

## BREAKING BARRIERS: EXPLORING BREAST CANCER DISCLOSURE TO PARENTS

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### ABSTRACT

*Objective.* Breast cancer (BC) diagnosis is considered as a traumatic and life changing moment. Throughout the illness women often need support from their close family. However, before receiving any support, women must navigate the challenging process of disclosing their diagnosis, which may bring about difficulties and reservations. This qualitative study explores the disclosure process in female patients with breast cancer, focusing on understanding reasons for hesitation, expectations related to parents' reactions, the act of disclosure, and its outcomes.

*Methods.* In-depth interviews were structured into two parts. The narrative part was followed by a semi-structured interview. The research population was recruited to meet the conditions of maximum variation sample (different regions of the country, different age categories, education, stage of the disease, treatment modality). 53 interviews were collected and transcribed verbatim. The age of participants at the time of the interview was 28–76 years, mean age was 48.61 (SD=13.12). Data from which categories were created were managed in NVivo10 software and were open coded. The codes were then grouped into themes for thematic analysis.

*Results.* Three main themes emerged for delaying disclosure to parents: a) protecting parents, b) fear of reactions, and c) fear of changes in the parent-child relationship. Each theme contained specific subthemes contributing to the disclosure hesitation.

*Conclusion.* Women with BC greatly benefit from the support offered by their parents. However, disclosing the diagnosis to them is often challenging. As a result, it is crucial to provide support to women with BC as they prepare to share their diagnosis. Medical staff should also consider including family members in the treatment and care process for patients with BC, recognizing the significance of family support in the overall well-being and coping of patients.

*key words:*

breast cancer,  
cancer,  
disclosure,  
oncology,  
parents,  
patient experience

### BACKGROUND

The act of disclosing a cancer diagnosis has long been recognized as one of the most challenging aspects of cancer (Hilton et al., 2009). Specifically, being diagnosed with breast cancer presents a situation in which individuals may feel their control over life is threatened and disclosing it could pose a heightened risk of losing that sense of control (Donovan-Kicken & Caughlin, 2011). Patients, understandably, desire a sense of ownership over their diagnosis and strive to retain control over its disclosure (Ewing et al., 2016). According to Ginter and Braun (2019), women often desire to share such information but prefer to do so on their own terms, including the timing, setting, and the amount of information they decide to reveal.

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On the other hand, research indicates that open communication about disease is associated with improved coping mechanisms (Donovan & Farris, 2019). Several studies (Applebaum et al., 2014; Ginter & Braun, 2019; Hasson-Ohayon et al., 2010; Jeong et al., 2016; Korotkin et al., 2019; Lai et al., 2017; Oztunc et al., 2013) have explored the positive effects of disclosing such information. Only a few studies have focused exclusively on parents (Wallner et al., 2017); therefore, we included studies focusing on disclosing the diagnosis in general. Disclosure can bring the advantages of receiving support and is an important part of coping with disease according to coping theory (Lazarus & Folkman, 1984).

Women dealing with breast cancer often require various forms of support, such as instrumental, social, emotional, and therapeutic support (Ginter & Braun, 2019). Social support has shown to facilitate better adjustment to the breast cancer diagnosis, leading to an improved quality of life (Applebaum et al., 2014; Korotkin et al., 2019; Lai et al., 2017), protection from psychological distress (Hasson-Ohayon et al., 2010; Jeong et al., 2016), and an increased level of hope (Oztunc et al., 2013). Furthermore, maintaining role functioning is crucial for patients as they navigate the challenges of breast cancer. A decline in their ability to manage their social roles often results in increased feelings of loneliness and a decrease in overall quality of life (Fischer & Seibaek, 2021).

Some women make the choice not to disclose their breast cancer (BC) diagnosis either at all or only to a limited social circle, which might include their spouse and doctor. In study of Henderson et al. (2002) 20–30% of individuals decided not to reveal their diagnosis to their entire social groups, including family and friends (Henderson et al., 2002). When it comes to families, patients diagnosed with cancer typically disclose the information to their family, including parents, as a secondary step (Arora et al., 2007; Munro et al., 2015). Wallner et al. (2017) conducted a study that revealed cancer patients listed up to three decision-support persons (DSPs), with parents being used as DSPs by only 6.1% of the participants.

