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“Understanding” as Support for Emerging Adults Whose Parents Have Chronic Health Conditions: A Life-Span Communication Perspective

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ABSTRACT

To better understand the “chronic burden of care” in the United States, we focused on an underrepresented demographic of youth caregivers in families, emerging adults (EAs). EAs are a newly recognized population of youth, 18–25 years of age, who are developmentally between adolescence and young adulthood. Guided by the life span communication perspective, we interviewed 98 EAs (30 males and 68 females, M age = 19.09, SD = 1.72) about their experiences providing support to a parent with a chronic health condition. Many EAs in this study said they provided “understanding” and our interpretive thematic analyses uncovered two broad meanings of the word: it is a form of support that EAs both have and communicate. When EAs have understanding, they have knowledge about the health condition and how it affects their parent. They also have acceptance to some degree that the health condition is a fixture of their lives and that their parents are imperfect and fallible people. They communicate the understanding they have through reciprocating support, sacrificing, being obedient, avoiding sensitive topics, and projecting emotional strength. We discuss the findings and their implications for emerging adult development as well as parent-child relational development parallel to difficult long-term health issues in families.

Nearly half of U.S. adults have one chronic health condition and about one third have multiple conditions (e.g., hypertension, diabetes; Gerteis et al., 2014). Although 86% of healthcare spending in the United States is being used to treat individuals with one or more chronic conditions (Gerteis et al., 2014), an estimated $522 billion dollars’ worth of caregiving services are provided by unpaid, informal caregivers who are most often family members (85%; Chari, Engberg, Ray, & Mehrotra, 2014; Weber-Raley & Smith, 2015) and children of all ages in particular (49%; Weber-Raley & Smith, 2015). These statistics point to what is being called a “chronic burden of care” in the United States (Bodenheimer, Chen, & Bennett, 2009; Weber-Raley & Smith, 2015) and suggest that within families, coping with a chronic illness may be a life span phenomenon that all members of the family participate in (Shifren, 2009). For children in particular, caring for ill parents may necessitate they build up and draw upon communication resources, accommodation, and competence over time in order to provide support.

Existing studies of child caregivers fail to capture previous experiences of caregiving that may have begun in childhood and persist across life stages. Research focuses largely on older children, middle-aged adults also known as the “sandwich generation,” who care for their parents while raising children of their own (Parker & Patten, 2013; Shifren, 2009). These adult caregivers, who are 49 years of age on average,
are the focus of most caregiver research. Large-scale national studies (e.g., Weber-Raley & Smith, 2015; Wolff & Kasper, 2015) and reviews and meta-analyses (e.g., Adelman, Tmanova, Delgado, Dion, & Lachs, 2014; Cheng, Chair, & Chau, 2014) document their experiences of stress and burden, as well as individual and relational growth.

This rapidly growing body of literature draws attention to a major public health concern, and yet a demographic of caregivers remains largely “invisible”: youth caregivers, including child, adolescent, and emerging adult caregivers (Levine et al., 2005; Lu, 2015). Although fewer in number than their middle-aged counterparts, 1.3 to 1.4 million children and adolescents 8–18 years of age provide care (Hunt, Levine, & Naiditch, 2005), and 12–18% of all caregivers are emerging adults 18 to 25 years of age (Levine et al., 2005). Beyond instrumental tasks such as keeping the ill family member company and completing household chores (Hunt et al., 2005), emerging adults provide unique types of support, including managing finances and making calls and arrangements for care (Levine et al., 2005).

Our focus on the perspectives of emerging adults (EAs; 18–25 years of age) in the United States who support parents with chronic health conditions offers an important context for contributing to the nascent literature on youth caregivers. Practically, as the U.S. population ages and the cost of formal care continues to rise, the number of young caregivers is likely to continue increasing (Wolff & Kasper, 2015). Particularly in homes where multiple adults (i.e., parents and grandparents) have health issues, children from young ages up to adulthood may be the individuals most capable of preparing meals, dispensing medication, working outside home, and contributing to the household in other integral ways (Belluck, 2009; Levine et al., 2005).

Theoretically, the context of emerging adulthood draws attention to the developmental influences that shape how emerging adults see themselves and their parents, and consequently, how they define and communicate support in the parent-child relationship. As individuals who are likely to be establishing themselves outside of their parents’ home, becoming employed, getting higher education, or even thinking about starting their own families (Arnett, 2014), EAs who support ill parents must manage the instability of their own life with the uncertainty of their parent’s illness. Thus, we view support through a life-span communication lens (Nussbaum, Pecchioni, Baringer, & Kundrat, 2002) and theoretical ideas about emerging adulthood (Arnett, 2000, 2014). In doing so we paint a more complex picture of EAs as support providers by exploring how the process of maturation into adulthood coincides with the progression of a parent’s chronic disease, and importantly, how the dynamic nature of support unfolds in this context.

**Extending research on youth caregiving: A focus on support through life-span communication and emerging adulthood perspectives**

Studies of youth caregivers focus on two aspects of their experiences: the types of caretaking activities they perform, including the frequency and difficulty with which these tasks are done (Gates & Lackey, 1998; Lackey & Gates, 2001); and the effects of caregiving, including social, personal, and familial outcomes (Shifren, 2009; Siskowski, 2009). The limited, yet necessary research on youth caregiving sheds light on how caregiving happens and how it can affect development for an underrepresented population of caregivers. At the same time, a review of the current literature reveals at least three opportunities to better understand youth caregiving experiences. The first is to broaden how caregiving is studied by exploring EAs’ experiences in terms of “support” rather than “care.”

Caregiving is often described in role-based terms; caregiving or being a caregiver is a full-time responsibility (Wood, 1991). This makes sense given that most primary caregivers are middle-aged women who also have jobs comparable in time and intensity to the care they provide to a family member at home (Weber-Raley & Smith, 2015). However, many children who provide care are not the primary caregiver in the home (Dellman-Jenkins & Blankmeyer, 2009), and many children who do provide care do not consider themselves caregivers (Lu, 2015). Moreover, emerging adulthood is
a time of residential instability and greater role flexibility, making the caregiver role possibly less salient than those related to love, work, and worldviews (Arnett, 2000). Asking EAs about their caregiving experiences may potentially exclude EAs who provide assistance in meaningful ways. Instead, we focus more broadly on the ways emerging adults provide “support” in terms of behaviors and activities, yet still providing room for EAs to talk about those activities in terms of roles, obligation, and duties.

