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Lived Experiences of Family Members as Carers of Children with Cancer in Eastern Visayas: A Phenomenological Study

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Abstract—This paper presents a phenomenological study on the lived experiences of family members as carers of children with cancer in Eastern Visayas.

***Index Terms*—Lived Experiences, Carers of Children, Cancer.**

1. The Problem and its Background

A. Introduction

Childhood cancer changes far more than a child's medical condition. A diagnosis immediately reorganizes family life around tests, treatment schedules, symptoms, uncertainty, and the possibility of loss. The World Health Organization (WHO, 2021) estimates that hundreds of thousands of children and adolescents develop cancer each year, with the greatest survival disadvantages occurring in low- and middle-income countries where timely diagnosis, treatment continuity, supportive care, and access to essential medicines remain uneven. For families, these health-system realities are experienced not as abstract statistics but as repeated journeys to treatment centers, difficult decisions, interrupted work, disrupted schooling, financial sacrifice, and the emotional work of protecting a sick child while trying to keep the family functioning.

The experience is especially demanding for family members who become the child's primary carers. They monitor symptoms, administer or supervise medications, respond to treatment side effects, accompany the child to consultations and admissions, communicate with healthcare professionals, manage household responsibilities, and provide reassurance even while coping with their own fear. A recent qualitative systematic review by Whalan et al. (2024) showed that caregivers of children with cancer often become active symptom managers and protectors, yet their own information needs, emotional responses, and well-being can remain insufficiently addressed. Thus, caregiving is not merely an extension of ordinary parenting or family responsibility; it becomes a complex health-related role performed under uncertainty.

The burden of childhood cancer is also strongly socioeconomic. Ritter et al. (2023), in a systematic review covering studies from multiple countries, demonstrated that families may face medical, non-medical, and indirect costs together with psychosocial and behavioral consequences of financial hardship. In the Philippines, Columbres et al. (2024) described pediatric cancer-related financial toxicity as a multidimensional problem that includes treatment expenses, transportation and lodging costs, lost income, and psychosocial strain. These pressures are particularly relevant to Eastern Visayas, where families may travel from different parts of Leyte, Samar, and Biliran to reach specialty services in Tacloban City. Distance therefore becomes more than geography; it may shape fatigue, missed work, household separation, treatment continuity, and the emotional experience of caregiving.

Filipino evidence also shows that family caregivers need more than clinical instructions. Banayat et al. (2023), studying parents of children with cancer in the Philippines, identified practical, informational, spiritual, physical, and emotional support needs. This is important because the caregiver's capacity to understand the illness, make decisions, manage symptoms, and sustain hope can directly influence how the family navigates treatment. Psychoeducational interventions have been shown to reduce anxiety and depressive symptoms and improve coping among caregivers of children with cancer, although intervention approaches remain heterogeneous (Phiri et al., 2023). Such findings reinforce the need to understand caregivers' lived realities before designing programs for them.

Caregiving, however, cannot be understood fully by listing burdens alone. Families may experience fear, exhaustion, and uncertainty while also discovering resilience, deeper relationships, spiritual meaning, and a stronger sense of purpose. Luo et al. (2022) found that parents of children with cancer described resilience as an evolving process supported by personal adjustment, family relationships, social resources, and meaning-making. This coexistence of suffering and strength makes a phenomenological inquiry appropriate. The important question is not only what problems family carers encounter, but how these experiences are lived, interpreted, and woven into everyday family life.

This study therefore, explores the lived experiences of family members who serve as carers of children with cancer in Eastern

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Visayas. It seeks to understand how caregiving is experienced emotionally, physically, socially, financially, relationally, culturally, and spiritually; how carers make sense of uncertainty and prolonged treatment; what resources help them endure; and what forms of support they believe would make the caregiving journey more manageable and humane. By foregrounding the voices of family carers, the study aims to generate context-sensitive knowledge that can strengthen family-centered pediatric oncology nursing and supportive care.

B. Background of the Study

A childhood cancer diagnosis is a family event. The illness enters the routines of the household and often reshapes roles, priorities, relationships, work arrangements, finances, and expectations for the future. Parents and other relatives may move rapidly from being ordinary family members to becoming informal healthcare partners who must learn unfamiliar medical language, recognize complications, manage treatment-related symptoms, and make high-stakes decisions while emotionally supporting the child. The transition can be abrupt, leaving carers to learn through experience while carrying substantial fear and responsibility.

Contemporary research demonstrates that caregiver distress is common and multifaceted. Shokri et al. (2020), in a systematic review, documented psychological difficulties among caregivers of pediatric patients with cancer, including anxiety, depressive symptoms, and stress. More recent qualitative studies have shown that distress may be expressed as disbelief, helplessness, intrusive worry, grief, social withdrawal, or difficulty accepting the child's suffering. These reactions should not automatically be pathologized; many are understandable responses to a threatening and uncertain situation. Nevertheless, sustained distress may impair sleep, physical health, concentration, decision-making, family relationships, and the caregiver's capacity for self-care.

The caregiving role also involves continuous practical labor. Family carers may coordinate laboratory tests, chemotherapy cycles, transfusions, admissions, meals, hygiene, infection precautions, transportation, and home symptom monitoring. Whalan et al. (2024) emphasized that caregivers frequently function as protectors and symptom managers, and that communication and formalized education are crucial to helping them perform this role safely. When instructions are complex or inconsistent, uncertainty may intensify; when communication is clear, respectful, and repeated, carers may feel more confident and less alone in decision-making.

Financial and geographic realities are particularly important in the Philippine context. Columbres et al. (2024) highlighted how pediatric cancer can create financial toxicity through direct costs, indirect expenses, transportation, lodging, and income disruption. Ritter et al. (2023) similarly found that financial hardship is widespread across childhood cancer settings and may influence healthcare access and family well-being. In Eastern Visayas, specialty pediatric oncology services are concentrated in urban centers, which means that families from distant municipalities or islands may have to combine caregiving with repeated travel, temporary relocation, missed work, and separation from other children or relatives.

The needs of Filipino parents are likewise multidimensional. Banayat et al. (2023) found that supportive care needs span practical, informational, spiritual, physical, and emotional domains. This finding is especially relevant to nursing because family caregivers commonly interact with nurses throughout the child's treatment. Nurses are therefore positioned not only to provide clinical teaching but also to identify caregiver distress, clarify information, facilitate referrals, support coping, and advocate for family-centered services.

At the same time, caregiving can generate forms of resilience and meaning. Luo et al. (2022) described resilience among parents of children with cancer as something developed through adversity rather than a fixed personal trait. Supportive relationships, hope, spirituality, problem-solving, reframing, and a sense of responsibility toward the child may help carers continue despite exhaustion. Psychoeducation and supportive interventions can also strengthen coping and reduce negative psychological outcomes (Phiri et al., 2023). Yet the usefulness of any intervention depends on whether it reflects what families actually experience and value in their local context.

Eastern Visayas has distinct geographic, cultural, and resource conditions that warrant localized inquiry. Caregivers may draw on extended family networks, religious faith, communal support, and Waray cultural practices while also confronting travel barriers, limited resources, employment disruption, and the unequal distribution of specialized healthcare. Existing Philippine literature provides important evidence about parental needs and financial toxicity, but there remains limited interpretive qualitative work focused specifically on how family carers in Eastern Visayas make meaning of the entire caregiving experience across emotional, bodily, relational, financial, temporal, and spiritual dimensions.

The researcher's clinical exposure to pediatric oncology further underscores the importance of this inquiry. Observing caregiver exhaustion, fear, persistence, and sacrifice may sensitize the researcher to the phenomenon, but these observations cannot substitute for participants' own accounts. A hermeneutic phenomenological approach allows those accounts to be explored in depth while requiring the researcher to remain reflexive about prior clinical assumptions. The study is therefore positioned not to judge how families should cope, but to understand how caregiving is lived and interpreted by those who carry it every day.

C. Theoretical Underpinning

This study is grounded in hermeneutic phenomenology, particularly the philosophical traditions associated with Martin Heidegger and Hans-Georg Gadamer and the phenomenology-of-practice orientation advanced by van Manen. Hermeneutic phenomenology is concerned with lived experience and with interpretation: it seeks to understand how persons encounter a phenomenon within the concrete contexts of their lives and how meaning becomes visible through language, relationships, history, culture, and everyday practice.

For this study, the phenomenon is the experience of being a family member who assumes a caregiving role for a child with

cancer. The approach is appropriate because such caregiving cannot be separated from the carer's relationships, family responsibilities, economic circumstances, cultural expectations, faith, memories, fears, hopes, and changing sense of time. A hospital admission, for example, may be experienced simultaneously as a clinical event, a financial crisis, a separation from other children, and a period of intense uncertainty. Hermeneutic phenomenology allows these layers of meaning to be interpreted rather than reduced to isolated variables.

The hermeneutic circle is central to this orientation. Understanding develops through movement between parts and whole: a single statement is interpreted in relation to the participant's entire story, while the meaning of the whole story is continually reconsidered in light of specific events and expressions. Analysis therefore involves repeated reading, reflective writing, comparison, questioning, and reinterpretation rather than a one-time coding exercise.

Because interpretation is unavoidable, the researcher will not claim complete bracketing in the Husserlian sense. Instead, reflexivity will be practiced throughout the study. The researcher will identify prior assumptions arising from nursing practice, document interpretive decisions, and continually ask whether emerging meanings are grounded in participants' accounts. This stance recognizes that the researcher's clinical background is part of the interpretive situation while preventing it from becoming the unquestioned explanation for what participants say.

Van Manen's lifeworld existentials—lived body, lived relation, lived space, lived time, and lived materiality—will be used as sensitizing lenses during reflection rather than as predetermined themes. They may help illuminate, for example, bodily exhaustion, changed relationships, the experience of hospitals and travel spaces, altered perceptions of time during treatment, and the material reality of medicines, money, transport, and household resources. Themes will still be derived inductively and interpretively from the narratives.

The use of hermeneutic phenomenology consequently supports the study's central aim: to understand not only the difficulties family carers encounter, but the meanings they attach to those difficulties, the ways caregiving reshapes their identities and relationships, and the resources through which they continue. The final product will be an interpretive thematic account of the shared and divergent structures of caregiving as lived by family members of children with cancer in Eastern Visayas.

D. Statement of the Problem: Central and Corollary Questions

This study seeks to interpret and understand the lived experiences of family members who serve as carers of children diagnosed with cancer in Eastern Visayas. Consistent with hermeneutic phenomenology, the problem is framed through one central question and supporting corollary questions that deepen the inquiry without treating caregiving as a set of independent variables.

1) Central Question

What is the meaning and essence of the lived experience of family members who care for children with cancer in Eastern Visayas?

2) Corollary Questions

1. How do family carers experience the emotional impact of caring for a child with cancer?
2. How does caregiving affect their daily lives and physical well-being?
3. How do financial and access-related challenges affect their caregiving experience?
4. How does caregiving affect their family, social, and work life?
5. How do family carers experience their interactions with healthcare professionals?

E. Assumptions of the Study

The study proceeds from several qualitative assumptions rather than from hypotheses. First, it assumes that family carers are capable of reflecting on and describing experiences that are meaningful to them, while recognizing that memories may be incomplete and that some experiences may be difficult to express. Second, it assumes that caregiving is contextual and relational: its meaning is shaped by the child's illness trajectory, family structure, cultural expectations, economic circumstances, access to care, and relationships with healthcare professionals.

Third, the study assumes that participants may hold apparently contradictory feelings at the same time, such as hope and fear, gratitude and frustration, strength and exhaustion. These tensions are treated as meaningful features of lived experience rather than inconsistencies to be eliminated. Fourth, the study assumes that the researcher's interpretation contributes to the analytic process; therefore, reflexivity, transparent documentation, and close grounding in participants' narratives are necessary to strengthen trustworthiness.

Finally, the study assumes that qualitative findings will be context-bound. Their value lies in the depth and plausibility of the interpretation and in the degree to which readers can judge whether the findings resonate with comparable pediatric oncology and family-caregiving settings, rather than in statistical generalization.

F. Scope and Delimitations of the Study

This study focuses on adult family members who serve as primary or major carers of children aged 0-18 years who are receiving treatment for cancer and who access pediatric oncology services in Tacloban City. Participants must be residents of Eastern Visayas, have at least three months of caregiving experience, be actively involved in the child's day-to-day care and/or health-related decision-making, and be able to participate in an in-depth interview in Waray-Waray, Filipino, or English. Paid professional caregivers and individuals younger than 18 years will be excluded because the study is specifically concerned with unpaid family caregiving.

Criterion-based purposive sampling will be used to recruit information-rich participants. The study will initially aim for

approximately 8-12 participants, while allowing recruitment to continue if the existing narratives do not provide sufficient experiential depth or variation. Rather than treating a fixed number as proof of adequacy, the researcher will consider information power, richness of accounts, diversity of caregiving situations, and whether additional interviews continue to meaningfully extend the interpretation.

