Single-Parent Caregivers of Children with Cancer: Factors Assisting With Caregiving Strains

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Abstract

Objectives: Caring for a child with a cancer can result in significant financial strain on families, which in turn can affect parental emotional, physical, and social health. We explored the supportive factors and resources that helped single parents of children with cancer throughout the caregiving process. Methods: Using a constructivist grounded theory approach, we recruited 29 single parents of children with cancer that were at least 6 months postdiagnosis and 2 hospital social workers across 4 Canadian pediatric oncology centers. Results: Many parents had knowledge of, accessed, and received support from family, friends, community (eg, teachers, religious organizations) and cancer organizations and government programs. Nonetheless, they reported a number of unmet needs. Conclusions: Participants reported their need for more social-emotional, practical, and financial support to assist them with their caregiving duties. We recommend that hospitals provide education to describe (a) supports available to families and (b) parental caregiver needs to families’ support networks. Further research is needed to identify limitations of the current public benefit schemes for caregivers.

Keywords
caregiving, childhood cancer, single parents, qualitative methods, support factors

Background

Many children diagnosed with cancer survive their initial disease (Ellison, Pogany, & Mery, 2007; Nathan et al., 2008). Caring for a child with a cancer can result in significant financial strain on families (Crozier, Butterworth, & Rodgers, 2007; Dockerty, Skegg, & Williams, 2003; Eiser & Upton, 2007; Fletcher, 2010; Fletcher, Schneider, & Harry, 2010; Heath, Lintuuran, Rigguto, Tokatlian, & McCarthy, 2006; Klassen, Dix, et al., 2012; Limburg, Shaw, & McBride, 2008; Miedema, Easley, Fortin, Hamilton, & Mathews, 2008; Mullins et al., 2010; Tsimicalis, Stevens, Ungar, McKeever, & Greenberg, 2011), which in turn can affect parental emotional, physical, and social health (Klassen et al., 2007; Klassen, Gulati, et al., 2012; Van Dongen-Melman et al., 1995). The financial strain of caring for a sick child is amplified for single-parent families because there is often only one person available to meet the financial and caregiving needs of the entire family (Brown et al., 2008; Crozier et al., 2007; Human Resources and Income Development Canada, 2011; Klassen, Dix, et al., 2012). According to the 2006 census, Canadian single parents represented 34.8% of all families with children (Milan, Vézina, & Wells, 2006). In 2007, Canadian single-parent families represented the lowest median after-tax income ($36 300) compared with 2-parent families having the highest income ($73 000; Human Resources and Income Development Canada, 2011).

In 2008, Brown et al. reviewed the literature and called single parents of children with chronic illness “an understudied phenomenon.” The review highlighted that few studies have investigated the strains resulting from being...
the sole caregiver of a child with a chronic illness (Brown et al., 2008). Additionally, there is evidence that informal caregiving for cancer patients is associated with caregivers having high needs (e.g., domestic help, financial assistance, etc.) and psychological morbidity, though few effective interventions have been identified (Harding & Higginson, 2003).

Caring for children with chronic illnesses can result in multiple strains on parents (Brown et al., 2008; Grootenhuis & Last, 1997; Klassen et al., 2007). In a separate publication, we report on the health impact of caregiving (Klassen, Gulati, et al., 2012). Parents identified a range of health problems related to caregiving (e.g., sleep disturbance, depression, etc.) as well as some of the positive effects of caregiving (e.g., gaining a greater appreciation for child and family, developing compassion, etc.). In this article, our team sought to identify factors that helped Canadian single-parent caregivers cope with the strains of caring for a child with cancer, including their knowledge and use of the various supports and resources available.

**Methods**

**Design**

Our research sought to understand and explore the experiences of single parents of children with cancer. As such, we employed an inductive qualitative methodology specifically, a constructive grounded theory approach (Charmaz, 2006). We used semistructured interviews to explore participant experiences (see Box 1 for the Interview Guide).