The second opportunity to better understand youth caregiving experiences is to theoretically deepen how developmental influences and implications of youth caregiving are studied. Specifically, a life-span communication perspective (Nussbaum et al., 2002) can enhance the study of youth caregivers because it demands greater attention be paid to the more dynamic nature of development in the caregiving context. It is grounded in several key life-span principles (Baltes, 1987) we draw upon in this study. Primarily, development is lifelong; individuals are continually evolving and each stage of life reflects and affects the next (Baltes, 1987; Harwood, 2014). In particular, the way in which individuals develop is multidimensional and multidirectional (Baltes, 1987; Harwood, 2014). This means that support provision influences EAs’ development, as the current literature shows, but that aging also affects how EAs view and give support (Harwood, 2014). Moreover, parents receiving support also influence their EAs’ support provision and this relationship is an “ongoing dynamic” (Shifren, 2009, p. 7).

That development is nonlinear and multidimensional also means that there exists great individual difference in development, even if age cohort similarities exist (Harwood, 2014). As case in point, Pecchioni, Wright, and Nussbaum (2005) wrote, “Individuals who on the surface have the same experience may actually have very different meanings for that experience” (p. 7). Although experiences may vary across individuals, individuals experience development as a series of gains and losses (Baltes, 1987; Nussbaum et al., 2002). This principle is mirrored in studies finding that youth caregivers report feeling stress, fear, and fatigue (Gates & Lackey, 1998), but also liking the opportunity to feel “appreciated,” “needed,” “important,” and “useful” (Lackey & Gates, 2001, p. 324). However, more research is needed on the interpersonal interactions and meaning-making processes by which they come to these conclusions (Lackey & Gates, 2001).

A communication focus layers onto these principles the proposition that communication is fundamentally developmental and that studying communicative change is critical to gaining deeper understandings of individuals and their relationships over the life course (Pecchioni et al., 2005). The nature and meaning of communication changes as individuals mature; as they are called upon to utilize their communication resources in conversations, individuals are provided with opportunities to process and reflect on these experiences moving forward (Nussbaum et al., 2002). In doing so, they can develop greater cognitive complexity (i.e., the constructs individuals have in order to make meaning) and perspective taking skills (i.e., the ability to see situations from another’s point of view; Nussbaum et al., 2002). Both are necessary to building interpersonal competencies that facilitate effective communication in relationships throughout the life span (Nussbaum et al., 2002).

This study is grounded in the assumption that providing effective support is one critical interpersonal competency EAs need to manage health issues in their families. To provide effective support, EAs must recognize that their parent’s illness, which may persist over EAs’ life spans and can introduce difficult new realities for them and their families, presents opportunities for communicative growth. Moreover, this study is guided by the reality that change in the context of a parents’ illness is multifaceted: the meaning of support changes for EAs as they age and gain communication knowledge (Nussbaum et al., 2002); as their relationship with their parent transitions to one of near-equals (Arnett, 2014); and as the nature of their parent’s illness evolves. From a life-span communication perspective, theories such as communication accommodation theory (CAT; Giles & Soliz, 2015) and relational dialectics theory (Baxter & Norwood, 2015) can illuminate the ways in which EAs and their parents communicatively navigate these changes in their relationship.

The third opportunity to better understand youth caregiving experiences is to collect the accounts of emerging adults (EAs; Arnett, 2000, 2014), a newly recognized population of youth 18–25 years of
age, who are developmentally between adolescence and young adulthood. Emerging adulthood in the United States is characterized by five major features: self-focus, as EAs have few obligations to others; identity explorations, particularly in the realms of love, work, and worldviews; instability, in the same realms and in terms of residence; feeling in-between, as most EAs believe they are not adolescents but not quite adults; and possibilities/optimism, because the future is uncertain yet full of “high hopes and great expectations” (Arnett, 2014, p. 15). Important to this study, “The feeling of in-betweenness that so many emerging adults have, that feeling of being no longer adolescent but not yet fully adult, is rooted in the changes taking place in their relationships with their parents” (Arnett, 2014, p. 49).

As the ways in which EAs relate to their parents and support them evolve (Harwood, 2014), how EAs negotiate the support they provide as they straddle two developmental stages is made more complex by a parent’s chronic health condition. Chronic health issues introduce layers of unpredictability for EAs, parents, and families, thereby inducing feelings of obligation and filial responsibility (Dellman-Jenkins & Blankmeyer, 2009) as EAs perceive they are needed at home and are called upon to provide support (Dellman-Jenkins & Brittain, 2003). Ultimately, having a parent with a chronic health issue can become a “legacy” that shapes how EAs view themselves and the goals and plans they have for the future (Arnett, 2014, p. 70).

In sum, this investigation draws on the life-span communication perspective, assuming that individuals not only change and develop over time, but their communication does, too (Harwood, 2014). Our research question was: Over the course of their parent’s chronic illness, how do EAs perceive they provide(d) support to parents with chronic health conditions?

**Methods**

**Participants**

We interviewed 98 EAs (30 males and 68 females, $M_{age} = 19.09$, $SD = 1.72$) about their experiences supporting a parent with a chronic health condition. In recruitment materials we specified that, “Chronic means the condition is enduring, persistent, long-lasting, or recurring. The health condition can be anything—visible or invisible, minor or severe, mental or physical.” EAs were recruited through the Communication Studies participant pool at a medium-sized midwestern university. Of the students who reported on ethnicity, 83.7% were Caucasian, 8.2% African American, 3.1% Asian, 1% Hispanic/Latino(a), 1% American Indian, 1% Middle Eastern, and 1% Multiracial/Other. A majority (55%) reflected on experiences supporting their mothers (including one grandmother); 45% reflected on their experiences with their fathers (including one stepfather). Parents’ health conditions included: cancers (14.57%), mental health conditions (13.54%), blood-related illnesses (9.38%), heart conditions (8.33%), diabetes (8.33%), colon conditions (6.25%), chronic pain (6.25%), and others (41.68%) for which there were three cases or fewer (e.g., Lupus, Cerebral Palsy). EAs reported being aware of their parent’s health condition from age three up until one and a half months before the interview ($M = 11.35$ years).

**Procedures**

As part of a larger study about EAs’ support to parents with chronic illnesses, EAs signed up for a scheduled interview and were asked to meet in a designated on-campus interview room to complete a short questionnaire and a face-to-face interview. The interview with the questionnaire took on average 30 minutes to complete, and this study reports findings from the interviews only. Data collection occurred over a 3-month period.