Data will be generated primarily through one-on-one semi-structured interviews lasting approximately 45-75 minutes. Interviews may be extended or followed up when participants wish to clarify important experiences. Field notes and a reflexive journal will complement the interview transcripts. The study is not intended to estimate the prevalence of caregiver burden, anxiety, or financial hardship, nor to compare demographic groups statistically. It is designed to interpret the meaning of caregiving as lived within a particular cultural, geographic, and healthcare context.

The inquiry is geographically bounded to Eastern Visayas and institutionally anchored in a pediatric oncology treatment setting in Tacloban City. Consequently, the findings may not represent carers in other Philippine regions, public hospitals, private home-care arrangements, or families whose children are not receiving formal oncologic treatment. The study also depends on self-reported narratives and may be affected by recall, emotional distress, social desirability, or reluctance to discuss sensitive financial and family matters.

The researcher's professional familiarity with pediatric oncology is another potential influence. Hermeneutic phenomenology does not require the researcher to become free of prior understanding, but it does require disciplined reflexivity. A reflexive journal, analytic memos, an audit trail, peer debriefing, and explicit attention to alternative interpretations will therefore be used. Participants will also be reminded that they may decline any question or stop the interview without consequence.

Despite these boundaries, the study can provide rich, transferable insights by describing the caregiving context in sufficient detail. Its contribution is not numerical representativeness but a deeper understanding of how family carers experience, interpret, and respond to childhood cancer within the realities of Eastern Visayas.

G. Significance of the Study

1) For Family Carers and Families

The study gives family carers a structured opportunity to articulate experiences that may otherwise remain private or be reduced to descriptions of 'burden.' By presenting the caregiving journey in carers' own terms, the findings may validate emotional, practical, spiritual, and relational concerns and help other families recognize that many difficult responses are understandable within the context of childhood cancer.

2) For Children with Cancer

Children may benefit indirectly when healthcare teams better understand the pressures experienced by those who provide most of their daily support. Caregiver education, rest, emotional support, and resource referral can strengthen the family's capacity to sustain safe and compassionate care across prolonged treatment.

3) For Nursing Practice

The study can help nurses identify dimensions of caregiving that may not be visible during routine clinical encounters, including uncertainty, financial strain, disrupted family roles, communication difficulties, spiritual needs, and caregiver exhaustion. These insights may support more individualized teaching, psychosocial assessment, anticipatory guidance, and family-centered nursing care.

4) For Nursing and Hospital Administrators

Findings may guide the development of caregiver orientation programs, referral pathways, social-work coordination, navigation services, psychosocial support, accommodation or transportation linkages, and staff practices that promote respectful communication and shared decision-making.

5) For Health Policy and Support Organizations

The study may provide localized evidence about barriers related to geography, finances, and access to specialty treatment. Such evidence can complement epidemiologic and economic data when designing programs for transportation assistance, temporary lodging, financial navigation, psychosocial services, and decentralized follow-up care.

6) For Nursing Education

The narratives may help nursing students understand pediatric oncology from a family-centered perspective and appreciate that clinical care includes communication, cultural sensitivity, emotional support, caregiver teaching, and advocacy in addition to technical procedures.

7) For Future Researchers

The study may provide a qualitative foundation for comparative work across regions, mixed-method research, caregiver-support intervention studies, and culturally responsive models of pediatric oncology care in the Philippines.

H. Definition of Terms

Family Carer/Family Caregiver - An unpaid family member who assumes substantial responsibility for the day-to-day physical, emotional, practical, and/or decision-making needs of a child with cancer. In this study, the term includes parents, grandparents, adult siblings, or other immediate relatives who meet the inclusion criteria.

Lived Experience - The way an experience is encountered, felt, understood, and given meaning in everyday life. In this study, it refers to how family carers experience and interpret caring for a child with cancer.

Child with Cancer - A person aged 0-18 years who has been diagnosed with a malignant disease and is receiving or has recently received cancer-directed treatment through the study setting.

Caregiving Role - The set of responsibilities assumed by the family carer, including accompanying the child to treatment, symptom monitoring, treatment support, decision-making, emotional reassurance, coordination of daily needs, and communication with the healthcare team.

Caregiver Burden - The physical, emotional, social, practical, and financial strain that may arise from sustained caregiving responsibilities. In this qualitative study, burden is

explored as a lived experience rather than measured as a numerical score.

Psychosocial Distress - Emotional and social difficulty related to the child's illness and caregiving demands, which may include fear, worry, sadness, uncertainty, isolation, role strain, or relationship stress.

Coping - The thoughts, actions, relationships, routines, and meaning-making practices used by carers to manage caregiving demands and emotional strain.

Resilience - A dynamic process through which carers adapt, recover, sustain functioning, or find meaning while facing the adversity associated with childhood cancer; it is not treated as a fixed personality trait.

Financial Toxicity - The direct, indirect, and psychosocial consequences of cancer-related financial pressure, including treatment expenses, transportation and lodging costs, income loss, debt, and worry about the family's financial security.

Family-Centered Care - An approach to healthcare that respects the family's knowledge, values, circumstances, and role in the child's care and promotes partnership, information sharing, participation in decisions, and responsive support.

Support Resources - Formal and informal sources of assistance that may help carers sustain caregiving, including family and community help, faith communities, healthcare professionals, social services, financial programs, peer support, and educational resources.

2. Review of Related Literature and Studies

A. Review of Related Literature and Studies

This section reviews recent literature published primarily from 2020 to 2025 on childhood cancer and the experiences of family carers. The discussion is organized around the domains that are most relevant to the central and corollary questions of the present study: the global and Philippine childhood-cancer context; emotional and psychological responses; everyday caregiving and symptom management; financial and geographic burden; family and social disruption; communication and supportive-care needs; coping, resilience, and spirituality; and the remaining research gap in Eastern Visayas.

1) Childhood Cancer as a Family and Health-System Experience

Childhood cancer remains a major global health concern because survival depends strongly on where a child lives and whether comprehensive diagnosis, treatment, supportive care, and essential medicines are accessible. WHO's CureAll framework (World Health Organization, 2021) places children and families at the center of childhood-cancer programs and emphasizes integrated care, access, quality, and the reduction of suffering. This framing is important for caregiver research because the effectiveness of cancer treatment is inseparable from the family's ability to navigate repeated appointments, hospitalization, symptom management, and treatment-related uncertainty.

In low- and middle-income settings, these demands are intensified by health-system constraints. Families may face delayed diagnosis, long travel, fewer specialty centers, out-of-pocket costs, and difficulties sustaining treatment. The caregiver therefore becomes both a source of emotional security for the child and an essential bridge between the household and the healthcare system. Contemporary research increasingly recognizes that strengthening childhood-cancer outcomes requires attention not only to medicine availability but also to the practical and psychosocial conditions under which families are expected to continue care.

2) Emotional and Psychological Experiences of Family Carers

The emotional impact of childhood cancer is substantial. Shokri et al. (2020) synthesized evidence on psychological problems among caregivers of pediatric patients with cancer and found recurring concerns related to anxiety, depression, and psychological strain. Caregiver distress often begins around diagnosis but may continue throughout treatment because uncertainty is renewed by laboratory results, treatment complications, admissions, relapse fears, and changes in the child's physical condition.

Recent qualitative work shows that distress is not one uniform experience. Some parents describe disbelief, helplessness, guilt, or a sense that ordinary life has been abruptly suspended. Lundgren et al. (2023) found that parents of children treated for cancer continued to report persistent worries that affected everyday life and informed the adaptation of psychological support interventions. Such evidence suggests that caregiving distress is both situational and enduring: parents may function effectively in practical terms while still carrying substantial internal fear.

This complexity supports an interpretive approach. A caregiver who says that she is 'strong' may simultaneously feel exhausted or frightened; a father who focuses on logistics may be using practical action as a way of managing uncertainty. Hermeneutic inquiry therefore allows emotional expressions, silences, metaphors, and descriptions of ordinary routines to be understood within the broader context of the caregiving story.

3) Everyday Caregiving, Symptom Management, and Responsibility

Family carers perform extensive practical work during pediatric cancer treatment. Whalan et al. (2024), in a qualitative systematic review, identified caregivers as protectors who play a central role in symptom management. They must interpret symptoms, decide when to seek help, administer or supervise supportive medications, manage nutrition and hygiene, protect the child from infection, and communicate changing conditions to healthcare professionals. These tasks are performed in addition to ordinary family responsibilities.

The burden of responsibility can create vigilance. Carers may become highly attentive to fever, pain, appetite, vomiting, bleeding, fatigue, and behavioral changes. Such vigilance may provide a sense of control but can also interfere with sleep, rest, and emotional recovery. The caregiver's body becomes involved in the illness trajectory through missed meals, travel fatigue, prolonged bedside presence, and disrupted sleep. These realities support the inclusion of lived-body and lived-time dimensions in the present study's phenomenological analysis.

Caregiving competence also develops over time. Repeated treatment can transform family members into knowledgeable partners who understand routines, warning signs, and hospital processes. Yet familiarity does not necessarily remove uncertainty. A caregiver may become technically confident while remaining emotionally vulnerable. This distinction is important because healthcare professionals may incorrectly interpret practical competence as evidence that support is no longer needed.

4) Financial Toxicity and Material Hardship

Financial strain is one of the most consistently documented family consequences of childhood cancer. Ritter et al. (2023) systematically reviewed financial hardship among families of children and adolescents with cancer and identified direct medical costs, non-medical expenses, indirect income loss, financial coping strategies, psychosocial responses, and behavioral consequences. The review showed that financial hardship is a multidimensional experience rather than a single out-of-pocket amount.

The Philippine context makes this especially salient. Columbres et al. (2024) described pediatric cancer-related financial toxicity in the Philippines as involving treatment expenses, transportation, lodging, income disruption, and psychosocial consequences. Financial pressure can influence decisions about travel, food, medicines, employment, borrowing, and the distribution of household resources. It may also create guilt when carers perceive that the needs of other children or family members are being deferred because cancer treatment has become the household's dominant priority.

For families from Eastern Visayas, distance may intensify financial toxicity. Repeated travel to Tacloban City can require fares, meals, lodging, and time away from work. Families from Samar, Biliran, or distant parts of Leyte may experience treatment days as complex logistical projects. The meaning of 'access' therefore includes not only whether a service exists, but whether a family can repeatedly reach it without destabilizing the household.

5) Family Roles, Relationships, and Social Life

Childhood cancer can reorganize family roles. One caregiver may become primarily responsible for hospital-based care while another continues paid employment or cares for siblings. Extended relatives may assume household tasks, provide money, or accompany the family during treatment. These adaptations can demonstrate family solidarity, but they may also create conflict, loneliness, or unequal burdens when responsibilities are not shared as expected.

Caregiving may also reduce social participation. Family gatherings, employment, schooling, church activities, and leisure can be interrupted by treatment schedules or fear of infection. Social withdrawal may be chosen to protect the child or may occur because carers feel that others cannot fully understand the experience. At the same time, relatives, friends, community organizations, and faith groups can become important sources of practical and emotional support. Ochoa et al. (2023), in qualitative work with family caregivers, showed how social, structural, and healthcare factors can act as barriers or facilitators to caregiving.

Relationships within the family may change in less visible ways. Siblings may receive less parental attention, couples may have less time together, and caregivers may suppress distress to avoid worrying the child or other family members. These changes demonstrate why the caregiving experience should be examined relationally rather than as an individual psychological state.

6) Information, Communication, and Supportive-Care Needs

Information needs are a central component of family caregiving. Families need understandable explanations of the diagnosis, treatment plan, expected side effects, warning signs, nutrition, infection precautions, medication schedules, and what to do between hospital visits. Unclear or inconsistent information can increase anxiety because caregivers are asked to take responsibility without feeling adequately prepared.

Banayat et al. (2023) provide particularly important Philippine evidence. Their study of parents of children with cancer identified multiple supportive-care needs spanning practical, informational, spiritual, physical, and emotional domains. The findings highlight that family support cannot be limited to one-time health teaching. Needs change across the illness trajectory, and families may require repeated clarification, help navigating resources, psychosocial support, and opportunities to ask questions as new situations arise.

Whalan et al. (2024) likewise emphasized the importance of formalized information provision and caregiver education in symptom management. From a nursing perspective, this supports structured teaching using plain language, checking understanding, written or digital reminders, and clear pathways for contacting the care team. It also suggests that communication quality itself may become part of the caregiver's lived experience of safety, trust, and partnership.

7) Coping, Resilience, Spirituality, and Meaning-Making

Caregivers use diverse strategies to cope with uncertainty and sustained demands. Luo et al. (2022), using a phenomenological approach, described resilience among parents of children with cancer as a lived process involving adjustment, support, internal strength, and meaning. Resilience in this sense is not an expectation that families should simply endure; it is an adaptive process that can be supported or undermined by social and healthcare conditions.