Parents play a crucial role in providing various forms of support throughout the entire illness journey. They support patients in finding appropriate medical assistance and act as a source of valuable information (Snyder & Pearse, 2010). Furthermore, they become an essential source of emotional support during the diagnosis period and lend a helping hand with daily tasks and caring for children while patients undergo medical examinations (Arora et al., 2007). Parents are also involved in the decision-making process (Arora et al., 2007; Yoo et al., 2010) and offer a sense of security to patients (Drageset et al., 2012). Daughters may disclose their BC diagnosis to their mothers to receive social support, experience the comforting feeling of having someone there for them, and to minimize distress (Fisher et al., 2017). Companionship and empathy are described as the highest needs for patients with cancer (Korotkin et al., 2019).

Disclosing the diagnosis to parents is an important step that requires careful consideration and planning (Fischer & Seibaek, 2021). Although such disclosure can bring many advantages, patients often try to avoid certain strains associated with it. Possible reservations about disclosing a BC diagnosis can range from the fear of receiving compassion (Trindade et al., 2018) to the feeling of being stigmatized due to the disease (Badihian et al., 2017) and concerns about privacy violation (Fisher et al., 2017). Zhang and Siminoff (2003) described the association of avoidance in communicating about BC with the desire for “mutual protection” to shield others from distress and a belief in positive thinking, which are commonly considered protective mechanisms (Van Humbeeck et al., 2015). The perception of parents as vulnerable might lead to a delay in disclosure (Hilton et al., 2009), as patients worry about their parents’ ability

to cope with the information (Ginter & Braun, 2019). Patients do not wish to cause pain to those close to them, as it may lead to feelings of guilt (Hilton et al., 2009), and they seek to avoid being a source of concern or worry for their loved ones (Fischer & Seibaek, 2021).

From a developmental perspective, most patients with BC are adults. Being diagnosed with BC and disclosing this diagnosis to parents can lead to relational changes. The patients' roles may shift from independence to dependency, resulting in a redefinition of their relationships (Fisher, 2010; Gawinski et al., 2021; Van Humbeek et al., 2015).

Considering the disclosure process, patients might expect certain reactions from their parents that could cause concern (Ginter & Braun, 2019). Parents' responses may vary, either providing supportive reactions or struggling to cope, which can lead to confusion and emotional distress for the patients (Ginter & Braun, 2019). In some cases, patients may perceive social support as daunting, making the disclosure process challenging (Drageset et al., 2012), which may hinder them from sharing their BC diagnosis.

Research has identified that patients could benefit from professional assistance during the disclosure process. Ewing et al. (2016) found that patients require support when disclosing their cancer diagnosis to family members and proposed a framework of intervention for medical personnel to aid patients in this process. Van Humbeek et al. (2019) suggested organizing family conferences to assist patients in disclosing such information to their families.

Over the past decade, there has been a growing number of articles dedicated to the disclosure process. However, limited information is available on how adults with breast cancer disclose this information to their families, particularly to their parents, who play a significant role in their lives by providing social and emotional support.

The process of how women disclose their BC diagnosis to their family remains relatively unknown. Therefore, this qualitative study aims to explore the disclosure process in female patients with BC when disclosing the diagnosis to their parents. The study aims to analyse the reasons for hesitation or delay in the disclosure process, patients' expectations of their parents' reactions, and the disclosure itself and its outcomes.

## METHOD

### Design

The study was carried out using the certified DIPEX methodology (Breuning et al., 2017; Herxheimer et al., 2000), which was standardized for the conditions of the Czech Republic (Tavel et al., 2015).

### Setting

This article is part of a larger applied research project focused on women's lived experience with breast cancer.