**Box 1. Interview Guide**

1. Can you tell me the process by which you discovered that your child had cancer? [If not answered: How did you first notice that something was “not quite right” with your child? Can you describe the events that led up to your child’s cancer diagnosis? What were you thinking/feeling about at the time? What were you most worried about?]
2. In what ways has having a child with cancer changed your day-to-day life? [Probe: What was a typical day like then?]
3. In what ways has having a child with cancer changed the lives of family members? [Probe: Draw family diagram to illustrate others at home and probe for impact caregiving has had on siblings?]
4. Tell me how you cope(d) with caring for a child with cancer? [Probe: Activities completed inside/ outside the home, leisure/social activities, and interactions with others.]

5. Are there ways in which your health has been affected by caregiving? By health, I mean both your physical, mental, and emotional health. [Probe: Sleep disturbances, changes in diet/exercise, activities participant engaged in to take care of his/her health].
6. As you think back on your experiences, tell me what has been a particularly low point? Tell me about a high point?
7. Who has been the most helpful to you through this cancer experience? [Probe: For people, organizations, community groups, religious groups, or health care resources and how they have been helpful?]
8. What kind of problems/special challenges do you face as a single parent of a child with cancer? [Probe: Financial impact, isolation, social support].
9. What do you think is the most important thing for a single parent with a child who has cancer needs to know?
10. What are some of the advantages to being a single parent?
11. Can you talk about your relationship with the people at the hospital who care for your child and your family? [Probe: Do they emphasize a partnership relationship? Are you included in decision making? Are you treated with respect? Are the needs of all family members considered? Do they provide you with information about how your child is doing? Did you ask specifically for information on how your child was doing or was information given to you? What kinds of questions did you ask the doctors, nurses, social workers? Was information given to you in a way you could understand and that made sense to you?]
12. Has a social worker ever approached you to talk about how you were feeling? [Probe: Where did s/he approach you? Did you feel you had enough privacy to talk about how you were feeling? If not, what would help you be able to talk about how you are feeling/doing?]
13. Do you feel you are treated differently because you are a single parent? Did you feel that you SHOULD have been treated differently because you are a single parent? What would have helped you the most? The least?
14. What do you think health care professionals need to know about single-parent families?
15. Who or what has been the most helpful to you through this cancer experience? [Probe: For people, organizations, community groups, religious organizations or health care resources and how they’ve been helpful]
16. After having this experience, what advice would you give to a single parent who has found out their child has cancer?
17. What have you learned as a result of going through this experience?
Box 1. (continued)

18. Going through this experience, do you feel that you have changed as a person? How? [Probe: Is there anything good that has come out of this experience?]
19. If you were conducting this study and you wanted to explore the experience of single parents whose kids have cancer, what kinds of questions would you ask the participants?
20. Is there anything that I have asked you about that you would like to expand on or add to?

Sample

A sample of 29 single parents was recruited using purposive sampling. Data collection took place between November 2009 and April 2011 from 4 Canadian pediatric oncology centers. Inclusion criteria for participants were as follows: the child was a minimum of 6 months postdiagnosis and not palliative; the parent was the primary caregiver, that is, the individual most responsible for daily care and decision making for the child; and the parent was a single parent, that is, the only adult living in a household with 1 or more children (including the child with cancer) for at least a 6-month period during the child’s active treatment phase. Participant characteristics are in Table 1. In addition, 2 social workers were interviewed to understand the experiences of single parents from the health care provider (HCP) perspective.

Data Collection

Research ethics board approval was obtained at each institution. Participants were approached and they provided consent to a research nurse, clinical research associate, or pediatric oncologist. The research team was notified and the parent was contacted by telephone to schedule an interview. Two team members (ZR and LG), trained in qualitative interviewing techniques during their graduate work, conducted all interviews. Before conducting the interview, informed consent and agreement to the interview being audio-recorded were obtained. Interviews began by asking the parent to tell the story of the child’s diagnosis. Questions and probes were used to explore the types of supportive factors parents knew about and/or accessed. The interview guide was developed collaboratively by our team, which included researchers with expertise in qualitative methodologies as well as health care professionals who work closely with this patient group (see Box 1).

Data Analysis

All interviews were transcribed verbatim with identifiable information excluded from transcripts. Data collection and analysis took place concurrently allowing us to revise the interview guide, gather data, and refine emerging categories. Analysis was inductive and involved line-by-line coding, with codes and categories developed from parent’s stories. Coding was performed by 2 members of the research team (ZR & LG) who coded the first 12 transcripts independently and then met to discuss discrepancies and establish consensus. Constant comparison was used to examine relationships within and across codes and categories. Focused and theoretical coding was used to develop core themes. Interviewing stopped when no new categories were developed at which point the team determined that saturation had been reached. QSR NVivo 8 was used to manage the data (QSR International, 2008).