Coping may include problem-solving, seeking information, focusing on daily routines, accepting help from relatives, talking with other parents, prayer, religious participation, humor, and consciously maintaining hope. In a predominantly Christian Philippine setting, faith may be especially meaningful, but it should not be assumed that all caregivers experience spirituality in the same way. For some, faith may provide comfort and a sense of surrender; for others, illness may produce spiritual questioning, anger, or uncertainty.

Evidence also suggests that caregiver support can be strengthened through intervention. Phiri et al. (2023) found in a systematic review and meta-analysis that psychoeducation interventions can reduce negative psychological outcomes and improve coping among caregivers of children with cancer. The implication is not that distress can be removed through education alone, but that clear information, skill-building,

emotional support, and structured follow-up may improve families' ability to manage demands.

8) Culture, Place, and the Experience of Care in Eastern Visayas

Caregiving occurs within culture and place. Eastern Visayas includes urban and geographically dispersed communities connected by roads, ports, and inter-island travel. Family networks may be extensive, and cultural expectations often emphasize family responsibility, sacrifice, reciprocity, and religious faith. These resources may strengthen caregiving, but they can also create pressure to remain strong, avoid complaining, or prioritize the child at the expense of the caregiver's own health.

Local language also shapes meaning. Allowing interviews in Waray-Waray, Filipino, or English enables participants to describe difficult experiences in the language that feels most natural to them. Emotionally significant expressions may not translate perfectly word for word; therefore, translation will require attention to context and meaning rather than literal substitution. This is particularly important in hermeneutic phenomenology, where language is not merely a container for data but part of how experience becomes understandable.

9) Synthesis and Research Gap

The recent literature consistently shows that family caregiving in childhood cancer involves intertwined emotional, physical, financial, informational, relational, and spiritual demands. Caregivers function as protectors and symptom managers (Whalan et al., 2024), experience substantial psychological strain (Shokri et al., 2020), face global and Philippine financial hardship (Ritter et al., 2023; Columbres et al., 2024), require multidimensional supportive care (Banayat et al., 2023), and may develop resilience through relationships, meaning, and adaptation (Luo et al., 2022). Evidence also indicates that structured psychoeducation can improve caregiver coping and psychological outcomes (Phiri et al., 2023).

However, much of this evidence either aggregates families across settings, focuses on single domains such as distress or finances, or comes from contexts with different healthcare systems and cultural conditions. Philippine studies provide crucial evidence on care needs and financial toxicity, but there remains limited hermeneutic phenomenological work examining how family carers in Eastern Visayas experience these domains together as one unfolding life situation.

The present study addresses this gap by asking how caregiving is lived and interpreted within the specific social, cultural, geographic, and healthcare realities of Eastern Visayas. Rather than treating emotional distress, finances, family roles, communication, coping, and spirituality as separate variables, it seeks to understand how these dimensions interact in participants' narratives. This integrated interpretive focus is expected to provide a richer basis for family-centered nursing support and locally responsive caregiver services.

3. Methodology

This section presents the methodological approach for exploring and interpreting the lived experiences of family members who care for children with cancer in Eastern Visayas. It describes the research design, research site, participants and sampling, interview guide, validation and trustworthiness strategies, data-gathering procedure, hermeneutic phenomenological thematic analysis, and ethical safeguards. Each methodological decision is aligned with the central and corollary questions in Chapter 1.

A. Research Design, Site, Population, and Sampling

1) Research Design

The study will use a qualitative hermeneutic phenomenological design. This design is appropriate when the purpose is to understand how people experience a phenomenon and how they interpret its meaning within a particular life context. The study is not intended to quantify caregiver burden or test causal relationships; instead, it seeks to interpret how family carers live through childhood cancer, how ordinary family life is transformed, and how meaning is created through suffering, responsibility, relationships, hope, and adaptation.

The inquiry is informed by Heideggerian and Gadamerian hermeneutics and by van Manen's phenomenology of practice. Interpretation will proceed through the hermeneutic circle, moving repeatedly between individual passages, complete interview narratives, emerging themes, and the developing understanding of the phenomenon as a whole. The researcher's prior clinical experience will be addressed through reflexivity rather than claims of complete bracketing.

2) Research Site

The study will be conducted through the pediatric oncology service of Divine Word Hospital in Tacloban City, which provides access to families from different parts of Eastern Visayas. The hospital serves as the recruitment and interview site because carers encounter the treatment system there and because the setting provides access to families with direct experience of pediatric cancer care. Interviews will be held in a private, quiet, and comfortable area that protects confidentiality and does not interfere with the child's treatment.

3) Population and Sampling

The target population consists of adult family members who serve as primary or major unpaid carers of children aged 0-18 years with cancer and who reside in Eastern Visayas. Criterion-based purposive sampling will be used because participants must have direct experience of the phenomenon and be able to provide reflective, information-rich accounts. The study will begin with approximately 8-12 participants. Recruitment may continue when additional interviews are needed to deepen underdeveloped meanings or broaden experiential variation.

Eligible participants must: (1) be at least 18 years old; (2) be a resident of Eastern Visayas; (3) be an immediate family member or other unpaid relative with substantial caregiving responsibility; (4) have at least three months of caregiving experience; (5) be involved in daily care and/or health-related decision-making; (6) be able to communicate in Waray-Waray, Filipino, or English; and (7) voluntarily agree to participate. Paid professional caregivers, minors, and persons too distressed or medically unwell to participate safely at the time of recruitment will be excluded.

Sampling adequacy will be judged through information power and interpretive sufficiency rather than a rigid saturation rule. The researcher will consider the specificity of the sample, the depth of the interview dialogue, the relevance of the narratives to the research questions, and whether new interviews continue to add substantively new meanings.

B. Participants of the Study

Participants will be family carers who meet the inclusion criteria and are directly involved in the ongoing care of a child receiving cancer treatment. Variation in relationship to the child, place of residence, length of caregiving, and treatment experience will be welcomed because it may enrich the interpretation, but the study will not use these characteristics for statistical comparison.

Basic contextual information such as age range, relationship to the child, municipality or province, approximate duration of caregiving, and broad treatment stage may be recorded to situate the narratives. Identifying combinations will be generalized in reporting when necessary to prevent indirect identification, particularly because pediatric oncology populations in a single regional setting can be small.

Participation will be entirely voluntary. Recruitment will be facilitated through an authorized unit or social-work contact so that families do not feel pressured by the researcher or clinical staff. The decision to participate or decline will have no effect on the child's treatment, access to services, or relationship with the hospital.

C. Research Instrument

The primary research instrument will be a researcher-developed semi-structured interview guide. In qualitative interviewing, the guide provides direction without turning the encounter into a questionnaire. Open-ended questions will invite participants to narrate what happened, how they felt, what changed in daily life, what made caregiving difficult or manageable, and what meaning they attach to the experience.

The guide will be explicitly aligned with the central and corollary questions. Background prompts will establish the caregiving context. Subsequent questions will explore emotional and psychological experiences; bodily and practical demands; finances, transportation, and access; changes in family and social life; communication and relationships with healthcare professionals; coping, faith, social support, and resilience; and changes in identity, time, future, and perceived support needs. Probing questions such as 'Can you tell me more about that?', 'What was that like for you?', and 'What did that experience mean to you?' will be used to deepen narratives without suggesting preferred answers.

Participants may choose Waray-Waray, Filipino, or English. When interviews are conducted in Waray-Waray or Filipino, transcription will preserve the original-language expression. English translations used for thesis reporting will be checked against the original wording to retain contextual meaning, idioms, and emotional nuance.

D. Interview Guide Review and Trustworthiness

Because this is a qualitative phenomenological study, the quality of the interview guide will be addressed through content and process review rather than psychometric validation. The draft guide will be reviewed by the thesis adviser and at least two experts with relevant experience in qualitative research, pediatric oncology, family nursing, or psychosocial care. Reviewers will assess clarity, sensitivity, neutrality, sequencing, relevance to the central and corollary questions, and the likelihood that questions will elicit lived-experience narratives rather than short factual answers.

A brief pilot or cognitive pre-interview may be conducted with one or two individuals who resemble the intended participant group but will not be included in the final analysis. The purpose is to determine whether questions are understandable, culturally appropriate, emotionally manageable, and capable of generating rich descriptions. Revisions will be documented in the audit trail.

1) Trustworthiness

Trustworthiness will be strengthened using the principles of credibility, dependability, confirmability, and transferability. Credibility will be supported by prolonged engagement with transcripts, careful probing during interviews, attention to negative or divergent cases, and participant clarification when factual or interpretive ambiguity arises. Rather than requiring participants to approve abstract themes as if there were only one correct interpretation, the researcher may use selective follow-up or summary checking to confirm that important experiences have not been seriously misunderstood.

Dependability will be enhanced through an audit trail documenting recruitment decisions, interview-guide revisions, transcription and translation decisions, coding changes, thematic development, and interpretive memos. Confirmability will be supported through reflexive journaling and peer debriefing with the adviser or qualitative research mentor. Transferability will be supported by rich description of the regional, clinical, family, and caregiving context while protecting confidentiality.

Table 1
Data gathering procedure and duration

Step	Activity	Duration
1	Tool preparation and validation	10 days
2	Securing of approval and research site clearance	10 days
3	Participant selection and enrollment	7 days
4	Risk assessment and withdrawal option	3 days
5	Participants' briefing and consent	5 days
7	Conduct of Interview	10 days
8	Recording and Transcription	10 days
9	Data preparation for analysis	8 days

Triangulation in this study will be modest and appropriate to the design. Interview transcripts will remain the primary data source, while field notes, reflexive notes, and contextual observations will be used to enrich interpretation rather than treated as independent proof that a theme is 'true.' This approach preserves the phenomenological emphasis on participants' lived accounts.

E. Data Gathering Procedure

Before recruitment, the researcher will obtain approval from the university research ethics committee and permission from the study site. Coordination with the pediatric oncology unit and/or medical social service will establish a neutral process for identifying potentially eligible family carers without disclosing unnecessary clinical information to the researcher.

Potential participants will receive an information sheet explaining the study's purpose, procedures, possible emotional discomfort, confidentiality protections, voluntary nature, and right to withdraw. Adequate time will be provided for questions before written informed consent is obtained. Consent for audio recording will be obtained separately or explicitly included in the consent process.

Interviews will be conducted one-on-one in a private setting and will generally last 45-75 minutes. The researcher will begin with rapport-building and descriptive questions before moving to more emotionally sensitive experiences. Participants may pause, skip questions, or end the interview at any time. If a participant becomes visibly distressed, the interview will be slowed or stopped and, with permission, appropriate psychosocial or social-work support will be offered according to the approved referral plan.

Audio recordings will be transcribed verbatim. Relevant nonverbal observations, pauses, crying, or changes in tone may be noted when they contribute to interpretation, but the researcher will avoid overinterpreting behavior. Each participant will be assigned a code. Names of persons, municipalities, healthcare workers, and other potentially identifying details will be removed or generalized in transcripts used for analysis and reporting.

When translation is necessary, the original-language transcript will remain the analytic anchor. Translation into English will prioritize conceptual meaning. Selected translated excerpts may be reviewed by a bilingual person familiar with Waray-Waray/Filipino and English to check semantic fidelity. Data will be stored in password-protected files accessible only to authorized research personnel and retained or destroyed according to institutional policy and the approved protocol.

F. Data Analysis: Hermeneutic Phenomenological Thematic Analysis

The interview data will be analyzed using hermeneutic phenomenological thematic analysis informed by van Manen's phenomenology of practice. This is more appropriate to the study than a generic thematic analysis because the objective is not simply to categorize topics but to interpret the meaning of caregiving as lived within family, cultural, material, and healthcare contexts. The analysis will remain iterative and will move repeatedly between individual statements, complete narratives, themes, and the phenomenon as a whole.

1) Step 1: Immersion and Reflexive Orientation

The researcher will listen to recordings and read each transcript several times to become familiar with the participant's story as a whole. A reflexive journal will be used to record prior assumptions, emotional reactions, clinical expectations, and early interpretive questions. In hermeneutic phenomenology, these pre-understandings are not claimed to disappear; instead, they are made visible and critically examined so that they do not silently determine the analysis.

2) Step 2: Holistic Reading

Each interview will first be considered as a complete narrative. The researcher will ask: What is the fundamental meaning of this caregiving experience for this participant? A concise holistic statement will be written for each transcript before detailed coding. This prevents isolated quotations from being interpreted without regard to the participant's broader story.

3) Step 3: Selective and Detailed Reading

The researcher will then identify phrases, events, metaphors, turning points, silences, and descriptions that appear especially revealing of the phenomenon. Detailed line-by-line reading will be used when passages contain dense experiential meaning. These meaning units will not be treated as final themes; they are starting points for interpretation.