We utilized the Retrospective Interview Technique (RIT; Huston, Surra, Fitzgerald, & Cate, 1981) and adapted it to capture perceived support levels and meanings over the course of parents’ illnesses. Drawing from common definitions of support (MacGeorge, Feng, & Burleson, 2011), we explicitly...
defined support at the onset of the interview as “verbal and nonverbal behavior produced with the intention of providing assistance to your parent. It can be any type—emotional, such as showing concern or giving affection; instrumental or tangible, such as giving money or helping around the house; and informational, such as advice or information.”

For the graphing portion of the interview, the vertical axis or y-axis represented the percentage of support the EA felt they gave, and the horizontal axis or x-axis represented time. The time in years or months was scaled based on how long EAs had known about their parent’s chronic condition. Participants were first asked to plot two points on the graph that we used as anchors. The first point represented the amount of support the EA provided to their parent when they first found out about their parent’s chronic condition. This point was placed at 0 on the x-axis. The second point represented the amount of support that the EA provided to their parent at the time of the study. The interviewer then instructed the participant to plot five points in between that they considered as major turning points in relation to their support of their parent. We limited the number of turning points to five to eliminate the possibility for participant fatigue.

Some EAs plotted fewer or more than five. After EAs plotted the five turning points, the interviewer again asked EAs about each point, using questions on the interview schedule as well as probing questions to solicit the details, significance, and story behind each turning point. Questions included, “Can you tell me how you were providing support to your parent at this point? What does it look like? What is happening here? Why did you put [percentage] support for this moment in time?” We utilized the RIT so EAs could identify and talk about particular points in time. Many EAs became aware of their parents’ health at very young ages, and we wanted them to speak to each of these important past moments rather than general recollections. Consequently, turning points were used to ground the interview and were not data in and of themselves. All of the interviews were recorded and transcribed. There were over 600 single-spaced pages of transcripts capturing approximately 35 hours of interviews.

**Analyses**

We conducted an interpretive thematic analysis to answer our research question about how EAs perceive they provide(d) to parents with chronic health conditions. Specifically, we adopted an iterative approach wherein we engaged in both emic (inductive or emergent) and etic (based on existing theories and literature) readings of the data (Tracy, 2013). These readings were done in a reflexive manner as we concurrently cycled through phases of engaging in analysis, discussing ideas as a team, and referencing the literature (Tracy, 2013).

As a first step, we began with data immersion, or reading and re-reading the data, talking about them with one another, and “marinating in the emerging findings” (Tracy, 2013, p. 202). In doing so we sought to answer our research question, “Over the course of their parent’s chronic illness, how do EAs perceive they provide(d) support to parents with chronic health conditions?” We initially selected 35 transcripts to read to ensure we had enough data to begin answering our broad research question with richness given the depth and number of our interviews (Tracy, 2013). We chose these 35 transcripts in such a way as to ensure we had approximately the same number of interviews represented from each research team member. We each read the same 35 transcripts and met multiple times to make sense of our data.

During these initial readings, an idea that emerged during the interview process resurfaced: we noticed that in response to questions about how they provide support, EAs did not respond with behaviors. As one research team member commented, “They’re not doing anything to support their parent” (in the ways of providing support we relayed to them). We kept the interview schedule unchanged, as wanted to see if this finding continued to emerge. However, during the immersion phase of data analysis, we discussed our thoughts on how EAs provided support if not behaviorally. We noticed that EAs frequently talked about support as and along with “understanding.” We then refocused our reading of the data on these salient instances of “understanding” and surrounding text.
We highlighted “understanding,” “understand,” and “understood” in the transcripts, and then at least two authors read through each of the 35 transcripts while engaging in several iterations of primary-cycle coding (Tracy, 2013) to develop descriptive subcodes that were more topical in nature (Saldaña, 2009). We met to discuss these codes and to develop and refine a codebook of first-level codes including, “school lessons,” “transference of control,” “blame,” “being strong,” “empathy,” and “sacrificing.”

We then shifted to secondary-cycle coding in order to “explain, theorize, and synthesize” the primary-cycle codes into meaningful interpretive themes (Tracy, 2013, p. 194). As an iterative process (Tracy, 2013), our coding involved emic and etic readings of the data and meeting to develop and refine codes based on the emergent primary-cycle codes and theory (i.e., caregiving and life span and developmental literature). Specifically, as we did some collapsing, we layered on an etic lens, referencing the literature and the definition of support (i.e., informational, emotional, and instrumental or tangible) to see how our codes fit existing theory. We did this while also preserving the emic, or inductive, codes that emerged during the analysis. Our second-level codes became hierarchical in nature (Tracy, 2013), and we conceptualized two broad meanings of “understanding”—as something EAs have and may not necessarily share or express to their parent, and as something they do and demonstrate in how they relate and interact with their parent. In the later stages of analysis, we returned to the remaining 63 transcripts to explicate, refine, and distinguish between the ways in which EAs came to “understanding” when it was something they have, and how they communicated “understanding” when it was something they enacted. We reached saturation when no new codes or refining characteristics of codes were uncovered after having read and coded all 98 transcripts.

**Findings**

When asked how they provide(d) support to parents with chronic health conditions over the course of their parent’s chronic illness, many emerging adults (EAs) in this study said they provided “understanding.” Our analyses uncovered two broad meanings of understanding; it is a form of support that EAs both have and communicate. When EAs said they had an “understanding,” they referred to knowledge acquired about their parents’ health condition and how the health condition affects their parent. Understanding was also expressed as a sense of acceptance that the health condition is a fixture of their own, their parent’s, and their family’s lives, and that their parent is imperfect and fallible.

*Understanding as something EAs have: Knowledge*

When understanding is knowledge, it answers the questions, “What does my parent have?” and “How does this condition affect them?” EAs articulated this learning happening through classroom experiences, from their parent in direct and indirect ways, and through their own experiences with health issues.