Table 1. Participant Characteristics

<table>
<thead>
<tr>
<th>Caregiver Characteristics</th>
<th>N = 29 (%)</th>
</tr>
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<tbody>
<tr>
<td>Age in years, mean (range)</td>
<td>41 (22-61)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>24 (83)</td>
</tr>
<tr>
<td>Male</td>
<td>5 (17)</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
</tr>
<tr>
<td>Divorced</td>
<td>8 (28)</td>
</tr>
<tr>
<td>Separated</td>
<td>4 (14)</td>
</tr>
<tr>
<td>Widowed</td>
<td>5 (17)</td>
</tr>
<tr>
<td>Single</td>
<td>12 (41)</td>
</tr>
<tr>
<td>Other children at home</td>
<td>15 (52)</td>
</tr>
<tr>
<td>Highest level of education</td>
<td></td>
</tr>
<tr>
<td>High school</td>
<td>12 (44)</td>
</tr>
<tr>
<td>College</td>
<td>7 (26)</td>
</tr>
<tr>
<td>University</td>
<td>8 (30)</td>
</tr>
<tr>
<td>Current annual household income, mean (range)</td>
<td>43 000 (0-91 000)</td>
</tr>
</tbody>
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<table>
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<tr>
<th>Child Characteristics</th>
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</thead>
<tbody>
<tr>
<td>Age at diagnosis in years, mean (range)</td>
<td>9 (3 months to 17)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>10 (34)</td>
</tr>
<tr>
<td>Male</td>
<td>19 (66)</td>
</tr>
<tr>
<td>Cancer type</td>
<td></td>
</tr>
<tr>
<td>Leukemia</td>
<td>17 (59)</td>
</tr>
<tr>
<td>Lymphoma</td>
<td>4 (14)</td>
</tr>
<tr>
<td>Sarcoma</td>
<td>3 (10)</td>
</tr>
<tr>
<td>Neuroblastoma</td>
<td>3 (10)</td>
</tr>
<tr>
<td>Wilm’s tumor</td>
<td>2 (7)</td>
</tr>
<tr>
<td>Treatment status</td>
<td></td>
</tr>
<tr>
<td>In follow-up</td>
<td>11 (38)</td>
</tr>
<tr>
<td>In active treatment</td>
<td>18 (62)</td>
</tr>
<tr>
<td>Relapsed</td>
<td>5 (17)</td>
</tr>
</tbody>
</table>

a. Numbers vary due to missing values.
Results

Parents discussed a range of social-emotional, practical, and financial resources and supports (see Table 2) received from a range of sources (eg, HCPs, family, friends, work colleagues, and different religious, cancer, and public organizations).

Social-Emotional Support

Parents received social-emotional support from a range of people including HCPs, family, friends, and people in their community (eg, other cancer families, work colleagues). A few parents reported not having anyone to share the emotional burden of caring for their child with cancer. Many parents reported that the most helpful source of emotional-social support primarily came from their family who gave them strength to persevere. An issue that came up for a few single parents was the inconsistent emotional support provided by the child’s other parent as well as the stress involved with being around their estranged partner:

You also have the stress of dealing with a partner that you don’t get along with . . . I think it makes the situation difficult. (No. 4, Father)

Although many parents were satisfied with the support received from family and friends, there were a few who expressed frustration or disappointment at those who could not handle the intensity of the situation and stayed away.