4) Step 4: Formulating Thematic Meanings

Related meaning units will be compared within and across participants. The researcher will formulate thematic statements that express what the experience reveals about caregiving—for example, living in continuous uncertainty, carrying responsibility without rest, stretching family resources, becoming the child's advocate, relying on faith, or feeling that ordinary time has been suspended. Theme names will be written in experiential language rather than as abstract variables whenever possible.

5) Step 5: Hermeneutic Circle and Lifeworld Reflection

Emerging themes will be repeatedly tested against complete transcripts. The researcher will ask whether each interpretation illuminates the participant's whole account and whether any important narrative contradicts or complicates it. Van Manen's lifeworld existentials lived body, lived relation, lived space, lived time, and lived materiality may be used as reflective prompts to deepen interpretation but will not serve as predetermined coding categories.

6) Step 6: Cross-Case Thematic Synthesis

Shared themes and meaningful variations will be compared across participants. The goal is not to count how many participants 'have' each theme as though themes were survey responses. Recurrence will be considered alongside intensity, contextual importance, and explanatory depth. A theme may be analytically important even if expressed vividly by only a smaller number of carers, provided it is well grounded in the data and relevant to the phenomenon.

7) Step 7: Writing and Rewriting the Interpretive Account

Phenomenological analysis will continue through writing. The researcher will produce narrative interpretations supported

by carefully selected participant quotations and will revise these interpretations to preserve context, complexity, and alternative meanings. Quotations will illustrate rather than replace analysis. The final themes will be woven into an interpretive description of the caregiving experience in Eastern Visayas.

G. Alignment of Analysis with the Statement of the Problem

The central question will be answered through the integrated interpretive essence developed across all themes. Corollary Question 1 will be addressed through themes concerning fear, uncertainty, grief, hope, and psychological strain. Corollary Question 2 will be addressed through themes related to bodily exhaustion, daily caregiving work, sleep, vigilance, and disrupted routines. Corollary Question 3 will be examined through financial toxicity, transport, distance, lodging, employment disruption, and material resources. Corollary Question 4 will be addressed through changes in family roles, relationships, sibling care, work, and social participation. Corollary Question 5 will be addressed through communication, information, decision-making, trust, and relationships with the healthcare team. Corollary Question 6 will be addressed through coping, social support, faith, resilience, and adaptation. Corollary Question 7 will be addressed through themes concerning identity, time, future orientation, meaning-making, and caregiver-defined support needs.

A research-question-to-theme matrix will be maintained during analysis to ensure that every corollary question is adequately represented while allowing unexpected themes to emerge. The matrix will be used as an alignment tool, not as a predetermined codebook. This preserves the openness required by phenomenological inquiry while ensuring that the final findings directly answer the Statement of the Problem.

H. Ethical Considerations

The study involves emotionally vulnerable circumstances and therefore requires careful ethical safeguards. Ethical approval will be obtained before recruitment. Participation will be voluntary and based on informed consent. Participants will be reminded that declining or withdrawing will not affect the child's treatment or their access to hospital services.

Confidentiality will be protected through participant codes, removal of identifying information, secure storage, and cautious reporting of contextual details. Because the pediatric oncology population in a regional hospital may be small, potentially identifying combinations of diagnosis, municipality, family role, or unusual circumstances will be generalized when necessary.

Emotional distress is a foreseeable risk. Interviews will not be conducted when a potential participant is in acute crisis or when participation would interfere with urgent care. During interviews, participants may pause or stop at any time. A referral pathway to an appropriate hospital social worker, counselor, psychologist, or other support professional will be prepared in advance for participants who request assistance or display significant distress.

The researcher will also manage role boundaries carefully. Clinical information that is not necessary for the research will not be accessed. Participants will not be recruited through coercive relationships, and healthcare staff will not be informed about who declined participation. The study will comply with institutional privacy requirements and the Philippine Data Privacy Act of 2012 (Republic Act No. 10173) in the collection, storage, processing, and disposal of personal information.

Finally, ethical interpretation is considered part of the research responsibility. Participants' accounts will be represented respectfully, without sensationalizing suffering or portraying families as passive victims. The final analysis will recognize both vulnerability and agency and will avoid presenting culturally or spiritually shaped coping practices as universal.

4. Presentation, Analysis, and Interpretation of Findings

This section presents an extensive illustrative hermeneutic phenomenological analysis of the lived experiences of family members who care for children with cancer in Eastern Visayas. It is organized around the central question and seven corollary questions in Chapter 1. Rather than reducing caregiving to isolated burdens or coping variables, the analysis treats caregiving as a lived situation in which fear, responsibility, family love, material sacrifice, hope, uncertainty, and the demands of the health system are experienced simultaneously. The analytic stance follows the hermeneutic circle described in Chapter 3: each meaning is considered in relation to the participant’s whole story, and the whole story is repeatedly reconsidered in light of particular events, relationships, and turning points.

The interpretation is informed by recent evidence. Shokri et al. (2020) documented substantial psychological problems among caregivers of pediatric patients with cancer. Ritter et al. (2023) showed that childhood cancer generates financial hardship across medical, non-medical, indirect, psychosocial, and behavioral domains. Banayat et al. (2023) identified practical, informational, spiritual, physical, and emotional supportive-care needs among Filipino parents. Luo et al. (2022) described resilience as an evolving lived process among parents of children with cancer, while Phiri et al. (2023) found that psychoeducational interventions can reduce anxiety and depressive symptoms and improve coping. More recently, Whalan et al. (2024) synthesized qualitative evidence showing that caregivers frequently assume a protective role in symptom management and require formalized information and education. These studies provide comparison and context, but the modeled themes below remain organized around the study’s own phenomenological questions.

A. Participant Context

Table 2 presents the profile of ten family carers. In a real analysis, such information would be used only to situate the narratives. Because pediatric oncology populations can be small and identifiable, combinations of municipality, child age, diagnosis, relationship, and duration of treatment should be generalized whenever disclosure could indirectly identify a family.

Table 2
Profile of the family carers

Code	Relationship	Residence	Child age	Caregiving duration	Primary care context
C01	Mother	Leyte	6	8 months	Chemotherapy / repeated admissions
C02	Father	Samar	10	1 year	Outpatient treatment and travel
C03	Grandmother	Leyte	4	7 months	Daily caregiving / parent support
C04	Mother	Biliran	13	18 months	Treatment, school disruption
C05	Mother	Samar	8	5 months	Newer diagnosis / frequent travel
C06	Father	Leyte	15	2 years	Long-term treatment follow-up
C07	Mother	Leyte	3	10 months	High dependency care
C08	Aunt	Samar	11	9 months	Shared family caregiving
C09	Mother	Biliran	7	14 months	Treatment and lodging away from home
C10	Grandfather	Leyte	16	2 years	Shared decision-making and transport

Table 3
Overview of the thematic structure

Theme	Core meaning	Primary SOP alignment	Interpretive emphasis
1. living between fear and hope	Cancer reorganizes emotional life around uncertainty.	Central; CQ1	Fear, anticipatory grief, hope, vigilance
2. caregiving without clocking out	Care becomes continuous bodily and practical work.	CQ2	Fatigue, symptom management, disrupted routines
3. the cost of staying close	Love is translated into financial and geographic sacrifice.	CQ3	Financial toxicity, transport, lodging, lost income
4. A family reorganized around illness	Roles, relationships, work, sibling care, and social life are rearranged.	CQ4	Family redistribution, strain, cohesion, social withdrawal
5. learning to speak medicine and become an advocate	Carers build knowledge, negotiate uncertainty, and depend on communication.	CQ5	Information, trust, decisions, advocacy, partnership
6. borrowed strength: family, faith, community, and small acts of control	Coping is relational and culturally situated.	CQ6	Faith, support, problem solving, resilience, self-care
7. time, self, and the future rewritten	Caregiving alters identity, time, expectations, and meaning.	CQ7	Lived time, selfhood, future orientation, meaning-making
8. making caregiving more survivable	Families need coordinated practical, emotional, informational, and financial support.	CQ7; Central	Family-centered support and nursing implications

The group reflects the kinds of variation that are analytically useful in this study: different family relationships, islands of residence, ages of children, and lengths of caregiving experience. Such variation matters because the burden of care is not produced solely by diagnosis. It is also shaped by distance from treatment, household responsibilities, the age and dependency of the child, the family's financial position, previous experience with the health system, and the availability of another adult who can share care. The purpose of including variation is therefore not representativeness in a statistical sense but interpretive depth.

B. Overview of the Thematic Structure

C. Holding the Family Together While Living in Uncertainty

The essence of caregiving is captured in the phrase holding the family together while living in uncertainty. Caring for a child with cancer is experienced as a form of continuous responsibility that extends beyond the visible tasks of bringing the child to the hospital, administering medicines, watching for fever, or preparing food. The carer becomes the person who keeps multiple worlds connected: the child's treatment world, the household, the school, employment, siblings, finances, extended family, and the caregiver's own emotional life. The meaning of caregiving therefore emerges from the effort to prevent these worlds from falling apart while the family faces an illness whose course cannot be completely controlled.

Uncertainty is central because childhood cancer repeatedly interrupts ordinary assumptions about the future. Families normally organize life around school terms, work schedules, birthdays, graduations, family gatherings, and longer-term plans. Cancer inserts laboratory results, chemotherapy cycles, admissions, infection precautions, treatment responses, and fears of recurrence into that temporal structure. The family does not simply add medical appointments to an unchanged life; life itself begins to be measured through treatment milestones. This is why lived time is important in hermeneutic interpretation. Waiting for results may feel much longer than clock time, while months of treatment may blur into a repetitive cycle of travel, hospital routines, and recovery at home.

The essence also contains a strong moral dimension. Family carers are not neutral observers of illness. They feel responsible for protecting the child, making the right decisions, noticing dangerous symptoms, finding money, staying emotionally steady, and helping the child tolerate painful or frightening treatment. Whalan et al. (2024) described caregivers as protectors in symptom management, a finding that helps illuminate why vigilance becomes so prominent. The carer's attention is repeatedly directed toward possible signs of danger. That protective orientation can be life-preserving, but it can also make rest difficult because relaxing may feel unsafe when the child's condition can change quickly.

Within this uncertainty, hope is not the simple opposite of fear. Hope functions more like a practice that allows the family

to continue. It may be expressed through faith, focusing on the next treatment cycle, celebrating small improvements, trusting clinicians, or refusing to imagine the worst outcome before it happens. Luo et al. (2022) showed that parental resilience develops through processes of adjustment and meaning rather than through the absence of distress. This distinction is important. A carer who cries, worries, or feels exhausted is not necessarily failing to cope. The capacity to continue despite emotional pain can itself represent adaptation.

The Eastern Visayas context gives this essence a material dimension. When specialty treatment requires travel from Samar, Biliran, or distant parts of Leyte to Tacloban City, caregiving becomes inseparable from transport schedules, food costs, lodging, missed work, and the availability of someone who can remain with children left at home. Columbres et al. (2024) described how pediatric cancer financial toxicity in the Philippines includes direct treatment costs, indirect costs such as transportation and lodging, and psychosocial consequences. Thus, the experience of uncertainty is not only medical. Families may also be uncertain about whether they can continue financing travel, whether employment will be maintained, or whether assistance will be available for the next cycle.

The essence is consequently relational. Family carers draw strength from spouses, grandparents, siblings, relatives, neighbors, religious communities, nurses, physicians, social workers, and other parents in the treatment setting. At the same time, caregiving can strain these relationships. The person staying with the child may feel isolated from family members at home; siblings may receive less attention; spouses may disagree about spending or decisions; relatives may be supportive at first but become less available as treatment continues. The same network that makes caregiving possible can therefore also become a site of tension, obligation, disappointment, and renegotiated roles.

From a nursing perspective, the essence suggests that family-centered pediatric oncology care cannot be limited to teaching medication schedules or giving discharge instructions. The caregiver's ability to carry out treatment recommendations depends on whether the family understands the plan, can afford the practical consequences, has a way to travel, can recognize symptoms, has someone to call when unsure, and has emotional support when fear becomes overwhelming. Banayat et al. (2023) identified practical and informational needs as major priorities among Filipino parents of children with cancer, followed by spiritual, physical, and emotional needs. The modeled essence is consistent with that multidimensional picture: the family needs support not in one domain but across the whole caregiving situation.

Interpreted hermeneutically, then, caring for a child with cancer is a way of being drawn into an altered world. The caregiver becomes more vigilant, more medically knowledgeable, more aware of financial limits, and more dependent on relationships that can either relieve or intensify strain. Ordinary routines acquire new meaning; a normal temperature, a completed chemotherapy cycle, a good appetite, a night at home, or a reassuring message from the physician can become emotionally significant. The family lives with the illness while also trying to preserve childhood, parenthood, work, faith, and everyday dignity. That simultaneous effort to protect the child and preserve the family provides the interpretive thread connecting all subsequent themes.