### Data Collection

The participants were recruited in the Czech Republic through the following channels:

1. Distribution of leaflets and emails to patient organizations: More than 40 patient organizations associated with the Alliance of Women with Breast Cancer<sup>1</sup> were contacted for recruitment.

<sup>1</sup> Non-profit organization, member of Europa Donna and European Cancer Patient Coalition. <https://www.breastcancer.cz/o-alianci/>

2. Distribution of leaflets to general practitioners: These leaflets were distributed during regional meetings of the Society of General Practice of the Czech Medical Association held in eight regions. Information emails were also sent to general practitioners in other regions.

3. Distribution of leaflets and emails through a research project advisory panel.

4. Utilization of social networks and websites of several organizations, including the research institute, Alliance of Women with Breast Cancer, Amelie, patient organizations, regional patient groups, and closed patient groups.

5. Snowball method: Participants were recruited through referrals from other patients.

Interested individuals who wanted to participate in the research contacted the researcher either via email or by using the contact form on the website. During the initial contact, potential participants were provided with detailed information about the research's objectives and the interview process. After this introduction, an entry form and a study description were sent to the applicants.

First contact was made with 87 applicants. Some of the contacts (n=4) declined to be interviewed after the study introduction and others (n=6) decided not to be part of the study because their health status had changed.

After meeting the criteria (see below), an interview was conducted with 54 participants, including:

- 25 participants from patient organizations,
- 2 participants from general practitioners,
- 3 participants from the members of the advisory panel,
- 13 participants via social networks,
- 11 participants from recommendations from other patients.

The interviews were conducted from October 2016 to March 2018 by a female researcher. The researcher had no previous relationship with the participants. As a psychologist, she underwent training and guidance from experienced researchers throughout the entire process. The data collection involved in-depth interviews, divided into two parts.

First was a narrative part, in which the participants freely talked about their illness from the moment they noticed the first symptoms. In the second part, the researcher explored specific topics that emerged during the narrative part and conducted a semi-structured interview to inquire about other relevant subjects. The interview guide for this part was developed in collaboration with experts from a multidisciplinary advisory panel.

The advisory panel was composed of twelve members, including an oncogynaecologist, a general practitioner, a breast unit doctor, a breast unit nurse, an oncology nurse, a psychologist, representatives from patient organizations, a patient, and a family member of another patient with breast cancer. This diverse team provided guidance throughout the research process, from its inception to data analysis.

The interviews were conducted in various settings, including the participants' homes, hotel rooms, or the offices of patient organizations. The duration of the interviews varied, ranging from 45 minutes to 5 hours, with an average length of approximately 2 hours. Before each interview, the participants received a comprehensive explanation of the interview process, its objectives, and the overall research scope.

## **Data Analysis**

The interviews were audio recorded, transcribed verbatim, and then thoroughly checked by the researcher to ensure transcription accuracy. Subsequently, the tran-

scribed interviews were shared with the participants for their approval. At this stage, the participants had the opportunity to clarify any details or request the exclusion of specific parts of the interview if they preferred not to have them included. Once approved, the interviews were anonymized, and ready for processing.

The management and coding of the checked and anonymized transcripts were conducted using the NVivo 10 program. In the initial phase of coding, the interviews were thoroughly read multiple times by three primary coders. Individual statements from the interviews were then grouped into thematic codes without adhering to any pre-defined coding scheme. Any coding discrepancies that arose were resolved through discussions among the coders and the research team. Subsequently, the codes were categorized, and these categories were further organized into distinct topics through thematic analysis.

To ensure reliability, the interviews were coded by three researchers, and cross-coding was employed. The researchers regularly engaged in discussions concerning emerging themes and their interpretations of the data. Memos and a research diary were maintained, documenting the context of the interviews and the researchers' reflections on the identified themes. The researchers involved in the analysis were all female psychologists with training in qualitative research, none of whom had personal experience with BC.