*Knowledge through classroom experiences*

One way EAs discussed learning about their parent’s illness was through different health-related coursework they had taken. Participant 77 recalled a salient memory of when she started to understand her mother’s depression. It was in a class where she saw “brain scans of people who had depression, chronic depression and people who didn’t.” She said at that moment, “I really believed that it wasn’t my mom’s fault...the support I gave was by understanding more what she was going through.” This participant explained that her health class helped her learn more about the medical facts about depression, which allowed her to process her mom’s depression. Although the participant said she never discussed what was learned in the class with the parent, the act of knowing about the condition created understanding she viewed as support.
There were also times when EAs would use lessons learned in class as springboards to find more information about their parent’s health condition. Participant 18 discussed how a diabetes presentation in a health class moved him to seek more information about his father’s diabetes. He recalled how the presentation’s focus on “how it affects people in their daily life” influenced him: “I spoke to the person who was presenting and they were telling me a little bit about it and where I could find more research… I actually started doing research, looking into it, see what it was, how it affected him.” Gaining knowledge in the classroom is a normative expectation of youth (Baltes, 1987); however, as these examples illustrate, when EAs were learning health information in class, they were not only gaining biological or medical information about a health condition. They were also engaged in a meaning-making process whereby they were making connections to how their parent experiences his or her health condition. The perceived impact of coming to these realizations through gaining knowledge is made salient through EAs’ decisions to have college majors and plans to join careers related to their parent’s illness. Participant 32, whose father has diabetes, shared, “I want to be a nutritionist, and I want to work with people that have diabetes and are really overweight and stuff, and I want to be able to change that.” For these EAs, identity exploration as a unique feature of this life stage is shaped by their knowledge of and experiences with their parent’s health condition (Arnett, 2014).

**Knowledge from parents**

A second way EAs gained knowledge was through their parents in conversation and by observation. Some parents would explain aspects of their illness. For example, Participant 16 described how she first found out about her mother’s illness when she was five:

She told me about her medication and stuff like that. Which I didn’t really understand how the medication worked. So I’m just like, “Okay, what does that mean?” And then it was finally like, “Oh, it helps the brain create happiness.”

Many parents, such as the one in this example, appeared communicatively competent because they attempted to create accommodative messages that were appropriate for the child’s age and ability to manage that information (Giles & Soliz, 2015). At younger ages, health issues were described in relatively simple and nonspecific terms. For example, diabetes meant the parent couldn’t have “candies, sweets, ice cream” (Participants 3, 32). In doing so, parents seemed to help EAs better understand parents’ health conditions and how they experienced it. Participant 54 said that at eight years old, “I got to the point where I could actually understand what was happening,” and that her mother described her Cerebral Palsy by saying, “Oh, I just am a little different than other people.”

Over time, the ways in which parents described their conditions changed and EAs said they gained more detailed knowledge of their parent’s illness. This was reflected in the specificity with which they talked about their parent’s health as they aged, including names for conditions and medications, as well as timelines. For example, Participant 2 said that he is now privy to conversations concerning his father’s cirrhosis diagnosis and prognosis of months to live. He described this as “a real understanding of what’s going on.” Participant 64, described her support as knowledge that her mother “can’t take Advil…she has to take Tylenol instead.”

The importance of parents’ tailoring their communication to their children’s developmental level is not simply to ensure message quality; according to communication accommodation theory (CAT; Giles & Soliz, 2015), doing so signals trust and respect to children and brings parents and children closer together. EAs recognized the shift in how their parents view and interact with them and the increased intimacy that accompanies it (Arnett, 2014). As Participant 58, whose mother has Sjogren’s Syndrome, disclosed:

It’s nice that she trusts me, I think that’s kind of a good thing she likes to bond over with me just because my sister and my Dad don’t really like hearing about it because that makes them sad, but when she talks to me… I can see how optimistic she is even though it will probably never be cured in her lifetime.
The second way that EAs gained knowledge from their parent was through observation. EAs recalled how they recognized and took notice of parents’ physical pain, sleep and mood changes, as well as their struggles to leave the house and get out of bed because of physical limitations or mental health conditions. Participant 3 described how her mother experiences her diabetes: “We’ll be out shopping now, and she’ll be like, ‘I need to get a candy bar,’ and her hands will start shaking.” In another example, Participant 59 explained she learned that her mother could not have antibiotics after she saw her mother go into anaphylactic shock at the dentist’s office. Visible cues to information about how their parent was doing were common in EAs responses, although understanding often meant having to read between the lines when parents would act in certain ways. EAs often referred to the subtlety of these moments in which they “could tell” what their parent was experiencing. For example, Participant 85 recalled how she would vigilantly monitor mealtime with her father who has diabetes because, “I could tell if he ate too much, he would just not want to do anything for the rest of the day.” As these examples illustrate, through being told by their parents and by seeing their parents being ill, EAs believed they gained insight into what it means to have the health condition and how their parent feels physically and emotionally.

**Knowledge through personal experiences**

A third way that EAs gained knowledge was through experiencing their own health issues, often the same ones as their parents. Experiencing similar symptoms or receiving a diagnosis were described as significant turning points, allowing EAs to give meaning to their parent’s past and present health experiences. Participant 20 said she originally had a hard time processing their mother’s depression. However, when she was diagnosed with depression as well:

I was able to compare what I was feeling with how my mom was feeling, and I was able to understand why she had been acting the way that she had been acting for so long. And it really helped me. And so I was able, I feel, to relate to her more and give her the support that I knew I would want to hear, ‘cause I was in that situation.

Similarly, Participant 87 said that his experience with depression lead to an “explosion of understanding” that “exponentially rose” from the time that he and his father first discussed their mutual depression. He said, “Us talking about how I was going to cope with it kind of really started jumping my mind into understanding what he had been going through the whole time.”

Other times, gaining knowledge of their own health issues that may be different from their parent’s helped EAs better understand their parent’s health condition. Participant 56, whose father has Parkinson’s Disease, recounted how getting diagnosed with her own chronic illness helped her understand “how he feels about it.” She also recognizes:

It’s not… the same thing at all, but it’s chronic and it’s going to be through my whole life so I understand like how he feels, like it’s going to be through his whole life and he can’t do anything about it.

This participant talked about her own illness and her father’s illness in near-identical ways, stressing the chronic nature of their health conditions and implying that because she does not have control over her health condition, she believes her father does not have control over his, either. Together, these examples illustrate how the self-focus that defines emerging adulthood (Arnett, 2014) allows EAs to connect their own illness experiences to those of their parents’, thereby facilitating perspective taking and empathy.

In sum, understanding was described by EAs as something they came to through the acquisition of knowledge. Parents often facilitated this process by accommodating their communication to their children’s developmental level, though knowledge also came from self-experiences with illness. From a life-span perspective (Nussbaum et al., 2002), gaining knowledge of their parents’ illness was important because it provided EAs with more constructs and the perspective taking skills to help them make sense of their parent’s condition and even their own health. They had language to talk about their parent’s health condition, and they knew what to look for to know when their parent was ill and needed assistance. Importantly, when EAs learned information about their parent’s health
condition, they felt more compassion toward their parent; when they learned new information about their own health, they could empathize with their parent and relate to his or her experiences. Although most EAs never discussed the realizations they came to with their parents, they nonetheless said that knowledge as understanding was support.