D. Theme 1: Living Between Fear and Hope

1) Shock as a rupture in ordinary life

The first pattern is the experience of diagnosis as rupture. Before cancer is named, symptoms may still be understood within ordinary childhood illness. Once cancer enters the conversation, the family's interpretive world changes quickly. Words that previously belonged to other people—chemotherapy, malignancy, remission, relapse, blood counts, infection precautions—become part of everyday family language. The diagnosis may therefore be experienced not only as frightening information but as a sudden loss of the taken-for-granted future. Plans that seemed stable become conditional on treatment response and clinical advice.

Psychological evidence supports the plausibility of this pattern. Shokri et al. (2020), in a systematic review of caregivers of pediatric patients with cancer, identified anxiety, depression, and other forms of psychological strain as recurring concerns. Such distress is understandable because the diagnosis places parents and family carers in a situation of high responsibility and limited control. They are required to act—to sign consent forms, learn care routines, arrange travel, and reassure the child—at the same time that they are processing their own fear. The need to function can therefore coexist with an internal sense of disorientation.

An important interpretive point is that initial shock should not be treated as a single brief phase that simply disappears. The emotional meaning of diagnosis can be reactivated by later events: an unexpected admission, a severe side effect, a delay in treatment, a new scan, or a discussion of prognosis. In this sense, the caregiver may experience repeated moments of being brought back to the seriousness of the illness. Emotional adaptation is therefore better understood as nonlinear. The family can have relatively stable periods and then be pulled again into fear by a change in the child's condition.

2) Vigilance, worry, and anticipatory fear

As caregiving continues, fear may become less dramatic but more persistent. The caregiver learns to monitor fever, appetite, pallor, bruising, pain, vomiting, weakness, and behavioral changes. This practical vigilance is necessary, yet it also changes the caregiver's relationship with ordinary signs. A temperature that might once have been managed casually can now signal the possibility of infection and urgent hospital evaluation. Everyday observations acquire clinical weight.

Whalan et al. (2024) found that caregivers often understand themselves as protectors in symptom management. The modeled analysis interprets this protective role as both empowering and exhausting. Knowledge can reduce helplessness because the carer knows what to watch for and when to seek help. At the same time, knowledge expands the field of possible danger. The caregiver may sleep lightly, repeatedly check the child, or feel uneasy when physically separated from the child. Such behaviors can be understood as

Table 4
Meaning domains and practice relevance for theme 1: living between fear and hope

Meaning domain	Interpretive meaning	Practice relevance
Fear and vigilance	Uncertainty enters ordinary life	Repeated distress screening and clear contact pathways
Hope	A practice that sustains action	Realistic hope and supportive communication
Emotional oscillation	Adaptation is nonlinear	Support across treatment, not only at diagnosis

rational responses to a situation in which early recognition of complications matters, even though sustained vigilance may eventually contribute to fatigue.

The psychological burden also extends to imagined futures. Caregivers may worry about treatment failure, recurrence, disability, fertility, schooling, social development, or whether the child will return to an ordinary life. Lundgren et al. (2023) found that parents of children treated for cancer described worry, low mood, parenting difficulties, relationship challenges, productivity difficulties, stress reactions, and feeling lost or lonely. Although their study included parents after treatment, it illustrates how concern can persist beyond the most medically intensive period. For the present study, this means that emotional burden should be interpreted across the whole trajectory rather than assumed to end when a treatment cycle is completed.

3) Hope as something actively maintained

Hope in the modeled findings is not presented as denial. Instead, it is a way of making an uncertain future livable. Families may narrow their focus to the next appointment, the next laboratory result, or the next week at home. This reduces the overwhelming size of the cancer journey into a sequence of manageable horizons. Hope can also be relational: a clinician's calm explanation, a nurse who remembers the child, another parent who has survived a similar journey, or a relative who continues to help can make hope feel more credible.

Faith can be especially significant in a predominantly religious setting. Prayer, church support, devotional practices, and the belief that suffering can be endured with divine help may provide language for experiences that medicine cannot resolve. Yet spiritual coping should not be romanticized. Faith may coexist with anger, doubt, bargaining, or questions about why the illness happened. The value of spiritual support lies not in assuming that every family interprets cancer religiously, but in recognizing spirituality as one possible source of meaning and endurance.

The relationship between fear and hope is therefore dialectical rather than binary. Hope becomes meaningful because fear is real; fear remains tolerable because hope is repeatedly rebuilt. This pattern is consistent with Luo et al. (2022), who described resilience among parents of children with cancer as a dynamic process involving acceptance, adjustment, family support, and meaning. In practice, nurses should avoid interpreting visible hope as absence of distress or visible distress as absence of resilience. Both can be present at the same time.

4) Interpretive conclusion for Corollary Question 1

Taken together, the modeled findings answer the first corollary question by showing emotional life as an ongoing movement among fear, grief, vigilance, hope, and temporary reassurance. The most important analytic point is continuity: caregiving does not simply progress from shock to acceptance in a straight line. Instead, emotional responses are repeatedly reshaped by the child's condition, treatment events, financial realities, family support, and communication with the healthcare team.

The practical implication is that psychosocial support should not be restricted to the moment of diagnosis. Screening for caregiver distress, clear information, opportunities to ask questions, and referral pathways should remain available throughout treatment and even after major treatment milestones. Phiri et al. (2023) found that psychoeducational interventions can reduce anxiety and depressive symptoms and improve coping among caregivers of children with cancer. That evidence supports a model of care in which caregiver emotional needs are treated as legitimate components of pediatric oncology practice rather than private problems families must manage alone.

E. Caregiving Without Clocking Out

1) The caregiver's body becomes part of the treatment journey

The second theme interprets caregiving as continuous embodied work. The family carer may spend long hours sitting beside the child, sleeping in unfamiliar places, carrying bags, arranging meals, watching intravenous lines, assisting with hygiene, and traveling repeatedly to and from the hospital. The body absorbs the treatment schedule indirectly. Fatigue, irregular meals, headaches, muscle tension, and poor sleep can become ordinary even though the caregiver is not the patient.

This bodily dimension matters because family caregiving is often described morally—as love, sacrifice, or responsibility—while the physical cost remains less visible. A caregiver may minimize personal discomfort because the child is perceived to be suffering more. The comparison can make self-care feel selfish. Yet prolonged neglect of sleep, nutrition, chronic conditions, or emotional recovery can reduce the caregiver's capacity to provide safe and attentive care. The meaning of exhaustion is therefore not merely discomfort; it is a sign that caregiving resources are being depleted.

Whalan et al. (2024) emphasized the intensive symptom-management role assumed by caregivers. In practice, this role involves observation, decision-making, and rapid response in addition to physical tasks. Cognitive load should therefore be considered part of the physical burden. The caregiver may constantly remember medication times, fluid intake, symptoms, appointments, laboratory schedules, transport arrangements, and instructions from multiple professionals. Mental vigilance and bodily fatigue reinforce one another.

2) Ordinary routines become treatment routines

Cancer reorganizes the family's day. Meals may be planned around nausea or neutropenic precautions; school attendance

Table 5
Meaning domains and practice relevance for theme 2: caregiving without clocking out

Illustrative meaning domain	Interpretive meaning	Practice relevance
Embodied fatigue	The caregiver's body absorbs the treatment schedule	Assess sleep, nutrition, respite and caregiver capacity
Continuous monitoring	Care continues outside the hospital	Practical symptom-management education
Routine disruption	Family time is reorganized around treatment	Simplify care plans and coordinate schedules

may depend on blood counts; work schedules may be adjusted to hospital visits; weekends may be determined by treatment cycles rather than leisure. The caregiver can experience ordinary life as temporarily suspended, yet the suspension may last months or years. What begins as an emergency arrangement gradually becomes the family's new routine.

This transformation has important phenomenological meaning. Routine normally provides predictability and a sense of control. In cancer caregiving, routine is rebuilt around uncertainty. Families create checklists, prepare hospital bags, keep records, save contact numbers, and learn which symptoms require urgent care. These practices are adaptive because they produce order, but they also reveal how illness has entered domestic life. The home can become partly clinical, and the caregiver can begin to think like a monitor even during periods when the child appears well.

The findings suggest that daily disruption may be especially intense for carers responsible for other children, older relatives, or employment. The practical question is not only how to perform cancer-related care, but how to keep the rest of family life functioning at the same time. Caregivers may depend on grandparents, spouses, older siblings, or neighbors to prepare meals, bring children to school, or manage household tasks. The experience of caregiving is therefore distributed across a family network even when one person is identified as the primary carer.

3) Caregiving competence grows, but responsibility does not become light

With repeated treatment, carers may become highly competent. They learn clinical vocabulary, recognize patterns in the child's side effects, understand routines, and become more confident when speaking with professionals. This growth can create a sense of mastery. However, competence should not be mistaken for reduced burden. In some cases, greater knowledge increases responsibility because the caregiver becomes more aware of what can go wrong.

The distinction is important for nursing education. A caregiver who appears skilled may still need reassurance, updated teaching, and permission to ask basic questions. Assuming that long-term carers 'already know' can leave them unsupported when treatment changes. Good education should therefore be iterative, confirm understanding, and adapt to new phases of care. It should also acknowledge what families already know rather than treating them as passive recipients of instruction.

From a hermeneutic perspective, competence becomes part of identity. The family member may begin to see the self as the person who knows the child's baseline, remembers the treatment history, anticipates reactions, and translates between the child, the household, and clinicians. This can be empowering, but it can also make it harder to step away. If no one else knows the routines as well, the caregiver may feel irreplaceable and therefore unable to rest.

4) Interpretive conclusion for Corollary Question 2

The second corollary question is answered by understanding caregiving as continuous labor that collapses the boundary between hospital and home. Physical fatigue, cognitive vigilance, altered sleep, disrupted meals, travel, symptom monitoring, and reorganized routines form a single lived pattern. The caregiver is effectively always on call because the illness continues outside formal clinical encounters.

The implication is that family-centered care should include practical strategies for sharing caregiving tasks, simplifying instructions, anticipating symptom-management needs, and identifying periods when respite is possible. Education should be paired with assessment of caregiver capacity. The goal is not simply to make families more capable of doing more work; it is to make necessary caregiving safer and more sustainable.

F. The Cost of Staying Close

1) Financial toxicity is experienced as repeated sacrifice

The third theme interprets financial hardship not as a background socioeconomic variable but as part of the lived meaning of caregiving. Families may experience treatment costs, medicines, laboratory tests, food, transport, accommodation, communication expenses, lost wages, and the costs of caring for other children at home. Even when major components of treatment are subsidized, repeated smaller expenses can accumulate over months and become difficult to sustain.

Ritter et al. (2023) demonstrated that financial hardship in childhood cancer spans direct medical costs, non-medical costs, indirect costs, financial coping strategies, psychosocial responses, and behavioral responses across countries. This multidimensional framework is highly relevant to the modeled findings. A family may sell assets, borrow money, request help from relatives, delay other household expenses, or reduce work. Each strategy solves an immediate problem but can create longer-term vulnerability.

Columbres et al. (2024) specifically situated pediatric cancer financial toxicity in the Philippine context, emphasizing direct costs, transportation and lodging, and psychosocial consequences. For carers in Eastern Visayas, these costs are likely to be experienced spatially: the farther the family lives from Tacloban City, the more treatment may require money simply to remain physically close to the child's oncology team. Geography therefore becomes economic.

2) Distance turns treatment into travel

Travel is not experienced as a neutral movement from home to hospital. Long journeys can begin before dawn, require multiple transport connections, and involve a child who is fatigued, immunocompromised, nauseated, or in pain. Bad

Table 6
Meaning domains and practice relevance for theme 3: the cost of staying close

Illustrative meaning domain	Interpretive meaning	Practice relevance
Direct/indirect costs	Treatment creates cumulative financial toxicity	Early social-work and financial navigation
Travel and lodging	Geography becomes part of treatment burden	Transport/lodging support and coordinated appointments
Lost income	Caregiving competes with employment	Flexible documentation and assistance referrals

weather, ferry schedules, road conditions, or limited public transport can add uncertainty. A caregiver may worry about arriving late, missing a schedule, exposing the child to infection, or being unable to return home quickly if the child deteriorates.

When treatment requires staying near the hospital, the family can experience a second layer of displacement. Temporary lodging may reduce travel burden but separate the caregiver and child from the rest of the household. The caregiver may live out of bags, rely on charity accommodation, or spend prolonged periods in hospital environments. Home becomes distant both physically and emotionally. This contributes to the phenomenological experience of lived space: the hospital and treatment city become necessary but not fully home-like spaces.

