. The adolescent patient–primary caregiver dyad therefore constitutes a clinical unit that requires specific assessment and targeted intervention. Moving toward dyad-centered models can improve emotional well-being, resilience, and therapeutic engagement.

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