Thematic analysis, as described by Braun & Clarke (2012), was employed to analyse the data. The "one sheet of paper" method (OSOP; Ziebland & McPherson, 2006) was utilized for the thematic analysis, wherein all data sections falling under a specific code or coding category were analysed. Relevant data from the interviews, along with the participants' ID, were noted on a single sheet of paper. Through this process, common elements and differences were identified, and various themes such as the protection of family members and fear of reactions were explored within the data. Please refer to Appendix 1 for the emergence of themes.

### **Ethical Consideration**

Throughout the research process, participants received both written and verbal explanations about the study on multiple occasions: during the initial contact, prior to the interview, and after the interview. To ensure their informed consent, participants signed documents consenting to the use of recordings and the anonymization of their data. They were also given the freedom to choose pseudonyms to protect their identities.

Participants' rights were emphasized, including the right to choose not to respond to certain questions and the option to withdraw from the research at any time without any adverse consequences. After the interviews, participants were provided with contact information for psychological support if needed.

### **Research Sample**

The aim of the research was to obtain a maximum variation sample to cover the different experiences (Coyne, 1997) of breast cancer patients. We determined the following criteria in advance: age, level of education, place of residence (regions of the Czech Republic, village/town, see Figure 1) and especially the experience with the disease, such as period since cancer diagnosis, type and process of treatment (planned, ongoing, discontinued treatment), recurrence. These criteria were gradually fulfilled, and missing cases were added over time. The interviews were conducted until data saturation.

A total of 54 interviews were conducted; one participant revoked her consent, resulting in the exclusion of her data from the analysis. Therefore, 53 interviews were

analysed. The participants' age at the time of diagnosis ranged from 25 to 72 years, while their age at the time of the interview ranged from 28 to 76 years, with a mean age of 48.61 (SD=13.12). The research sample consisted of participants who were diagnosed within six months before the interview and others who were more than five years past their diagnosis. For further details on the characteristics of the research sample, please refer to Table 1.

## RESULTS

The participants in the study shared their experiences of disclosing a breast cancer diagnosis to their parents, which they described as a challenging and emotional process. They expressed a strong desire not to cause any hurt to their parents, leading them to struggle in finding the right words to communicate the diagnosis. Many of the women felt apprehensive about burdening their parents with such distressing information. As a result, they carefully considered the timing of when they revealed their diagnosis to their parents. It is worth mentioning that age was not a determining factor in disclosing the diagnosis.

### Disclosure with final results

Some of the participants did not disclose the information until the final results. They wanted to protect their parents from the psychological distress caused by a false alarm. *"I kept it secret, of course, in front of the family, because I did not want to stress them unnecessarily before it was confirmed. Before this diagnosis was actually confirmed, I did not tell anyone."* (Liba, age 47)

### Delayed disclosure

Some women did not want to disclose the BC diagnosis, or found themselves unable to do so. As a result, they postponed the disclosure for as long as possible, sometimes waiting until it became necessary or until they faced visible changes, such as hair loss, which made it evident that something was amiss. Some women waited until they themselves had got over the diagnosis before they told their parents about it.

#### *Reasons for delaying disclosure to parents*

The decision to delay disclosure to parents revolved around three main themes: a) protection of parents; b) fear of reaction; c) fear of relational changes. Each theme had its own set of subthemes, which provided more specific insights into the reasons behind the delayed disclosure.

### Protection of parents

The hesitation to disclose a BC diagnosis to parents was motivated by the participants' desire to shield their parents from potential sorrow caused by the disclosure. Some participants empathized with their parents and put themselves in their shoes, understanding the distress that such news could bring. They didn't want to put their parents *"in a place where no one wants to be"*, influenced by their own experiences as parents themselves.