Material conditions can also shape clinical decisions indirectly. Families may postpone nonurgent appointments, seek assistance before agreeing to recommended tests, or experience distress when clinicians discuss a plan without considering travel and cost. This does not necessarily reflect lack of commitment. It may instead reveal a mismatch between medically ideal schedules and what the family can realistically sustain. Recognizing this distinction is crucial to avoid moralizing treatment difficulties.

3) Financial strain affects dignity, relationships, and hope

Money problems are emotionally charged because they touch parental responsibility and dignity. A caregiver may feel shame when repeatedly asking relatives for help or frustration when donations are uncertain. Financial dependence can alter relationships within the extended family. Support may be generous and strengthening, but it can also create feelings of indebtedness or worry about becoming a burden to others.

Financial stress can also shape hope. When a family believes treatment is clinically available but materially difficult to continue, uncertainty takes on a different form. The fear is no longer only whether treatment will work but whether the family can keep reaching treatment. This creates a morally painful situation in which economic capacity appears linked to the child's chance of recovery. The emotional weight of such circumstances helps explain why financial support should be treated as a psychosocial and clinical issue rather than merely an administrative concern.

Banayat et al. (2023) found practical needs to be the highest-ranked category among Filipino parents of children with cancer, with information, spirituality, physical, and emotional needs also prominent. Practical need includes the resources required to make care possible. In this study's modeled interpretation, financial and geographic assistance are therefore not peripheral conveniences. They are part of the infrastructure that enables adherence to pediatric cancer treatment.

4) Interpretive conclusion for Corollary Question 3

The third corollary question is answered through the theme that love is repeatedly translated into material sacrifice. Financial burden, distance, transport, accommodation, and lost work reshape caregiving by consuming household resources and narrowing choices. The family's ability to continue treatment is influenced not only by clinical need but by the practical conditions under which care must be accessed.

For nursing and hospital practice, the finding supports early screening for financial and transport difficulty, timely referral to social work and charitable resources, coordinated scheduling where possible, and clear explanation of expected treatment-related costs. The goal should be to identify material barriers before they become crises that threaten treatment continuity or caregiver well-being.

G. A Family Reorganized Around Illness

1) Roles are redistributed under pressure

A child's cancer changes more than the caregiver's schedule; it can reorganize the family system. One adult may become the hospital-based caregiver while another becomes responsible for income, siblings, household tasks, and travel arrangements. Grandparents or extended relatives may assume roles that were previously carried by parents. These changes can demonstrate remarkable flexibility, but they can also create tension when responsibilities are uneven or unclear.

The primary caregiver may experience both gratitude and guilt. Gratitude comes from knowing that others are helping; guilt may arise from being physically absent from other children, missing school events, or depending financially on relatives. The caregiver can therefore feel pulled between equally important obligations. Caring for the ill child is urgent, but the needs of siblings, partners, and older relatives do not disappear. The family's moral world becomes crowded with competing claims.

The analysis treats these tensions as structural rather than personal failure. A caregiver cannot be fully present in two places at once. When one child requires prolonged treatment, absence from other roles is often unavoidable. Supportive interventions should therefore help the family reorganize realistically rather than simply encouraging the caregiver to 'balance everything.'

2) Relationships can deepen or fray

Serious illness can strengthen family cohesion. Relatives may become more attentive, spouses may develop new appreciation for one another, and siblings may learn responsibility and empathy. Shared adversity can create a sense that the family is fighting together. Yet the opposite can also occur. Chronic fatigue, financial strain, different coping styles, and uneven information can produce conflict.

Spouses may disagree about money, treatment decisions, the amount of information to share with the child, or how much risk to accept. A partner who remains at home may feel excluded

Table 7
Meaning domains and practice relevance for theme 4: a family reorganized around illness

Illustrative meaning domain	Interpretive meaning	Practice relevance
Role redistribution	The whole family participates in caregiving	Assess family functioning, not only the primary carer
Relationship strain/cohesion	Illness can both strengthen and stress relationships	Family communication and psychosocial support
Sibling impact	Other children remain affected	Sibling-sensitive family-centered care

from medical decisions, while the hospital-based carer may feel that others do not understand the intensity of the experience. These differences are not necessarily evidence of poor relationships. They can reflect different positions within the caregiving situation.

The hermeneutic perspective helps explain why the same family relationship can be both supportive and stressful. Dependence increases the emotional importance of others. When support is available, it is deeply relieving; when it is absent or inconsistent, disappointment can be especially painful. Family relationships are therefore not separate from caregiver coping—they are part of the structure through which coping becomes possible or difficult.

3) Siblings and social life become less visible but remain important

Siblings may experience reduced parental attention, changes in routines, fear about the ill child, and restrictions caused by infection precautions or finances. The primary caregiver may worry that well children are being asked to grow up too quickly. Even when siblings appear cooperative, they may carry questions or resentment that are not openly expressed. Family-centered care should therefore recognize siblings as affected members of the illness experience.

Social participation can also shrink. Families may attend fewer gatherings because of the child's health, treatment schedules, fatigue, or fear of infection. Friends may be supportive initially but gradually return to ordinary lives while the family remains in treatment. This can create a sense of being left behind. Lundgren et al. (2023) described loneliness and relationship challenges among parents after childhood cancer treatment, illustrating how social consequences can persist even when medical intensity decreases.

At the same time, new social networks can emerge. Caregivers may form bonds with other parents in the oncology unit, connect through social media, or receive support from religious communities and civic groups. These relationships can be uniquely helpful because they reduce the need to explain the seriousness and practical complexity of cancer care. Shared experience creates a form of recognition that ordinary social support may not fully provide.

4) Employment and caregiving become competing forms of responsibility

For employed family carers, work can be both a source of income and an additional burden. Frequent absences, reduced hours, loss of opportunities, or the need to resign may have long-term effects on the family's financial stability. Employers who provide flexibility can become important sources of support; inflexible workplaces can intensify stress and force painful choices between income and bedside presence.

The meaning of employment disruption is not only economic. Work may be part of identity, independence, and social connection. Leaving work to care for a child can therefore involve both relief and loss. The caregiver may be grateful for the ability to focus on the child while simultaneously worrying about career interruption, professional skills, or future employability.

This tension reinforces the broader interpretation that childhood cancer reorganizes the whole family system. The illness does not remain confined to medical settings; it changes how time, money, labor, and attention are distributed across the household.

5) Interpretive conclusion for Corollary Question 4

The fourth corollary question is answered by showing caregiving as a family reorganization rather than an individual role. Family members redistribute tasks, income work, sibling care, decision-making, and emotional labor. Relationships may become more cohesive, more strained, or both at different points in treatment.

Nursing assessment should therefore ask who is caring for the child, who is caring for everyone else, who makes decisions, and who may be missing from the bedside but carrying essential responsibilities at home. Such questions help move family-centered care from a general principle to a practical understanding of how this particular family is functioning.

H. Learning to Speak Medicine and Become an Advocate

1) Information becomes a form of safety

The fifth theme centers on communication because information reduces uncertainty only when it is understandable, timely, and connected to action. Family carers need to know what treatment is being given, what side effects are expected, which symptoms are urgent, who to contact, what laboratory results mean, and what changes require returning to the hospital. In the absence of clear guidance, caregivers may feel that responsibility has been transferred to them without adequate tools.

Banayat et al. (2023) identified informational needs as one of the highest priorities among Filipino parents of children with cancer. This is consistent with the modeled experience that information is not simply educational content; it is a form of psychological and practical safety. A parent who understands what to expect may still be afraid, but fear is less chaotic because there is a plan for responding.

Information overload is also possible. Diagnosis and treatment initiation often involve multiple new concepts at a time when caregivers are emotionally distressed. This means that communication should be repeated, paced, and checked for understanding rather than delivered once. Written instructions, teach-back, and clear contact pathways can help convert information into usable knowledge.

2) Trust is built through honesty, presence, and continuity

The caregiver-clinician relationship becomes a major source

Table 8
Meaning domains and practice relevance for theme 5: learning to speak medicine and become an advocate

Illustrative meaning domain	Interpretive meaning	Practice relevance
Information	Knowledge becomes safety	Repeated teaching and teach-back
Trust	Continuity and honesty reduce uncertainty	Consistent communication across the team
Advocacy	Carers become active partners	Invite questions and respect caregiver knowledge

of security when families perceive professionals as competent, approachable, consistent, and honest. Trust allows families to tolerate uncertainty because they feel that they will be informed if the situation changes. Conversely, inconsistent messages, unexplained delays, dismissive interactions, or sudden changes in plan can intensify anxiety even when the medical care itself is technically appropriate.

Qualitative pediatric oncology studies reinforce the importance of communication. Mack et al. (2020) identified communication functions that parents value, including relationship-building, information exchange, emotional support, and decision support. Additional work by Sisk et al. (2021) showed that negative communication experiences can lead to emotional distress, reduced understanding, loss of trust, inconvenience, and decreased engagement. These findings help explain why communication is not a 'soft' aspect of cancer care but part of how families experience safety and partnership.

The analysis also recognizes that trust is not blind acceptance. Highly engaged caregivers may ask repeated questions, request clarification, seek second opinions, or challenge decisions because they are trying to protect the child. Advocacy can therefore be a sign of commitment rather than mistrust. A family-centered approach treats questions as part of partnership, not as resistance.

3) Caregivers learn to advocate and translate

Over time, caregivers may become translators between medical language and family life. They explain treatment to relatives, decide what the child should know, coordinate instructions from different professionals, and communicate the child's baseline behavior or symptoms to the healthcare team. This advocacy role grows from intimate knowledge of the child and from repeated exposure to the system.

Communication advice from parents and clinicians in pediatric oncology emphasizes asking questions, speaking up, organizing information, forming partnerships, and identifying support (Sisk et al., 2021). Such advice aligns with the modeled theme: caregivers become more confident when they are invited to participate and when professionals respect their observations. The nurse is especially important because nurses are often more continuously available than physicians and can help families interpret instructions between formal consultations.

However, the demand to advocate can also become burdensome. Families should not have to fight repeatedly for basic information or coordination. When advocacy is required because systems are fragmented, it adds work to already overloaded caregivers. Effective systems should therefore support, rather than depend upon, exceptionally assertive families.

4) Decision-making carries moral weight

Cancer treatment decisions can feel heavy because caregivers understand themselves as responsible for choosing on behalf of a child. Even when there is a medically recommended plan, consent can be emotionally difficult because treatment itself may be painful, toxic, or uncertain. The caregiver may experience a painful paradox: agreeing to interventions that make the child temporarily sicker in the hope of cure or control.

Good shared decision-making does not remove this burden, but it can make it more bearable. Families need honest information, realistic hope, space to ask questions, and confirmation that they are not alone in carrying responsibility. Communication research in pediatric oncology has repeatedly highlighted the challenge of balancing hope with honest discussion of uncertainty and prognosis. The modeled interpretation therefore views communication as an ethical relationship, not merely a transfer of facts.

Culturally, decision-making may also be distributed across family members. Grandparents, spouses, or other relatives may have strong voices. Clinicians should ask families how they prefer decisions to be made rather than assuming an individualistic model. Respecting family structure can reduce conflict and improve the fit between clinical recommendations and the family's lived reality.

5) Interpretive conclusion for Corollary Question 5

The fifth corollary question is answered by understanding communication as the bridge between medical uncertainty and family action. Clear information, relational trust, continuity, and respectful inclusion in decisions help caregivers move from helplessness toward informed participation. Poor communication does the opposite: it amplifies uncertainty, creates avoidable emotional burden, and can weaken trust.

The implication for nursing is direct. Nurses can provide repeated teaching, use teach-back, normalize questions, document family concerns, coordinate messages across professionals, and identify when caregivers have misunderstood or are overwhelmed. Family-centered communication should be planned as deliberately as symptom management because both influence the family's ability to continue care.

I. Borrowed Strength - Family, Faith, Community, and Small Acts of Control

1) Coping is relational before it is individual

The sixth theme rejects the idea that coping is solely an internal trait. Caregivers often continue because other people lend practical and emotional strength. A spouse may take over work or sibling care; grandparents may provide money or food; relatives may accompany hospital visits; neighbors may help with transportation; another parent in the oncology unit may provide advice that feels credible because it comes from lived experience.

This relational understanding of coping is consistent with resilience research. Luo et al. (2022) described resilience

Table 9
Meaning domains and practice relevance for theme 6: borrowed strength

Illustrative meaning domain	Interpretive meaning	Practice relevance
Family/community support	Coping is socially distributed	Map and mobilize support networks
Spirituality	Faith may provide meaning and endurance	Offer individualized spiritual care
Small acts of control	Routines create agency	Provide practical tools and psychoeducation

among parents of children with cancer as an evolving experience supported by personal adjustment and external resources. The caregiver's ability to endure should therefore not be interpreted as evidence that support is unnecessary. Often, apparent strength is produced by a network of visible and invisible assistance.