**Understanding as something EAs have: Acceptance**

A second kind of understanding that was related but distinct from knowledge was acceptance. Whereas knowledge is a kind of recognition of what the health condition is and how it affects their parents, acceptance represents EAs’ acknowledgment that their parents’ chronic health condition is a permanent fixture in their own, their parent’s, and their family’s lives. As Participant 7, whose mother has arthritis expressed, “[Support here] is higher because I was starting to understand, ‘This is not gonna go away because it hasn’t gone away and…I feel like if they would’ve found something that would’ve it helped her by now, they would have.’” Acceptance also means coming to terms with the fact that parents are imperfect and fallible.

**Pushing/challenging parent**

Many EAs provided examples of how they push or challenge their parent to manage his or her health condition, often through encouraging parents to be more mindful about what they are eating, to engage in physical activity, to take medications, and to seek medical treatment. The perceived shift in power in the parent-child relationship can be seen in EAs’ attempts to influence their parents and change their health behaviors (Arnett, 2014). In one more extreme instance, Participant 52 issues an ultimatum to her mother to compel her to seek treatment for her mental health condition: “I told her she could either go to rehab, or I would never talk to her again and I would leave the house and I would call the cops on her for child abuse, verbal abuse…”

EAs’ experiences illustrate how the path to acceptance was often fraught with conflict and ongoing tension as they tried to hold their parents accountable for their own health. Participant 35 said that because she knows her father “eats like crap,” she is “on him a lot about [what he eats].” Now in college, she finds it harder to monitor his food intake, but shared that, “I’d come home and there’d be an empty bag of something. We’d get into fights all the time.”

Relational dialectics theory (Baxter & Norwood, 2015) provides insight into the power struggles in EAs’ recollections. EAs draw upon discourses about what is healthy to push their parents to do what they perceive as good management of parents’ health issues. In particular, a dialectic of acceptance/challenge captures EAs’ attempts to influence their parents (Baxter & Norwood, 2015). For some, acceptance was expressed as resignation that though they try to motivate, encourage, and even demand compliance, they cannot force their parent to do what they would like. For others, it meant “giving up on trying,” or acknowledging that their parent is a person who can and does make his or her own decisions. Such is the experience for Participant 3, who gets frustrated with her diabetic mother for not managing her insulin levels:

Even when we’re here, like [at college] for orientation, there’s all the hills and stuff, she couldn’t make it up some of the hills and I’m just like, “I don’t know what to do at this point. I can tell you to like…When we’re having like dinner, I can tell you to pick vegetables instead of something else, but when we’re in the moment and you run out of breath so easily, I don’t know what to do. I can’t carry you up the hill.”

**Role expansion and reversals**

“Trying out” different roles is developmentally appropriate for EAs (Arnett, 2014, p. 9); however, when their parent is sick, taking on new, more “adult” roles, and performing roles parents normatively perform (e.g., pay bills, care for sibling) meant EAs gained a deeper understanding of the limitations imposed by the health condition. For many, this lead to greater empathy for their parent. EAs shared how difficult it can be for their parents to allow them to perform these adult roles inasmuch as it can be hard for EAs to accept that they are
being asked to perform them. Participant 16 revealed to us what this struggle was like, describing the time her mother disclosed her depression:

> But it's hard seeing a woman, especially your mom, who is like a Superwoman to you in all your life, and then you realize that she has all this inside, she's keeping it all to herself, and you're that person to help her and listen to her and get the work-day off her and stuff like that.

Here the participant discloses to us her realization that her mom is imperfect; she no longer sees her mom as “Superwoman.” This understanding moves her to accept the new roles she must take on, like helping to “get the work day off her,” by being a friend as well as daughter. As another example of role expansion (Arnett, 2014), one EA said she learned to do her mother’s job duties at work because her mother was experiencing severe complications associated with her cancer.

Role reversal meant EAs had to take on a provider role, providing material assistance to their families, often in the form of money. At times, EAs talked about paying for their own tuition and expenses while in college as a role reversal by implying that it is normally a parent’s role. Some EAs did both; Participant 84 disclosed how she and her sister use leftover scholarship money to pay their mother’s (who has Crohn’s Disease) bills:

> But every time I’m around her [and] I wanna do something and she’s like, “Oh, I don’t have the money.” It’s just like, “Of course.” I get sassy so I’m like, “Of course. You haven’t had a job for three years.” I get so mean sometimes when I think about it ‘cause all of my peers have their parents helping them and my mother hasn’t given me anything since I was 15, which I don’t expect her to because I’m an adult.

For this participant, having to engage in these role reversals is seen as a sacrifice that she has begrudgingly accepted, as evidenced by the specific way in which she references time and the long-term nature of her assistance. This example reflects the ambivalence and hesitation with which some EAs take on adult responsibilities (Arnett, 2014). It also reveals a child/peer dialectical tension arising from competing, normative discourses about roles and responsibilities in the relationship: parents should care for their children, and yet, adult children have an obligation to care for their aging parents (Dellman-Jenkins & Blankmeyer, 2009).

Additionally, EAs recounted how parents had a difficult time allowing their children to take on these new roles. Many refused help or took assistance with hesitation. Participant 3 disclosed that her mother will go without insulin testing strips because she cannot afford to buy more. If she bought them for her mother, “Well, she’d probably take them, but she’d be like, ‘Don’t do that again. Don’t get me… Let me pay you back.’” The importance of role reversals for coming to acceptance is made salient by Participant 90, who cooked, did laundry, and cared for his brothers before and after school every day as his stepfather battled leukemia in another city and his mother worked or spent time with his stepfather. His description of the role reversal reflects a deeper understanding of his stepfather, himself, and their relationship:

> It was meaningful for both of us, I think, knowing that he could do what he needed to do and not have to worry all the time about the house, and stuff. And then it was meaningful for me because at least I’m making a difference, somehow.

**Witnessing**

In this form of acceptance, understanding was facilitated by participants visibly seeing their parent ill and vulnerable. The significance of witnessing is manifested in visceral descriptions EAs gave of what they saw when their parent had health issues. Participant 74 shared her experience of her mother’s breast cancer postsurgery saying:

> Blood, anything, freaks [me] out...She was in pain, and there’s obviously a lot of blood and a lot of stitches. She would vomit a lot, obviously, from all of the medication. It’s just amazing how... I surprised myself, even. I was holding buckets and cleaning stitches...