*"The family, I mean my mum, for her it was probably pretty hard, like for everyone, of course, but I know what it is like to be a mum and have kids, how terribly afraid I am for them, how I'd be half-crazy if I found out that something was wrong with them; so I think it must have been terrible for my mother."* (Lenka, age 32)

Experience with a cancer diagnosis within the family (in grandparents, parents, spouse, and siblings) resulted in reservations about disclosure. Daniele described how hard it was to tell her mum, who lost her own mother to a similar diagnosis:

Table 1 Sociodemographic and illness-related characteristics of the participants

<i>Sociodemographic characteristics of participants</i>	n
Age at diagnosis (years)	
18–30	4
31–40	27
41–50	11
51–60	9
61–70	1
71+	1
Age at interview (years)	
18–30	1
31–40	16
41–50	17
51–60	5
61–70	10
71+	4
Period since the diagnosis	
Up to 6 months	6
6 months – 1 year	16
1–2 years	3
2–5 years	11
5+ years	17
Recurrence	
Once	4
Multiple times	1
Education	
Vocational School	5
High School	24
University	24
Marital Status	
Single	7
Divorced	10
Separated	1
Married	29
Widowed	6

Note. N = 53. Participants were on average 48.61 years old (SD = 13.12).

*“Well, with my mother, it was the worst. She also lived with us and since she went through the same with her mother when young, with her. I feared the most... that it would be worse for her. So I told her when I was already in the hospital; I called her the night before the surgery and just told her the news, over the phone, and hung up right after that and my husband was there, you know, so I knew that she could discuss it with him, but I feared the most with her.” (Daniele, age 73)*

Conflicting events within the family were an important factor in postponing the disclosure to parents. Some participants believed that the information would be overwhelming “*too much for their parents to take in*”. They expressed the desire to shield their parents from further loss or losing a sense of “safe haven” where nothing bad could occur. Factors such as the serious health issues of a family member, a recent death in the family, the timing of the diagnosis (during Christmas or holidays, for instance), and geographical distance from parents were additional considerations that contributed to hesitation or reluctance in disclosing a BC diagnosis.

### *Fear of reaction*

Some participants mentioned fear of how their parents would react. Witnessing their loved ones suffer from sorrow and pain due to the disclosure was emotionally challenging for them. Some participants expressed their concern that the reaction would be hysterical, or their parents would cry, and that it would be very difficult for them to cope with. For some participants, the fear of disclosing their BC diagnosis to their parents extended beyond not wanting to hurt their feelings; they also worried about how they would handle the surge of emotions from their loved ones. They felt the expectation to provide emotional support in such situations, but acknowledged that they might not have enough energy to do so, as they would also need emotional support themselves.

*“Well, only it was a bit hard, because, I wanted to tell my family, and because I am divorced, I lived with my 18 years old son. The first ones I wanted to tell was my mother and my sister and I thought about how to tell them, because my mum was, well first, she is a bit of a negative person, and second, she tends to get a bit hysterical. I did not know how she would react. And since I already struggled with it myself, I was thinking where I should tell them, and I thought I’d tell them somewhere other than home, because if we were home and they started to act hysterical, I could not get rid of them. It sounds awful like that but yes, I did not have the strength to deal with a hysterical scene. I didn’t know how they would react, so I planned to tell them someplace else – both at once. And if it is too much for me, I would just get up and leave.” (Zlatuse, age 61)*

Some older participants mentioned their fear of *being stigmatized* because of the disease. They had never heard about anyone else being diagnosed with BC. They were concerned about the reactions of the neighbourhood, and the loss of social ties, contacts and parents was no exception.

*“And it was terribly hard for me. I certainly would not go like that just the first five years. I would have tried at least to make sure that nobody saw it or whatever and I did not want to show it anywhere. And I was not exactly proud of it. I thought everyone would look at me as a person, well.... as a person who is somehow out of the common run, with something being wrong with her. I wanted to be outside the events, not in the middle of things.” (Kamca, age 41)*

### *Fear of effects on relationships*

As previously mentioned, some participants empathized with their parents and tried to imagine how the situation would impact them. They considered the potential changes in their relationship as a result of the BC diagnosis.