The corollary question also directs attention to uneven support. Some families have extensive kin networks; others may have relatives who are far away, financially constrained, or unable to help. A caregiver's coping options are therefore partly determined by social position. Recommendations should avoid assuming that every family can simply 'ask relatives for help.'

2) Faith provides meaning, ritual, and companionship

Spirituality can function as a way of holding uncertainty that medicine cannot resolve. Prayer may provide structure during waiting, a language for hope, and a sense that the family is not facing the illness alone. Religious communities may also provide tangible support through visits, fundraising, meals, and transportation.

Banayat et al. (2023) identified spiritual needs among Filipino parents of children with cancer, which supports the cultural relevance of this dimension. Yet spiritual care should remain individualized. Some caregivers may want prayer and religious conversation; others may prefer private spirituality or no religious framing. The ethical role of healthcare professionals is to assess and support rather than assume.

Faith can also coexist with doubt. A caregiver may pray intensely and still feel angry, frightened, or abandoned. Such experiences should not be interpreted as spiritual weakness. They may represent the caregiver's effort to make sense of suffering that has no easy explanation. Sensitive spiritual care gives room for complexity rather than offering simplistic reassurance.

3) Small acts of control make uncertainty manageable

Problem-focused coping appears in ordinary practices: organizing medicines, writing questions before rounds, keeping laboratory records, saving emergency contacts, planning transport, preparing hospital bags, and tracking expenses. These actions do not control the cancer, but they create islands of predictability. The family can act on what is controllable even when treatment outcomes remain uncertain.

Such routines have psychological value because helplessness is reduced when the caregiver knows what to do next. Psychoeducation is relevant here. Phiri et al. (2023) found that psychoeducational interventions improve coping and reduce anxiety and depressive symptoms among caregivers of children with cancer. Information is therefore not only knowledge; when designed well, it can support a sense of agency.

However, problem-solving has limits. No amount of organization can fully compensate for severe financial hardship, inaccessible treatment, or chronic emotional exhaustion. The modeled theme therefore distinguishes adaptive coping from structural burden. Families should be supported to strengthen their coping capacities, but healthcare systems must also reduce avoidable sources of strain.

4) Rest, humor, and ordinary moments protect personhood

Caregivers may also cope through brief moments that restore a sense of normal life: sharing food, watching a movie with the child, laughing with another parent, sleeping when a relative takes over, or going home for a short period. These acts can appear small compared with cancer treatment, but phenomenologically they matter because they remind the caregiver that life is larger than illness.

Self-care language can become burdensome when it is offered without practical support. Telling a caregiver to rest is unrealistic if no one can stay with the child. Meaningful self-care therefore depends on respite, flexible visitation, family assistance, and reassurance that stepping away briefly is acceptable. The question should be not simply whether caregivers know they need rest, but whether the care environment makes rest possible.

The theme 'borrowed strength' captures this relational reality. Caregivers often sustain themselves by drawing on family, faith, community, knowledge, routines, and moments of normality. Coping is therefore not a private achievement but a process supported by relationships and resources.

5) Interpretive conclusion for Corollary Question 6

The sixth corollary question is answered by identifying coping as a layered process involving emotional regulation, practical problem-solving, social support, spirituality, information, humor, and intentional preservation of ordinary life. Resilience is not the absence of suffering; it is the capacity to continue, adapt, and find meaning while suffering remains present.

This interpretation suggests that nursing support should build on what families already use. Asking 'What helps you get through difficult days?' can reveal culturally meaningful resources. Nurses can then reinforce effective coping, connect families to formal support, and avoid imposing generic strategies that do not fit the caregiver's situation.

J. Time, Self, and the Future Rewritten

1) The caregiver becomes a different version of the self

The seventh theme interprets caregiving as an identity-changing experience. Family members may begin treatment as parents, grandparents, siblings, or relatives with ordinary responsibilities. Over time, they may also become symptom monitors, schedulers, advocates, medication managers, fundraisers, transport coordinators, and interpreters of medical information. These roles can strengthen confidence while also narrowing personal identity around caregiving.

Table 10
Meaning domains and practice relevance for theme 7: time, self, and the future rewritten

Illustrative meaning domain	Interpretive meaning	Practice relevance
Identity change	Caregiving becomes part of selfhood	Recognize strengths and losses
Altered time/future	Life is organized around treatment milestones	Support transition and future planning
Meaning-making	Families integrate illness in different ways	Avoid imposing positive-growth narratives

Some caregivers may discover capabilities they did not know they possessed. They become more assertive, more knowledgeable, or more patient. Others may feel that parts of their previous identity have been placed on hold—career, friendships, hobbies, or plans. Both experiences can coexist. Growth does not cancel loss, and loss does not eliminate the possibility of growth.

Hermeneutic phenomenology is especially suited to this dimension because identity is understood through lived meaning rather than as a fixed psychological trait. The caregiver asks, implicitly or explicitly, who am I now that this has happened to our family? The answer develops through repeated encounters with fear, responsibility, support, and uncertainty.

2) Lived time is reorganized by treatment

Cancer changes the texture of time. Waiting for results can feel suspended; hospital days can feel long; months of treatment can pass in repetitive cycles. The future may become difficult to imagine beyond the next clinical milestone. Families may stop making long-range plans because plans feel vulnerable to sudden change.

This temporal narrowing can be protective. Focusing on the next step prevents the caregiver from becoming overwhelmed by the entire course of illness. Yet it can also create a sense that ordinary life has been deferred. Birthdays, school progression, employment goals, travel plans, and family celebrations may be reconsidered around treatment.

Lundgren et al. (2023) found that concerns about children's future, relationships, productivity, and stress can continue after treatment. This suggests that the reorganization of time may persist beyond active therapy. Families may need support not only in surviving treatment but in rebuilding a future afterward.

3) Meaning is reconstructed through suffering and care

Caregivers may search for meaning in different ways. Some interpret the experience through faith, others through family solidarity, gratitude, personal growth, or a sharpened awareness of what matters. Meaning-making does not imply that cancer is viewed positively. Rather, it reflects the human effort to integrate an unwanted event into a life story that can still be lived.

The caregiving role can also clarify values. Families may become less concerned with minor conflicts, more appreciative of time together, or more willing to ask for help. At the same time, they may experience anger about inequities in access, frustration with bureaucratic systems, or grief for the ordinary childhood and family life that have been interrupted. Meaning is therefore morally and socially situated.

A humanized interpretation avoids turning suffering into a lesson the family was 'meant' to learn. Not every caregiver wants to frame the experience as growth. The analytic task is to respect the meanings families themselves make, including meanings of injustice, exhaustion, or simply endurance without transformation.

4) Support needs become clearer through experience

As families move through treatment, they often learn which forms of support are genuinely useful. Practical assistance with transport, lodging, food, and financial navigation may be more valuable than general encouragement at certain points. At other times, the family may need clear information, a clinician who listens, a social worker who can explain assistance, or a private space to express fear.

Banayat et al. (2023) found a wide range of care needs among Filipino parents, while Phiri et al. (2023) demonstrated the value of structured psychoeducation. The modeled findings integrate these strands by suggesting that support should be stage-sensitive. Newly diagnosed families may need orientation and crisis support; long-term carers may need help with cumulative fatigue, finances, family relationships, and future planning.

Support also needs to be coordinated. Families can become exhausted by repeatedly retelling their situation to different services. A named contact person, clear referral pathways, and communication among oncology, nursing, social work, psychology, and charity partners can reduce the administrative burden of seeking help.

5) Interpretive conclusion for Corollary Question 7

The seventh corollary question is answered by showing that caregiving rewrites identity, time, and the imagined future. Carers become more clinically knowledgeable and often more resilient, but may also feel that previous roles and plans have been suspended. They reconstruct meaning through family, faith, values, advocacy, and the daily act of continuing care.

The support they are likely to value is therefore multidimensional: practical, financial, informational, psychosocial, spiritual, and relational. No single intervention can address the entire experience. The implication is a coordinated family-support pathway that recognizes changing needs across the treatment trajectory.

K. Making Caregiving More Survivable - An Integrated Response to Support Needs

Although Theme 8 is most directly connected with the support component of Corollary Question 7, it integrates the entire analysis. The modeled findings suggest that family carers do not need one isolated program. They need a system that recognizes how emotional distress, information, symptom management, finances, travel, family roles, and spirituality interact. When one domain fails, pressure increases in the others. For example, unclear discharge teaching can increase anxiety and unnecessary travel; travel costs can worsen financial strain; financial strain can create conflict at home; conflict can reduce the emotional support available to the

primary caregiver.

A family-support pathway should therefore begin with early assessment. At or soon after diagnosis, families could be screened for transport distance, lodging needs, employment vulnerability, number of dependent children, caregiver health conditions, health literacy, language preferences, and available family support. This information would not be collected merely for documentation. It would trigger referrals and anticipatory guidance. Families from distant islands may need transport and accommodation planning before the first crisis. Caregivers with limited support may need a clearer respite plan. Those who appear overwhelmed may benefit from early psychosocial contact.

Information support should be organized around the treatment journey. Families need concise orientation at diagnosis, repeated symptom-management teaching before discharge, written or digital instructions in accessible language, and a reliable contact pathway for urgent questions. Whalan et al. (2024) concluded that formalized information and education are essential to support caregivers in symptom management. The nursing team is well positioned to lead this component because nurses observe how families perform care and can identify misunderstandings that may not surface during physician consultations.

Psychosocial support should be normalized rather than reserved for families who appear visibly distressed. Caregivers often prioritize the child and may minimize their own symptoms. Brief routine screening for anxiety, depressive symptoms, sleep problems, or overwhelming stress can create permission to discuss personal well-being. Phiri et al. (2023) provide evidence that psychoeducation can improve coping and reduce negative psychological outcomes. In practice, this could take the form of short structured sessions, caregiver handouts, peer-support groups, tele-support, or referral to counseling when indicated.

Financial navigation should be treated as part of treatment continuity. Families may need assistance understanding PhilHealth coverage, hospital social-service processes, charitable funds, temporary lodging, transportation support, and documentation for employers or local government assistance. Columbres et al. (2024) and Ritter et al. (2023) make clear that financial hardship is multidimensional and can affect behavior and psychosocial well-being. A family-centered program should therefore identify financial risk early and follow it longitudinally rather than waiting until debt or treatment interruption is already severe.

Support should also respect cultural and spiritual resources. In Eastern Visayas, extended family networks and religious communities may be important sources of practical and emotional help. Healthcare professionals can ask about these resources without assuming that they are always available or positive. Spiritual care may include facilitating contact with a chaplain or religious leader, providing private space for prayer, or simply allowing carers to speak about faith and doubt without judgment.

Finally, families need transition support. The end of intensive treatment does not automatically restore ordinary life. Caregivers may remain vigilant, financially depleted, socially isolated, or uncertain about recurrence and the child's development. Lundgren et al. (2023) demonstrate that parental concerns can persist after treatment. A survivorship-oriented transition should therefore include information about follow-up, late effects, signs that require consultation, psychosocial support, school reintegration, and the gradual redistribution of family roles that had been organized around treatment.

The overarching interpretation is that family caregiving becomes more survivable when support reduces avoidable uncertainty and distributes responsibility. Families will continue to face the emotional reality of cancer, but healthcare systems can reduce the burden created by fragmented information, inaccessible resources, unnecessary travel, unrecognized distress, and poorly coordinated referrals. In this sense, family-centered care is not simply compassionate communication. It is the organization of services around the practical and existential realities families are actually living.

L. Cross-Theme Interpretation: How the Findings Work Together

The eight themes should not be read as separate compartments. In lived experience, they continuously shape one another. Emotional distress intensifies when the caregiver lacks information or money; financial strain becomes harder when employment is threatened; work disruption can create family conflict; family support can protect emotional well-being; clear communication can reduce unnecessary fear; faith can strengthen endurance but may not solve transport or income problems. The analytic value lies in understanding these interactions.

One important cross-theme pattern is the distinction between burden and meaning. Caregiving is burdensome because it requires time, money, bodily effort, emotional regulation, and sustained vigilance. Yet it is also deeply meaningful because it expresses love and responsibility toward the child. These two truths coexist. Attempts to reduce caregiver burden should therefore avoid language that makes caregiving itself sound unwanted. Families may not want less closeness to the child; they may want fewer avoidable obstacles around the act of caring.

A second pattern is the accumulation of small burdens. Not every stressor is dramatic. Repeated transport fares, interrupted sleep, waiting, paperwork, minor misunderstandings, missed work hours, and the need to explain the situation repeatedly can gradually create exhaustion. This cumulative quality helps explain why carers who appear to be coping at one point may become overwhelmed later. Support systems need longitudinal attention rather than one-time assessment.

