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LETTER TO THE EDITOR

Comorbidity of distress experienced by parents of childhood cancer survivors points to the importance of understanding transdiagnostic cognitive–affective mechanisms

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We read with interest Wikman et al.'s [1] paper describing the prevalence and predictors of symptoms of anxiety and depression, in parents of childhood cancer survivors and bereaved parents. Wikman et al. [1] reported that symptoms of anxiety, depression and post-traumatic stress were highly correlated, and that 7–24% of parents experienced comorbidity.

There is a long history of discussion in mental health research regarding the high rates of comorbidity in mental health disorders and the flow-on implications for treatment [2–4]. Emerging evidence has pointed to the effectiveness of transdiagnostic treatments that target cognitive, affective and behavioral mechanisms that are common across different mental health disorders [5–7]. Although transdiagnostic interventions in the cancer space are emerging [8–10], there is still a need to better understand the cognitive and affective mechanisms that underlie patients' and family members' distress. Wikman et al. [1] found that symptoms of anxiety, depression and post-traumatic stress were highly correlated, and that psychological factors explained a great proportion of variance in their multivariable regression for depression/anxiety. These findings support the idea that common, maladaptive psychological processes may underpin separately categorized forms of distress in this group.

Our team has collected qualitative data from parents of childhood cancer survivors in the context of two large-scale research projects. The first, the long-term follow-up study of childhood cancer survivors [11,12] aimed to quantify and characterize the medical and psychosocial late effects and needs of childhood cancer survivors and their parents. The second, ‘Cascade’ [10,13], delivered and evaluated a new online intervention for parents, designed to mitigate some of the psychological aftereffects of childhood cancer survival. Qualitative data collected across these two projects amounted to a total of 77 interviews with parents (n = 59 mothers, 76.6%) of childhood cancer survivors, 0.5–16 years after treatment. Qualitative thematic analysis of this data revealed that, even in the context of their child having successfully completed cancer treatment, parents, especially mothers, reported strong feelings of guilt (n = 32, 41.6%).

Some reported a sense of over-responsibility for their child’s cancer diagnosis and suffering, while many expressed guilt surrounding perceived neglect of siblings’ emotional needs, difficulty managing other responsibilities and ‘moving on’ with their lives after their child’s treatment. To illustrate, three mothers reported:

I always feel guilty about something. The ‘mother guilt thing’. I think it’s always on my mind about what’s happened to her and I always fear did I do something, was it my fault? We just don’t know what causes it so – I have in the back of my mind is there something that I could have done differently. (Mother, three-year old female survivor, 10 months since treatment)

I’m a working mother doing her Master’s [degree] with three children. I’m in a permanent state of mother guilt. (Mother, 17-year old female survivor, 11 years since treatment)

That’s just me thinking that I wasn’t a good mum… have done something to cause… I know it’s stupid and irrational and illogical but… that I caused her cancer – I sort of have that guilt at the back of my mind. (Mother, 10-year old female survivor, 12 months since treatment)

The current [14] diagnostic criteria for both post-traumatic stress disorder and major depressive disorder include guilt-related constructs; ‘exaggerated blame of self or others for causing the trauma’ and ‘feelings of worthlessness or excessive or inappropriate guilt’, respectively. Of course, parental guilt is not necessarily pathological, and while many parents of childhood cancer patients/survivors report guilt, not all will develop psychological disorders. However, as reflected in the empirical literature [15–18], guilt and over-responsibility may both function as pathological affective mechanisms that underlie some psychological disorders. For example, parental guilt may inhibit adaptive behaviors which promote psychological wellbeing, such as engaging in self-care and seeking treatment for their own difficulties. Although we did not include bereaved parents in our interview study, we also note that others have pointed to parental guilt as a factor that may predict prolonged grief and psychosocial morbidity in bereaved parents [19–21].

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Transdiagnostic interventions targeting the underlying cognitive-affective processes that drive distress, such as maladaptive guilt-related processes, may reduce parents’ cancer-related distress. They may also bolster parents’ general coping and resilience skills to prevent ongoing and future distress. Given Wikman et al.’s [1] finding that (bereaved) parents’ current distress was often unrelated to the cancer experience, the capacity for interventions to support parents to navigate both cancer- and non-cancer-related stressors seems an important focus for future clinical research [22]. Transdiagnostic approaches that target common underlying mechanisms hold great potential for achieving this, in ways that enhance intervention efficacy and cost-effectiveness [23].

We thank Wikman et al. [1] for their interesting paper and encourage future researchers to further explore the mechanisms of parents’ clinical distress after their child’s cancer treatment or when their child dies, so that we can develop more effective interventions for parents of children affected by cancer.

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