This description exemplifies many of the bodily experiences associated with chronic disease (e.g., blood, stitches) that EAs shared. These moments were powerful because they fostered an empathetic
understanding of parents’ health and compelled EAs to provide more support. For many, this is when the reality of their parent’s condition became solidified. Participant 32 who recalled a vivid memory in which she gained understanding of her father’s diabetes:

I remember my dad being like, “I have to stay overnight, you have to go home and get all of my medical stuff.” So I went to the house, and he told me where everything was, but I literally was like “Oh my gosh,” like there’s so much. There’s all… Kinda like, “I need this medication, I need this medication. I need my test strips, my pricker…”

One succinct example of a participant (97) whose father was having thyroid cancer surgery captures the importance of EAs bearing witness to difficult moments that helped them understand:

We could talk for as long as we wanted but we didn’t know what to say and we didn’t know what to do. I could tell that he was emotional and that it was hard for him to keep it together. That was hard…He would say that he was doing ok and that surgery was going well…and change the subject and make it more about what was going on in our lives.

In summary, acceptance as a form of understanding came from EAs’ more complex experiences navigating their parent-child relationship, such as when they pushed or challenged their parents’ health choices and behaviors, took on adult roles (e.g., caring for siblings, contributing financially to the household), and witnessed their parents being sick and vulnerable. Coming to acceptance was not a linear, tidy, or rapid process, and it was never complete. It was often marked by frustration, conflict, sadness, and resignation. It moved EAs to empathy and engagement at best and resentment and withdrawal at worst. Some EAs refused to accept some aspects of their parent’s illness. Despite the challenges, EAs talked about how acceptance helped them let go of control and anger and lay less judgment and blame on their parent. Maturity can be felt in their reflections: As Participant 2 explains, acceptances means “being like okay, maybe his decisions did lead up to this point, but there is not really anything that I can do about it. We’re here in the situation now, and he is still my dad and I still care about him.”

Understanding as something EAs do: Communicating understanding

Understanding was not only something EAs had in the form of knowledge and acceptance; it was also something that guided their interactions with their parent. Having understanding equipped EAs with communication resources (i.e., knowledge and acceptance) and competencies (i.e., perspective taking, empathy) to respond to their parent in supportive ways. Put simply, having understanding was a catalyst to showing understanding. EAs communicated their understanding through reciprocating support, sacrificing, being obedient, avoiding sensitive topics, and projecting emotional strength.

Reciprocating support

Supporting a parent was often described as reciprocal exchanges where the participant described giving support in return for receiving support in the past or present. Interestingly, EAs often responded to questions about how they supported a parent by providing an example, and then talking at length about how their parent had supported them. For example, Participant 54 said that in high school, “My shitty ex-boyfriend was awful, and my mom was the only person there.” As a relational turning point that “broke down a bunch of walls,” she is now more patient with her mother. Participant 68 recalled a similar turning point with his mother, who supported him through a breakup with his girlfriend. He resolved, “Alright, mom. You’re the one. It’s you and me,” and he began to provide more emotional and instrumental support, such as carrying his mother up the stairs because of her knee pain.

At times, reciprocated support evolved from reciprocated conflict. Conflict is important to understanding because it provides a site for EAs to learn about the relational expectations and rules of others, including how they differ from their own (Nussbaum et al., 2002). Conflict also
presents opportunities for EAs to develop the conflict management skills necessary to navigate these differences in relationships over the life span (Nussbaum et al., 2002). Participant 13 recalled how her relationship with her mother, who has colitis, hypothyroidism, and depression, changed when she moved from home. She reflected on this multidimensional transition:

I didn’t take into account how she felt about anything and how it was making her feel. I started realizing “I’m on my own now and my mom is my support system,” so I would start supporting her. And that was a good time because she started Weight Watchers and she started losing…She lost 100 pounds in the first year.

Here, the participant acknowledges how she lacked understanding of her mother’s illness and how she felt compelled to support her mother when she needed her, going as far to attribute her mother’s improving health to her newfound awareness. Though EAs described the support they reciprocated in more general terms as compared to others in this larger theme of communicating support, reciprocation is important in its own right because it reflects the changing nature of EAs’ relationships with their parents (Arnett, 2014). In particular, EAs were guided by an understanding that returning support to their parent was a way to strengthen their relational commitment as well as meet expectations for reciprocity in a more peer-like relationship (Arnett, 2014). Reciprocating support also shows EAs’ readiness in the present to “give back” to their parent based on a relational history marked by supportive interactions.

**Sacrificing**

At times providing support meant giving up certain privileges or desire to make time for parents, or assuming roles and responsibilities to help parents. For example, understanding the responsibilities of caring meant that EAs had to forego spending time with friends. Participant 74 describes reorganizing her priorities:

I stopped doing some things that I would normally do. Like when I go home, maybe I don’t go out so much. And that’s fine; it doesn’t upset me at all. Whereas before, if I missed out on hanging out with my friends, it’s the end of the world. But it’s more like she is the most important thing…in perspective, like this, you really see what’s important.

In another example, Participant 17 recalled how she refrained from asking for money, and in particular, money to buy homecoming and prom dresses that were very important to her for fear that it would raise her mother’s already problematic blood pressure. She said, “She was just stressed out about money. So, I feel like I felt bad because I was the one who needed the money or wanted the money. So just to be a little bit nicer helped, and more cooperative about the money.” As this example demonstrates, EAs were willing to forego or stall their own needs because they felt it would help their parent. However, some felt that even though they understood what their parent needed, they could not do enough to help their parent while simultaneously taking care of their own needs. There is tension between being self-focused and having growing care and concern for parents as people (Arnett, 2014). One participant (56) describes this as a dilemma as her father’s credit card bills were piling up. She could only get work in fast food, and her family was on the verge of losing their home to the bank:

It was really frustrating because I felt like I couldn’t, I couldn’t help but I like literally couldn’t help because I couldn’t like make money and then I needed to save it, too, for college and I also paid like for my car, like everything for my car and sometimes my phone…financially I wish I could have helped more but I literally just like couldn’t.