*“So mummy, when she learned of it, I was already in treatment; she felt really bad and the news saddened her; she told me off: why didn’t I tell her when I had the surgery? I did not want to burden her. She told me off but in a good way, you know; she was really thoughtful. She was very kind, loving mummy, who just...all of a sudden you were the child, who needs to be taken care of even at this age. I always said, when my mummy was ill: Mum, you need to stay here, who else would take care of me like you do, this will not do, alright. So mummies, our precious mummies, those mummies who are always mummies and all of a sudden, their child is sick, in pain, well how could that fell for such mummy, right.” (Ingrid, age 59)*

## **Relational changes**

The gender of parents seemed to be an important factor in disclosing the diagnosis promptly. Some participants rather chose to disclose their BC diagnosis to their mothers. For some of them, their mother was the contact of first choice when the diagnosis was made. They “needed someone to confide in the person who is closest to them.”

Jana (age 32) was scared to tell her mother because she was controlling.

*“I was scared to tell my mum. Well, I must say, my mum is scared when we are not around. She somehow lost control over our lives and is afraid what is going to happen to us. I was scared to tell her, to tell my mum. She basically learned that at the point when there was no other way, which means when I learned I will get chemotherapy.” (Jana, age 32)*

With regard to their fathers, some participants worried about their reactions and unsupportive behaviour. They found it more challenging to identify communication strategies that would be appropriate in this situation. The father of Zofka (age 34) did not want to talk or know about the BC at all.

*“And the other thing is that my dad is very sensitive to that. Precisely this topic, you see. And he actually did not want anyone to know about it. I’m from a small town. I don’t know if anybody knows or not, but I think they do. They won’t tell you. Maybe when they see you afterwards, like after a year; when it’s good...” (Zofka, age 34)*

## **DISCUSSION**

In this paper we have explored the process of disclosure among patients with BC. We focused on understanding the possible reasons behind hesitation or delay in the disclosure process, the expectations related to parents’ reactions, the disclosure itself, and its outcomes.

Disclosure brings many benefits in receiving different types of support. Participants who decided to disclose the information promptly had that in mind, and as shown in previous research, they used the emotional support of “someone being there” during this difficult time (Fisher et al., 2017). Participants who hesitate to disclose the information and delayed this decision were mainly trying to maintain control over the situation, aligning with findings from previous research (Ngwenya et al., 2016). They carefully considered and selected the appropriate conditions for the disclosure, such as finding the right words, the right place, and the right time, or they disclosed the diagnosis when no other choice was viable, like when visible side effects emerged or when they required support. Exerting control over the disclosure process seemed to help them manage insecurities in other areas of their lives with BC.

Our findings indicate that participants with open communication with their parents tended to disclose the diagnosis without too much hesitation, and they communicated their need for support. In contrast, participants with less open relationships with their

parents chose to wait before disclosing or experienced some degree of hesitation. Ultimately, all participants in our study disclosed the diagnosis to their parents, but they did so at different stages of the diagnosis-treatment process.

Protecting parents was the most frequent reason for reservations in disclosing BC diagnosis. Participants do not want to cause pain or sorrow to their loved ones. One subtheme within this protective stance was their prior experience with cancer, which became a reason for hesitating to disclose the diagnosis. Interestingly, this contrasts with previous findings, which suggested that prior experience with cancer can actually facilitate understanding and support (Fischer & Seibaek, 2021). In the current study, it appears that participants anticipated negative reactions and consequently refrained from sharing the diagnosis, leaving them to face the disease on their own without valuable guidance.

Additionally, some participants used conflicting events as a justification for delaying the disclosure. They wished to allow their family to enjoy these events without being burdened by upsetting information. These events were seen as the last grasp of normalcy, offering a respite from the horrid thoughts of BC.