She (her girlfriend) never phoned . . . she . . . doesn’t know how to deal with everything and it just makes her really sad. (No. 9, Mother)

Pediatric oncology care is delivered within the context of a multidisciplinary team that includes social workers who work alongside parents to assess family needs and to help them access resources. Parents spend many hours at the hospital and often developed close relationships with HCPs including but not limited to nurses, child life specialists, and social workers. Some parents preferred to go to HCPs for social-emotional support than a friend or family member because they know their conversations were confidential, but also because HCPs are very understanding of what parents are going through:

I went to a social worker . . . she’s been counseling me. . . . It’s something that I probably wouldn’t lay on anybody else. (No. 1, Mother)

Also at the hospital were other parents of children with cancer who provided an important source of social-emotional support. For some single parents, talking with other parents of children with cancer was one of the few sources of adult-to-adult social interaction they had. This was due to spending most of their time in the hospital as

<table>
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<tr>
<th>Table 2. Supporting Factors</th>
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<tr>
<td><strong>Social-Emotional Support</strong></td>
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<tr>
<td>- Health care providers: Provide counseling and support to families</td>
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<tr>
<td>- Family/friends: Spouse, children, extended family, and friends provide comfort and care</td>
</tr>
<tr>
<td>- Community: Other cancer families, work colleagues, teachers, neighbors, and so on, interact, console, help, and support</td>
</tr>
<tr>
<td>- Charitable organizations: Organized support groups provide opportunities for parents to share experiences and participate in social events</td>
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<tr>
<td>- Online/telephone: Online groups and forums provide opportunities to share cancer experiences and communicate with family and friends</td>
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<tr>
<td><strong>Practical Support</strong></td>
</tr>
<tr>
<td>- Health care providers: Arrange support services for child and family (e.g., teachers for home schooling, volunteers to babysit child with cancer and siblings)</td>
</tr>
<tr>
<td>- Family/friends: Help in practical ways (eg, preparing meals, laundry, grocery shopping, providing child care); making the hospital environment more comfortable for the child with cancer (e.g., bringing food and activities the child likes); providing transportation to and from the hospital</td>
</tr>
<tr>
<td>- Community: Assist with transportation (eg, to and from the hospital); provide child care (e.g., Good Samaritans); and provide other support services (e.g., housekeeping tasks)</td>
</tr>
<tr>
<td><strong>Financial Support</strong></td>
</tr>
<tr>
<td>- Health care providers: Help parents to access government, hospital, and other resources to reduce the financial burden they experience</td>
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<tr>
<td>- Family/friends: Help cover additional expenses that childhood cancer incurs</td>
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<tr>
<td>- Community: Organize fundraising events to raise money for families</td>
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<tr>
<td>- Work place: Employment earnings and benefits (eg, extended health care benefits that cover outpatient medications)</td>
</tr>
<tr>
<td>- Public aid programs: Municipal, provincial, and federal aid programs (see Table 3)</td>
</tr>
<tr>
<td>- Charitable organizations: Provide funds to cover cancer related expenses (e.g., parking, transportation, food, exercise facilities)</td>
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well as having to focus on caring for their child. Some parents discussed how helpful it was to attend parent support groups:

I thought it was a wonderful meeting . . . it was really positive but it kind of fell apart after that. I think too many of the parents just couldn’t take the time to come. (No. 12, Mother)

Other parents were described as particularly helpful because they understood what this experience was like. For example, one parent noted:

I’ve . . . created close relationships with some of the families . . . It’s just nice to be able to talk to other people going through the same thing . . . that was a huge help. (No. 24, Mother)

Single parents were often isolated from their social contacts because of living at the hospital or being “trapped” at home with their child(ren). Many parents chose to not have any visitors out of fear that their child would be exposed to infectious agents while their child was neutropenic. Other parents lived a considerable distance from family and friends. Some parents described that online and telephone support was helpful to them:

There’s so many groups on the internet and posts and forums . . . I thought that’s a nice way of reading other people’s experiences and commenting and sharing yours without having to leave the house. (No. 12, Mother)

Having a supportive work environment was crucial to single parents given that their primary obligation was to care for their child, but they also needed to retain their jobs. Work-time flexibility and having an understanding employer were mentioned as supportive factors. Parents often had mixed reports about their employers. One parent when asked who was the most helpful in terms of any support received replied:

I think it would have to be work, even though they caused a lot of stress as well, they were very supportive financially and quite understanding. (No. 4, Father)

Other informal community-level sources of social-emotional support included people from their child’s school as well as churches and religious organizations. Some parents, however, described their disappointment and even anger with their unmet need for community support:

I called them (her Church). . . . I never heard back from them at all. I was . . . mad. (No. 3, Mother)