**Being obedient**

When EAs felt they understood their parent’s health and how it affected him or her, they were mindful to not create more stress or hardship than already existed. Specifically, EAs described being obedient, or “being a good kid,” who wasn’t “deviant” or “didn’t act out” as a type of understanding that reduces instability and uncertainty associated with the health condition. Some participants were
proud that they were “good kids,” helping when called upon and generally trying not to add stress to the family situation. Participant 65 expresses this sentiment while also admitting to typical teenager behavior: “I didn’t really ever do anything wrong. I mean I… Don’t get me wrong, I did a lot of things wrong, but I didn’t do anything big. I was always the one that was like, ‘Yeah, I’ll do that,’ or ‘I’ll get that done.’” Another participant (7) shared that she tries to follow the principle: “be understanding and just don’t be rude or disrespectful ‘cause like it’s hard for your parent and they need help sometimes.” In addition to being kind to parents in interactions, EAs shared how obeying parents’ wishes was a way they were communicating support. Several EAs said that doing well in school and “getting good grades” were examples of this support. Participant 2 explained:

He wants me here, he wants me to be like doing those like things of like… Studying, getting good grades, like going to school and all of that. So, in a way, like I can support him by doing well in the things that he admires or what not.

Avoiding sensitive topics

Some EAs said they avoided asking certain questions or bringing up certain topics that might upset their parent. Many said they were diligent in calling, texting, and FaceTiming their parents to see how they were, but that they were careful to ask generally, “How are you?” and let their parent decide whether to talk about his or her health. Participant 83’s experience illustrates how this can be a frustrating experience because efforts to be sensitive can block access to information about the parent’s health:

I’m like, “How are you doing?” He’s like, “Okay fine, I’m fine.” And it’s like, “Okay well, how really how are you?” And he’s like, “Good,” but you never really know because he’s very to himself, doesn’t want anyone to know. So kinda makes it hard to support someone like that because they don’t give you any like room to support.

In particular, mental health conditions seemed to require a high level of sensitivity. For example, Participant 87 whose father has depression explained how he learned to approach his interactions with his father differently. He said, “Every time I’ve talked to him on the phone like we end up cutting it short ‘cause he gets really, he’s a really sobby guy.” Because of this, he is careful not to bring up specifics related to his father’s mental health; they have “that really typical father-son interaction, ‘How you doing? How’s things been?’ Hug when we see each other.”

Avoidance was also a way to respect privacy boundaries EAs believed their parents had. For example, Participant 57 disclosed her feelings about avoiding certain topics with her father, who has depression:

I feel like even bringing up and hoping to have a conversation about it would be inappropriate almost. And no way can I ever understand what he went through, and for me to pretend, or try, or… I feel like it’s a little bit disrespectful and inappropriate.

Projecting emotional strength

EAs communicated their understanding by “being strong” for their parent, even when they were scared or uncertain themselves. When Participant 24’s mother was in the hospital for a recently discovered tumor, and although the tumor was not surprising given her type of cancer, she said:

But that day I was absolutely like, “Oh Mom, don’t worry about it. They’ll figure it out. It’s going to be fine.”

Even if I wasn’t sure if it was actually gonna be fine, I was telling her that it was gonna be fine. And I definitely think that was important for her to hear.

Participant 47 shared her memory of when her mother, who has heart issues, woke from surgery. Knowing that her mother would be “freaking out” because she had a ventilator “down her throat,” she joined her family in saying, “They’re gonna take it out, they’re gonna take it out. It’s going to be okay. And when they take it out, we’re gonna get you a nice milkshake. Do you want a milkshake?” After “playing a little game” of communicating only with figures to determine which flavor her
mother wanted, they were able to get her a chocolate milkshake that made her “very happy.” Even as young children EAs recalled recognizing the need to diffuse difficult situations. Participant 3 said of her mother with diabetes, “If I saw she was down about something or she wasn’t feeling well ‘cause her sugar was low or something, I would draw her a picture. She would always take them and hang them up.” EAs recounted situations requiring emotional strength as turning points in their support of their parent.

In summation, EAs said they communicated support by reciprocating support they had received themselves; by sacrificing their own wants; by obeying parents’ wishes; by being sensitive and avoiding talking about certain topics related to their parent’s health that might be upsetting; and by projecting emotional strength. Interestingly, these ways of communicating support were not always explicitly directed at helping the parent with his or her health, and they were not necessarily actions. Instead, EAs often said they avoided doing and saying things that might upset their parent. They strived to be “good kids” in order to minimize their parent’s distress; they told their parent “It is going to be okay” even when they were not sure it would be; and they chose to spend time with their parents instead of their friends. As such, EAs were attempting to accommodate (Giles & Soliz, 2015) to what they perceived as their parents’ needs, drawing from and moved by their understandings (i.e., knowledge and acceptance) of their parent and his or her health condition developed through interactions over the course of their parent’s illness.

Discussion

Guided by the life-span communication perspective (Nussbaum, 2014; Pecchioni et al., 2005), our goal was to understand how EAs support their parents over the course of their parent’s illness. We interviewed 98 EAs and uncovered a type of support that EAs perceived to be meaningful to them as well as helpful to their parents: understanding. “Understanding” as a form of support reveals how the subjective meaning of communication reflects and changes as a function of development, the premise of the life-span communication perspective (Harwood, 2014). To illuminate how understanding is something that is developed communicatively across the life span, we drew upon complementary communication theories, life-span principles, and theoretical ideas about emerging adulthood.

We uncovered two general meanings of understanding: it is something that EAs have and something that they communicate to their parents. We explicated these meanings through a number of sub-themes. First, understanding was described by EAs as something they have in the form of knowledge. EAs came to understand their parent’s illness and how it affects him or her through school lessons, from their parent directly and through observation, and through self-experiences with health issues. EAs’ recollections of learning about their parent’s health condition, particularly in school, is not entirely surprising. What is significant, however, is how EAs talked about these instances in which they connected some health-related information to their parents’ experiences as moments of clarity that raised their consciousness, influenced them to seek more information and share it with their parent, and made them more sympathetic toward and empathetic of their parent’s health challenges.

The nature of knowledge and the means of gaining it changed over time. As young children, EAs had illnesses described to them by parents in simple terms without medical jargon or gruesome detail; as EAs aged, they became privy to more personal and sensitive information, including their parent’s own feelings about his or her health. Parents were perceived to tailor messages to their children’s developmental needs by simplifying, and at times, withholding, information about their health. Consequently, EAs believed their parents were sensitive and that parents’ communication accommodation (Giles & Soliz, 2015) helped them make sense of their parents’ health condition—and at times, their own—helped their family better manage the health condition, and also strengthened their relationship. Ultimately, gaining knowledge provided a means of increasing cognitive complexity, thereby equipping EAs with the communicative resources needed to facilitate meaning-
making about their parent’s illness and its role in their own and their family’s life (Nussbaum et al., 2002). EAs came to knowledge, then, through a process of growth in which their learning was not only a developmental task for their own sake, but a search for understanding about their parent and his or her health.