Fear of the reaction of loved ones is what is holding patients back from disclosing a BC diagnosis. They worry that they might receive overwhelming compassion (Trindade et al., 2018) or unsupportive responses, such as crying or becoming hysterical, which would be challenging for them to handle. The women did not want the responsibility for the feelings of others. They were overwhelmed with their own process of understanding this new situation and they could not imagine a situation in which they would have to be supportive to others. As a result, women who anticipate problematic reactions carefully select the situation in which they disclose their diagnosis, aiming to make it easier for them to distance themselves if needed. For instance, they might choose to disclose in a public place or over the phone, where they have the option to hang up if necessary. By controlling the circumstances of the disclosure, they hope to manage the expected behaviour of their loved ones.

In cases where patients anticipate challenging reactions, involving psychologists, nurses, or medical personnel in the disclosure process could be valuable. Such professionals can assist in planning and mediating communication between the patient and their parents, providing support and guidance during this delicate and emotional time.

Some women, particularly those aged 60 years and over, experienced a fear of potential stigma if they were to openly discuss their BC diagnosis. They worried about the possible consequences, such as losing social connections or becoming the subject of public attention due to the disease. Therefore, they decided to keep it secret at the time, which could serve as a part of their coping strategy or as avoidance behaviour.

Family relations influenced the decision to disclose. Women going through this process, particularly women who themselves had children, did not want to cause distress to family members or parents. Having children brought them an understanding of what their parents might feel like when they learn their child is ill, and thus it was difficult to share this information. They often named it as “*being put in position where no one wants to be*”; they empathized with the parents. Putting themselves in the position of parents, they lost the possibility of being cared for as a sick adult-child. This shift would place them back in the role of a dependent child, which might feel uncomfortable and create a barrier that was challenging to overcome. Relational changes during BC have been also described in previous research (Fisher, 2010; Gawinski et al., 2021). Women were more likely to disclose their BC to their mothers than their father, as mentioned in previous research (Fisher et al., 2017). This pattern could be attributed to gender-specific behaviour, where mothers are often closer to their

daughters. Additionally, women had higher expectations of receiving support from their mothers compared to their fathers. In some cases, fathers displayed unsupportive behaviour, which was difficult for women with BC to understand and affected their relationship.

In conclusion, our findings suggest that parents play an important role in coping with BC. Patients with BC are most likely to disclose their diagnosis to close family to be able to receive support (social, emotional, tangible etc.). The disclosure is a difficult process in which women consider when, where and how to communicate this information. Some women delay the disclosure for various reasons. Based on our findings, we identified three main reasons for delayed disclosure: a) protection, b) fear of reactions, and c) concern about potential effects on the relationship. However, there is still limited understanding of effective communication methods with family members and their inclusion in the treatment and care process for BC patients. We propose exploring communication approaches at two levels: the patient-family level and the medical staff-family members' level. This investigation could shed light on improved ways to involve and support families during the BC treatment journey.

### **Clinical Implications**

The process of disclosure poses significant challenges as women carefully contemplate when, where, and how to communicate their BC diagnosis. We have identified three key reasons for delayed disclosure: a) protection, b) fear of reactions, and c) concern about potential effects on their relationships. These factors are crucial to consider when working with women in clinical practice. As healthcare providers, it is essential to offer support to women with BC as they navigate the decision to disclose their diagnosis. Providing guidance and a safe space for discussions about the disclosure process can help alleviate some of the emotional burden and uncertainties that women may experience during this critical phase. Taking these factors into account can enhance the quality of care and emotional well-being of women with BC as they embark on this challenging journey of disclosure.

### **Limitations**

The results should be considered in the light of some limitations. The research sample consisted mainly of Czech women; we were not able to recruit women from other ethnic groups living in the Czech Republic. Additionally, our study focused on the perspective of women with BC when disclosing their diagnosis to their parents. Even though we mentioned that the process of disclosing the diagnosis was not age specific, there could be some difference in family dynamics. However, to gain a comprehensive understanding of the disclosure process, it would be valuable to include the parents' point of view as well. Incorporating their experiences would provide deeper insights into the dynamics of the parent-child relationship during the time of BC diagnosis, potentially influencing the disclosure process. In conclusion, while this study provides valuable insights into the challenges and considerations of disclosing a BC diagnosis to parents, it is essential to acknowledge these limitations and further explore perspectives from diverse ethnic groups and incorporate the parents' viewpoint to enrich our understanding of this complex process.