**Practical Support**

Parents recognized the importance of the practical support they received; however, many described unmet needs. Practical support came from a range of people, and the nature of such support varied widely (see Table 2). As one of the social workers interviewed explained:

They (the parents) need accommodation for both when the child is inpatient and outpatient . . . some of the families need assistance with traveling back and forth to their home . . . And then . . . meals . . . the patient is covered when they’re inpatient, but often times families stay here and it becomes expensive. (No. 2, Social worker)

Some parents complained about their inability to engage in exercise and to purchase and cook healthy food while at the hospital. There were some parents who simply could not afford to purchase food at the hospital. It was suggested by a few parents that the hospital provide parents food given how difficult it is for them to access and afford food:

I think it would be beneficial if they (the hospital) . . . served you both dinner . . . there’s obviously two of you in the room . . . just serve two meals. (No. 20, Father)

Some parents found it helpful to be told about access to a laundry facility at the hospital. Moreover, parents talked about how helpful it was when a volunteer or Child Life workers played with their child to give them a chance to have a break or run errands, but arranging for volunteers was sometimes difficult:

There are volunteers. They’re few and they’re very hard to get. (No. 22, Mother)

It was often challenging for parents to keep up with regular household chores and duties while caring for their sick child. Many single parents talked about how helpful it was to receive practical support (e.g., cleaning, shopping, cooking, and laundry) from people:
My parents . . . never questioned anything, “If you need me to do laundry, I’ll do laundry; if you need me to go shopping or whatever.” (No. 24, Mother)

A few single parents had no support system in place to provide practical support (e.g., immigrant families; families that had moved) and as one social worker commented:

I think the single most important thing for them (single parents) is to have a number two . . . [for] emergency day care relief. (No. 1, Social worker)

One participant with other young children talked about how she received much help and support from someone she had never even met from her child’s school:

I didn’t have anybody to take care of my children. One day . . . [she] called me from school. . . . She just told me that she’s there for me . . . and if I need help I can call her . . . . And when I had to take her to the hospital . . . I called her and I said, “Look I don’t have anybody to take care of my children” and she said . . . “Don’t worry about anything just leave the children with me.” She came took my children . . . . for three weeks. (No. 13, Mother)

Some parents received practical support from religious and other organizations in their community. While parents in our study talked about how important it is to take any and all help that is offered, some parents were reluctant to take assistance, even when they were entitled to it.

Financial Support

The majority of parents were not working during the time of their child’s treatment, and most of the parents who were not working received some form of public aid assistance. Table 3 lists the public aid programs accessed by parents during their child’s treatment. The parents that did not apply, were ineligible, or had exhausted their benefits for public aid resorted to using their financial savings or credit, private benefits (e.g., union), loans from family members, or continued working.

As with practical support, some parents seemed reluctant to accept financial support, even when they needed it. There were parents that described receiving financial support from family, friends, coworkers, and people in their local community. Parents talked about fundraising initiatives that were undertaken to raise money to help them. Others described receiving individual donations to help with expenses. Parents also received financial support from cancer organizations (e.g., Childhood Cancer Canada Foundation, 2011), which provided food and/or taxi/parking vouchers as well as government public aid programs (see Table 3).

Having a financially supportive work environment was important for single parents caring for a child with cancer, especially retaining access to extended benefits to ensure that the child’s medications were covered. Some parents described having to use their holiday time to care