In addition to gaining knowledge, EAs expressed coming to acceptance as a form of understanding. They did in this three ways: pushing/challenging their parent, role expansion and reversals, and witnessing their parent’s health. Together, these paths mirror two important life-span principles. First, emerging adulthood is characterized by a strong desire to gain independence, of which one criterion is the establishment of equal relationships with parents (Arnett, 2014). To the extent that EAs in this study see their parents as peers, their attempts to influence their parents, their exposure to difficult sights (e.g., pain, blood) and disclosures, and their taking on adult roles reflect this developing sense of autonomy. Second, the life-span perspective is grounded in the idea that development is a gain-loss dynamic (Baltes, 1987), which may also be conceptualized as a dialectical tension (Baxter & Norwood, 2015) that subsumes other tensions we uncovered in this study.

Tensions arose through interactions with parents in which competing discourses between the roles and responsibilities of being a child and a peer, and those between accepting parents for the people they are and challenging them to be “healthier,” were evident. In becoming a peer, EAs lost the security of being cared for as a child; in accepting their parents as persons, they lost an image of parents as “demigods” (Arnett, 2014, p. 62). Negotiating these tensions was a developmental process of figuring out who they are, who their parent is, and what their relationship with their parent is. For some, it meant acknowledging and even welcoming the role of their parent’s confidant and main support system. For others, it meant living with constant strain in their relationship as they pushed their parent to be healthier but felt they could make no impact. In sum, relational dialectics theory (Baxter & Norwood, 2015) was helpful to organize and make sense of contradictions evident in EAs’ recollections and how they inform the meaning of understanding as acceptance.

Knowledge and acceptance were communicative resources (Nussbaum et al., 2002) EAs drew upon in order to communicate their understanding through reciprocating support, sacrificing, being obedient, avoiding sensitive topics, and projecting emotional strength. These ways of communicating understanding embody EAs’ changing relationships with their parents (Arnett, 2014). Specifically, EAs move from being their parent’s child toward establishing a more peerlike relationship with their parent by seeing their parents as “people and not merely as parents” (Arnett, 2014, p. 49); by respecting their parent’s privacy boundaries; and by sympathizing—and even empathizing—with their parents’ pain. This child-to-adult transition is more apparent when we contrast their “being a good kid” with their “sacrificing,” their keen sensitivity to their parents’ needs with their focus on themselves during the interviews (e.g., “me getting good grades,” “my prom dresses”), and their displays of emotional strength with their acknowledgments that they still need and want their parents’ support. There is simultaneous focus on the self and concern for their parent in their recollections (Arnett, 2014).

These ways of communicating understanding also reflect a central tenant of life-span communication theory: the nature and meaning of communication changes as people age (Nussbaum et al., 2002). Over the course of their parent’s illness, EAs’ support generally came in the form of providing or sacrificing things important to children at that age. Drawing pictures was support as small children; forgoing their own wants was seen as a selfless and supportive act as teenagers; and being the “strong” one in the relationship was support as an emerging adult. Furthermore, specific ways of communicating support meant different things at different ages: as small children, being “obedient” meant staying out of trouble and doing as children were told; in college, it meant getting good grades and fulfilling parents’ wishes for EAs. In sum, our findings illustrate how the support EAs perceive themselves to give reflects their individual development and their relational development with their parent.
Limitations and future directions

The current study has several limitations. Firstly, this study was retrospective. The participants were asked to remember support-related turning points in the trajectory of their parent’s condition that limits the scope and depth of the participants’ stories and experiences of their parent’s health. Moreover, because this study is based on EAs’ recollections, we cannot be sure if they provided any of the support they shared with us at various ages, or if those experiences only reflect their current development stage. A related limitation of this study is our college-only sample. Access to education influences our findings related to gaining knowledge from the classroom. More research is needed to understand the support experiences for EAs who may not have the same financial resources and opportunities as those who attend college. Nonetheless, a strength of our approach was that we were able to glean insight into how EAs make sense of themselves, their parent, and their parent’s health in the past, present, and future. Second, the sample was not diverse; participants were all college students and most were White and female. Many have acknowledged the importance of gender, socioeconomic class, and race in caregiving disparities (Shifren, 2009). Future research should consider these factors because life-span development cannot be understood devoid of history and context (Baltes, 1987). Future research should utilize methodologies that can attend to the ways in which support may be seen as a reciprocal communicative process that is not only enacted at one static moment in time but across time. We recommend longitudinal studies that take seriously support as a process.

Contributions and conclusion

This study contributes to caregiving and support literature by identifying “understanding” as a type of assistance and unpacking the complexity buried in the word. Our findings suggest that having and communicating understanding differ from typical activities reported in caregiving research; caregivers of all ages are reported to perform the same kinds of tasks—personal (e.g., getting in and out of bed), medical/nursing (e.g., administering medication), and household (e.g., preparing meals)—although they may vary in frequency, intensity, and duration (Dellman-Jenkins & Blankmeyer, 2009; Gates & Lackey, 1998; Weber-Raley & Smith, 2015). Moreover, “understanding” differs from traditional forms of social support (e.g., emotional, tangible, instrumental; see MacGeorge et al., 2011, for a review). Of course, understanding can be expressed as and through these types of support, for example when EAs go to work on behalf of their parents. However, EAs in this study said understanding—in and of itself—was an important type of support they provided. Understanding also differs from assistance studied in caregiving and social support literatures because it involves a level of awareness about and concern for parents not captured by verbal and nonverbal behaviors, and because it reflects EAs’ shifting orientation toward parents as peers, a hallmark of emerging adulthood (Arnett, 2000).

By taking a life-span communication perspective that focuses on the development of communication within relationships, we shifted the basis for this study from a quest to identify the “what” of support (i.e., types and consequences) to a more fundamental exploration of what social support means and to whom. We are in agreement with Goldsmith (2004), who critiqued the literature on stress, coping, and social support for its inattention to processes of communication such as social support. We believe that our use of life-span communication as a metatheoretical lens has allowed us to expand theoretically what it means to provide care and support. We advocate for continued exploration of the “how” of support as a way to enrich our understandings of support and of families living with chronic health conditions.

This study shines a light on the importance of parent-child relational development parallel to difficult long-term health issues in families. It is of interest to family communication the ways in which EAs’ relationships with their parents are simultaneously enabled and constrained by the presence of a chronic health condition. Chronic illness is cast solely as a challenge and impediment to individuals
and family life (i.e., “burden”). However, in our study some EAs believed that their parent’s health condition brought them closer to their parent, even when it presented conflict. Our findings suggest that chronic illnesses can build resilient bonds between parent and child.

References