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Appendix 1 The Emergence of Themes

THEMES	DESCRIPTION	SUBTHEMES	CLAIMS USED TO DEFINE THEMES
Disclosure Timing	Some women did not disclose their BC diagnosis until the results to protect their parents from distress caused by a false alarm.		We only told dad when it was confirmed (Nada, age 32). I first called them as soon as I came in with the results (Monika, age 38).
DELAYED DISCLOSURE	Delayed disclosure until visible changes, such as hair loss, appeared, or until they had come to terms with the diagnosis themselves.		I didn't even tell my mom until my hair started falling out and I had to say it (Ingrid, age 59). I called my mom here to tell her that I needed to take care of some work stuff, and that I needed her to come babysit. Of course, I told her afterwards, but in a sort of soft way, so she wouldn't be scared, of course. (Lucie, age 35). So, I was afraid to say it, to tell my mom. So, she basically found out when there was no other option, which was when I found out I was having chemo (Jana, age 34). And I didn't really tell her until three days before I went into the hospital for the breast surgery (Jitka, age 45). My sister was forbidden to tell my mom until I knew what was and wasn't going on. So then once I knew, then we had to come out with the truth because I was in the hospital, so then she was told. But I say, I don't want to overload her. So, she was told after about the 14 days later when I came home (Jana, age 55). My parents found out completely by accident. I didn't plan to tell them at all. I just figured I'd fight it out and be done with it. And it just so happened that actually my mom suddenly showed up at the door here, even though it's almost halfway across the country (Monika, age 43).

THEMES	DESCRIPTION	SUBTHEMES	CLAIMS USED TO DEFINE THEMES
Disclosure Strategies OF PARENTS	The hesitation in disclosing the BC diagnosis was motivated by the participants' desire to protect their parents from potential sorrow. They empathized with their parents' situation and tried to spare them distress.	<i>Experience with a cancer diagnosis</i>	<p>The worst part was with my mom. She also lived with us, and because she had gone through the same thing with her mother when she was young, I was afraid that it would be hard for her. So, I didn't tell her until I was in the hospital, the day before the surgery. I called her in the evening, and I just told her over the phone, and then I hung up, and it was done (Daniele, age 74).</p> <p>And then I really struggled with how to tell my mom. Because, you know, cancer had already struck our family once; my dad didn't survive it. And now, I had to tell her, how do I say this to her? It was just, you know, cancer again. It was really tough. It was really difficult (Vendy, age 41).</p> <p>When it came to telling my dad, I knew it wouldn't be good at all because my grandma had breast cancer. She actually had one breast removed in her 40s, and it came back in the other one five years later. So, my dad has been really upset about it all the time. And I knew that I didn't want to unnecessarily stress him out, even if nothing was happening yet (Veronika, age 32).</p> <p>Considering, how I mentioned that my mom had been through all of this herself, I didn't want to burden her either. Maybe it was also a bit of a defense mechanism on my part because she's the one person I knew would cry for me and feel sorry for me. I didn't want that, so even my mom didn't know about the surgery, what was waiting for me (Jitka, age 45).</p> <p>My mom was on vacation, and I didn't want to ruin her trip, so I told myself I would tell her once she came back (Zlatusa, age 61).</p> <p>That was the worst weekend because it was right before the weekend when we were supposed to go to my parents' and celebrate my daughter's birthday. I couldn't tell anyone that I was going to the oncology department on Tuesday, where they would be doing everything (Lucie, age 35).</p> <p>I didn't tell anyone at home, not even my parents, nobody. Even my mom didn't know... My dad had passed away, so we were arranging the funeral, dealing with everything around that. My mom was already feeling bad about it, so I couldn't tell anyone. It just wasn't possible. So, my mom found out about it at the end of June, and she took it even worse than I did (Stana, age 51).</p>
		<i>Conflicting events</i>	