### Table 3. Public Aid Programs Accessed by Study Participants During Their Child’s Treatment

<table>
<thead>
<tr>
<th>Type of Program</th>
<th>Description of Assistance Provided</th>
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<tbody>
<tr>
<td><strong>Child Support</strong></td>
<td>Federal program, for example, <em>Universal Child Care Benefit</em> (Childhood Cancer Canada Foundation) provides parents with $100 a month per child under the age of 6. Provincial programs (e.g., Ontario’s Assistance for Children with Severe Disabilities; Grootenhuis &amp; Last, 1997); British Columbia’s program Severe Disabilities or Complex Health Needs (Ministry of Children and Family Development, 2011) provides money to families of children with a disability (e.g., travel for medical appointments, respite, assistive devices, etc.).</td>
</tr>
<tr>
<td><strong>Employment Insurance (EI) Benefits</strong></td>
<td>Federal EI programs include Compassionate Care (Greening &amp; Stoppelbein, 2007), which provides up to $468 per week for 6 weeks to caregivers caring for a dying family member as well as Sickness Benefit (2007), which provides up to $468 per week for up to 15 weeks to people who are unable to work due to a sickness, injury, or quarantine</td>
</tr>
<tr>
<td><strong>Housing Programs</strong></td>
<td>Provincial (e.g., BC Housing; Jackson et al., 2009) and municipal (e.g., Canada-Ontario Affordable Housing Program; James et al., 2002) programs provide people with subsidized housing if they meet certain criteria including, though not limited to, having earnings below certain income limits</td>
</tr>
<tr>
<td><strong>Social Assistance</strong></td>
<td>Provincial programs (e.g., Ontario Works; Patterson, Holm, &amp;Gurney, 2004) provide financial assistance to help cover the costs of basic needs and housing costs. The amount of money individuals receive varies</td>
</tr>
</tbody>
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for their sick child or not having access to any benefits through their employer. A few parents feared taking time off would result in loss of employment or demotion. As one parent explained,

Right away my boss says, “You can’t have once a week-off all the time. . . . We’ll have to give you a new contract.” . . . The contract . . . it’s saying that I’m on probation for three months. . . . This means they can kick me out if they’re not pleased. (No. 2, Mother)

Parents also described some of the difficulties they encountered with accessing public financial aid, including having insufficient time to complete required paperwork, which social workers are aware of, and help as necessary. Some parents reported difficulty accessing financial resources because of failing to meet the eligibility criteria. One parent explained that because she was ineligible for Employment Insurance (EI), which is a Canadian government program providing temporary financial assistance to unemployed who have lost their job or are sick, pregnant, or caring for a newborn, adopted child, or a family member who is seriously ill (see Table 3). She explained that her only option was to apply for Social Assistance.

I talked to . . . my social worker . . . and I said . . . “I’m not making enough money . . . to keep . . . supporting myself so . . . what are my options? I can’t collect unemployment (EI) . . . We talked about Social Assistance.” (No. 12, Mother)

Parents meeting the eligibility criteria for EI have a 2-week waiting period during which they do not receive any money. Sometimes it can take up to 4 weeks to process the claim, which posed a hardship for some single parents who had ongoing expenses to meet. Additionally, it did not provide sufficient financial support:

Unemployment (EI) only pays half . . . and . . . they take time to kick in. . . . I got no money. I’ve got rent I’ve got to pay. I’ve got food I’ve got to buy. I’ve got medical supplies now I’ve got to buy. (No. 2, Mother)

A few parents described choosing not to access Social Assistance or charity because of feelings of embarrassment. One parent described his feeling about accepting charity:

I was feeling very uncomfortable to take that route (charity) . . . I would not want to deprive somebody else who really needs it by taking somebody else’s donor money. (No. 17, Father)

Despite knowledge of and access to financial support many parents described experiencing financial need and subsequent substantial financial strain resulting from having insufficient funds for daily expenses:

Even with two parents the financial stress is insane, let alone when you’re on your own. Like the first two times when we were still together—still paying back a line of credit from that . . . I was in school and working part time jobs when he relapsed like the third time. So I was forced to put school on hold, quit my jobs, move down here. Fortunately I got unemployment (EI) and I got the full amount . . . but still it’s not a lot of money. (No. 6, Mother)

### Discussion

Our study further supports the existing literature on caring for a child with a chronic illness by demonstrating that social-emotional, practical, and financial support were crucial to parents’ abilities to cope with their role as the primary caregiver (Banerjee et al., 2011; Beltrao, Vasconcelos, Pontes, & Albuquerque, 2007; Fletcher et al., 2010; Greening & Stoppelbein, 2007; Grootenhuis & Last, 1997; Jackson et al., 2009; James et al., 2002; Last & Grootenhuis, 1998; Patterson, Holm, & Gurney, 2004). Our study contributes to the existing literature by identifying the particular needs of Canadian single parents caring for a child with cancer.

Despite the social-emotional and practical support received by parents as well as the financial resources accessed, many parents identified the need for greater support on a number of fronts. First, our study has shown that social-emotional support for parents was most often given by family and parents of other children with cancer. This presented a challenge for single parents with no family support. Identifying parents with limited support is critical and hospital social workers working with families do make an effort to address this issue.

Second, our study demonstrated that practical support was important to single parents. Some participants were unaware of practical resources available at the hospital (e.g., laundry facilities). Additionally, many parents needed encouragement to accept help. As such, we recommend HCPs provide education (e.g., pamphlets or educational sessions) to parents to ensure they know the full range of resources available to them, and to their support networks to ensure that they know the kinds of assistance parents of children with cancer need. HCPs may also want to create programs within their hospital to ensure that their parents are well supported (e.g., suffi-
cient volunteers for child care, exercise facilities for parents, access to healthy and affordable food).

Finally, although caring for a child with cancer results in financial stress on most families our study has demonstrated that the financial burden on single-parent families makes it difficult for them to manage. Single parents who are often low-income earners to begin with have increased expenses when caring for an ill child (e.g., medications). This increase in spending, often combined with lost income, represents a substantial burden for low-income families (Lukemeyer, Meyers, & Smeeding, 2000). Generally, caregivers caring for individuals with cancer have a great need for support (Harding & Higginson, 2003), and this need is amplified for single-parent caregivers of a chronically ill child as they are faced with additional strains.

Internationally, government policies directed toward minimizing poverty in single-parent families have been beneficial especially when considering that caring for a child with cancer is costly and results in financial strains on families (Dockerty et al., 2003; Eiser & Upton, 2007; Heath et al., 2006; Limburg et al., 2008; Miedema et al., 2008; Tsimicalis et al., 2011). Additionally, in the Canadian context, it is important to recognize that more than 80% of the care required by those with a long-term condition is provided by caregivers and this unpaid work contributes more than 5 billion dollars to the Canadian health care system per year (Lukemeyer et al., 2000). The responsibility of caregiving in Canada directly results in extra expenses (e.g., transportation, prescription and nonprescription medication, medical supplies, etc) for the caregiver (Cranswick, 2003; Health Canada, 2002): it is estimated that two thirds of caregivers spend more than 100 additional dollars per month (Health Canada, 2002).

One type of policy that attempts to address poverty is child support policies that range in type and are not specific to single-parent families or chronic illnesses like cancer. A number of countries have established child support policies (e.g., Australia, USA, Canada), which play a critical role in improving the well-being of low-income families ("Doing Better for Families," 2011). However, it is important to consider that low-earning single parents are not necessarily financially better off working (Barrett & Cragg, 1994). To address this issue, child care policies could be aimed at decreasing the cost of child care ("Doing Better for Families," 2011).

Policies targeted at primary caregivers are an essential area for policy development. In Canada, the federal government implemented the EI Compassionate Care Benefit in 2004 (see Table 3; Service Canada, 2012). However, this policy does not meet the needs of most parents of children with cancer because the 6-week benefit is only applicable to people caring for family member who is palliative and it provides an insufficient amount of financial aid (55% of insured earnings).

A number of countries have established a public financial benefit for caregivers (e.g., Australia, Sweden, the United Kingdom; Health Canada, 2002). At the time of our study, no such benefit existed in Canada for our Canadian parent participants who left work to be the primary caregiver of their ill child. Our study further supports the report by the National Profile of Family Caregivers in Canada, in which 42% of caregivers thought that it would be very helpful to have short-term job and income protection through the federal government EI program (Health Canada, 2002). On August 7, 2012, the Canadian government announced an upcoming change to its EI program. This change, if passed by Parliament, will allow parents caring for a child suffering from a life-threatening illness or injury to be eligible for 35 weeks of the special benefits beginning in June 2013 (Moore, 2012). This policy change is an important first step to ensuring that parent caregivers receive necessary financial support.

Our study provides evidence that many Canadian single parents experience substantial financial hardship when caring for a child with cancer. We recommend further research to identify limitations of the current public benefit schemes for Canadian caregivers in order to ensure a more accessible, comprehensive, and inclusive program is available to parents. Once limitations have been identified, the information collected could be used to lobby for policy changes to ensure there are appropriate benefits available to help Canadian families meet their financial needs. Regardless of country, a caregiver benefit policy needs to consider the inclusion of part-time workers (as many parents work part time), the amount of financial relief that should be provided to meet basic needs, as well as the duration of the benefit.

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