A third pattern concerns visibility. Much of caregiver work is invisible to the health system because it occurs between appointments. Families monitor symptoms at night, negotiate with employers, find money, comfort siblings, manage medicines, and decide whether a symptom is serious enough to travel for. Recognizing this work can change the tone of clinical encounters. Instead of viewing the caregiver as an accompanying adult, the team can recognize the caregiver as an

active care partner carrying substantial responsibility.

A fourth pattern is the centrality of uncertainty. Every theme contains uncertainty in a different form: uncertainty about the child's condition, whether symptoms are dangerous, whether money will be enough, whether siblings are coping, whether the healthcare team understands the family's concerns, whether faith will sustain hope, and what the future will look like. Effective support repeatedly converts uncertainty into manageable next steps without pretending that the future can be guaranteed.

A fifth pattern is inequality of resources. Families enter cancer treatment with different incomes, distances from care, family networks, educational backgrounds, transport options, and employment flexibility. Consequently, the same medical regimen can impose very different caregiving burdens. Equity in pediatric oncology therefore requires attention to the conditions surrounding treatment, not only equal access to the same clinical protocol.

The final cross-theme pattern is transformation. Caregivers are changed by the experience. They may become more knowledgeable, assertive, spiritually reflective, financially cautious, or emotionally sensitive. Family relationships may be reshaped. The future may be imagined differently. Some changes feel like growth; others feel like loss. Hermeneutic analysis allows both to remain visible without forcing a single positive or negative conclusion.

M. Exhaustive Hermeneutic Description of the Caregiving Experience

The family carer enters pediatric cancer through an event that interrupts ordinary life. The diagnosis is heard not only as a medical statement but as a threat to the child, the family's future, and the assumptions that previously organized daily life. In the early period, the caregiver must learn quickly while emotionally overwhelmed. Hospital spaces, unfamiliar terms, consent forms, and treatment schedules become part of a world the family did not choose but must now inhabit.

As treatment continues, caregiving becomes embodied. The caregiver's days and nights are shaped by the child's symptoms, medication times, laboratory schedules, travel, hospital admissions, and periods of recovery. Sleep becomes lighter, attention becomes more vigilant, and ordinary routines become conditional. The caregiver's body carries fatigue while the mind remains oriented toward the child. Personal discomfort is frequently minimized because the child's needs appear more urgent.

The caregiving world is also material. Money, transport, accommodation, food, communication, and employment are woven into treatment. A recommendation that appears straightforward in the clinic may require complex family arrangements to carry out. Distance from Tacloban City can mean hours of travel, lost work, or separation from siblings. The family continuously translates clinical plans into practical action using whatever resources are available.

Relationships become both shelter and pressure. Family members share tasks, send money, care for siblings, and offer emotional support. Yet stress can reveal differences in coping and decision-making. The primary caregiver may feel alone even when surrounded by people because only the person at the bedside fully experiences the daily intensity. Other parents in the treatment setting can become important companions because they understand without lengthy explanation.

The healthcare team enters the family's moral world because clinicians hold knowledge the family urgently needs. Trust is built through honesty, competence, availability, and respect. Nurses often become translators of the treatment experience, helping families understand what to expect and what to do. When communication is fragmented, uncertainty expands. When communication is clear and relational, families can act with greater confidence even though the illness remains frightening.

Coping unfolds through repeated acts rather than one dramatic achievement. Families pray, organize, ask questions, borrow money, accept help, laugh when they can, and focus on the next step. Resilience is visible not in the absence of tears or fear but in the continuation of care. The caregiver can feel close to collapse and still perform the next necessary task. This complexity is essential to a humanized interpretation.

Over time, the caregiver becomes changed by the role. The person may discover strength and competence while also mourning suspended plans and lost normality. Time is no longer neutral. The future may be imagined through treatment milestones, and ordinary events can take on new significance. A meal eaten well, a normal temperature, a good laboratory result, or a night at home can become evidence that life still contains spaces of relief.

The caregiving experience therefore cannot be summarized

Table 11
Illustrative answers to the central and corollary questions

Question	Illustrative answer	Primary themes
Central	Caregiving is experienced as holding the family together while living in sustained medical, emotional, material, and existential uncertainty.	All themes
CQ1	Emotional life moves nonlinearly among shock, vigilance, fear, grief, hope, and temporary reassurance.	Theme 1
CQ2	Care is continuous embodied work involving symptom monitoring, fatigue, altered sleep, and reorganized routines.	Theme 2
CQ3	Financial and geographic conditions shape whether treatment is practically sustainable and affect dignity, work, and relationships.	Theme 3
CQ4	Cancer reorganizes family roles, sibling care, employment, relationships, and social participation.	Theme 4
CQ5	Clear information, trust, continuity, and inclusion in decision-making transform caregivers from uncertain recipients into informed partners and advocates.	Theme 5
CQ6	Coping is sustained through family, community, faith, knowledge, routines, humor, problem-solving, and relational support.	Theme 6
CQ7	Caregiving reshapes identity, time, future orientation, and meaning; families need coordinated practical, psychosocial, informational, financial, and spiritual support.	Themes 7-8

as burden alone. It is sacrifice, fear, learning, advocacy, exhaustion, family love, practical improvisation, faith, uncertainty, and hope carried together. The family is asked to sustain the child through treatment while also sustaining itself. The quality of professional support matters because it can either add to that work or help distribute it. The deepest implication of the modeled findings is that pediatric oncology care is always care of a family, even when the child is the identified patient.

N. Direct Answer to the Central Question and Corollary Questions

See table 11.

O. Synthesis

Section 4 has interpreted the caregiving experience as a whole rather than as a list of separate burdens. The central meaning holding the family together while living in uncertainty explains why emotional, physical, financial, relational, and spiritual experiences repeatedly overlap. The caregiver is simultaneously protecting the child, learning medicine, preserving household life, negotiating material limits, and trying to sustain hope.

The discussion also shows that caregiver distress is not evidence of failure. Fear, sadness, fatigue, and ambivalence are understandable responses to a demanding and uncertain situation. Resilience should therefore be understood as an adaptive process supported by relationships and resources, not as an expectation that caregivers remain continuously strong. This distinction protects against placing responsibility for systemic problems on individual families.

The literature supports the multidimensional nature of the modeled findings. Recent systematic reviews and qualitative studies identify psychological distress, financial hardship, intensive symptom-management responsibilities, persistent parental concerns, supportive-care needs, and the value of psychoeducation. Philippine literature adds particular relevance to practical needs and financial toxicity. Together, these sources suggest that family-centered pediatric oncology care should combine clinical treatment with deliberate caregiver support.

P. Extended Interpretive Discussion: Lifeworld Dimensions of Family Caregiving

A further way of deepening the interpretation is to examine the themes through the lifeworld dimensions used in phenomenology of practice. These dimensions are not additional variables and should not replace the emergent themes. Instead, they help reveal how cancer caregiving is lived through the body, through relationships, through space, through time, and through material conditions. Reading the themes in this manner makes visible why apparently practical problems such as transportation or sleep loss carry emotional and existential meaning for carers.

Lived body is evident in the physical exhaustion of long hospital stays, interrupted sleep, travel, poor appetite, and sustained vigilance. The caregiver's body becomes an instrument of care: it stays awake, carries the child, prepares food, travels, waits, and remains available. Yet the same body is often treated as secondary because attention is directed toward the child's illness. This can create a pattern in which the caregiver recognizes personal limits only after fatigue becomes severe. A family-centered nursing response should therefore make caregiver bodily well-being discussable without implying that attention is being diverted from the child.

Lived relation is visible in every theme. Cancer changes the meaning of being a parent, grandparent, sibling, spouse, and extended family member. Relationships with clinicians also become unusually consequential because families rely on professionals for information that shapes hope, fear, and decisions. In this situation, a short conversation can carry more meaning than its duration suggests. A calm explanation can restore a sense of order, while a dismissive response can remain memorable because it occurs at a moment of vulnerability. This explains why communication quality becomes part of the lived experience of treatment itself.

Lived space is transformed because home, hospital, transport terminals, temporary lodging, and oncology waiting areas acquire new meanings. Home may represent safety but also distance from specialized care. The hospital may represent both fear and security: it is where painful procedures happen, but also where help is available when the child becomes unwell. Temporary lodging may offer practical relief while reminding the family that they are displaced from ordinary life. In Eastern Visayas, island geography makes lived space especially important because access to treatment can involve travel across long distances or transport links that cannot be taken for granted.

Lived time changes when the family starts measuring life through treatment cycles, laboratory schedules, admissions, and follow-up visits. Clock time and calendar time remain, but experiential time becomes uneven. Waiting for a result may feel prolonged; a stable week at home may pass quickly; months of treatment may be remembered as a continuous sequence of appointments. The future may contract to the next clinical milestone. This temporal narrowing can protect the caregiver from being overwhelmed, but it can also make long-term planning difficult and contribute to the feeling that the family's previous life is temporarily suspended.

Lived materiality is especially visible in money, medicines, bags, transport fares, food, phones, lodging, laboratory requests, and documents used to obtain assistance. These objects and resources are not merely background details. They mediate whether care can be carried out. A phone with load may be the means of reaching the oncology team. A fare may determine whether the family can return for an appointment. A hospital bag kept permanently ready may symbolize the family's state of preparedness. Materiality therefore connects large structural issues such as financial toxicity with the intimate routines of daily caregiving.

Looking across these lifeworld dimensions reinforces the central interpretation that caregiving is a whole-world transformation. The carer does not experience cancer only through thoughts or feelings; it is lived through the body, family relationships, movement across places, altered time, and dependence on material resources. This is why fragmented interventions can feel insufficient. Support becomes

meaningful when it acknowledges the full situation in which the caregiver is living.

Q. Extended Interpretive Discussion: Tensions and Apparent Contradictions

Hermeneutic analysis becomes richer when it pays attention to tensions rather than trying to produce a completely consistent story. One recurring tension is between competence and vulnerability. Caregivers may become highly skilled at monitoring symptoms and navigating the hospital while still feeling frightened. Their competence may even hide their distress from professionals. A family member who speaks confidently about blood counts or medications may be assumed to be coping well, even though that knowledge has developed through months of anxiety and responsibility.

A second tension is between gratitude and dissatisfaction. Families may be deeply grateful for clinicians, charitable support, or access to treatment while also being frustrated by waiting times, costs, inconsistent information, or bureaucratic requirements. These positions can coexist without contradiction. Gratitude should not be used to silence concerns, and dissatisfaction should not be interpreted as lack of appreciation. Human experiences frequently contain both.

A third tension lies between hope and realism. Families may need hope in order to continue treatment, but they also need accurate information to make decisions. Communication that is technically honest but emotionally insensitive can damage trust, while reassurance that avoids difficult realities can create false expectations. The practical task for clinicians is not to choose between hope and honesty but to hold them together: to explain what is known and unknown while affirming what the team can still do for the child and family.

A fourth tension is between sacrifice and sustainability. Family carers may willingly sacrifice sleep, income, comfort, and personal plans because caring for the child is meaningful. Yet voluntary sacrifice can still become unsustainable. The fact that a caregiver chooses to remain at the bedside does not mean the system should assume unlimited endurance. A humane interpretation respects the moral meaning of sacrifice while also asking what can be done to reduce preventable costs and exhaustion.

A fifth tension is between family closeness and family disruption. Cancer can bring relatives together around a shared purpose, but it can also redistribute attention and money in ways that generate conflict. Siblings may become more responsible and compassionate while also feeling neglected. Couples may become stronger through cooperation while also arguing more because of fatigue and financial stress. The study should therefore avoid labeling families as either resilient or distressed. Most families are likely to show both capacities and vulnerabilities across time.

These tensions are analytically important because they prevent simplistic conclusions. The purpose of phenomenological interpretation is not to classify carers as coping or not coping, supported or unsupported, hopeful or fearful. It is to understand how these meanings are lived together. Such complexity is precisely what quantitative scales can miss and what the present qualitative design is intended to illuminate.

R. Extended Interpretive Discussion: Implications for Nursing Practice in Eastern Visayas

The findings have particular implications for nurses because nurses are often the professionals with the most sustained contact with the child and caregiver. Nursing practice can reduce burden by anticipating what families will need rather than waiting for caregivers to identify every problem themselves. This begins with assessment that is clinically focused but context-aware. Asking where the family lives, who traveled with the child, who remains at home, how they will return for treatment, and who understands the discharge plan can reveal risks that are invisible in a standard biomedical assessment.

Education should be treated as a process. Families receive information under stress, and memory can be affected by fear, fatigue, and unfamiliar terminology. Repetition is therefore a safety strategy rather than unnecessary duplication. Teach-back can be used respectfully: instead of testing the caregiver, the nurse can frame it as a way of checking whether the explanation was clear. Written instructions in the caregiver's preferred language can reduce dependence on memory, particularly for fever thresholds, medication schedules, infection precautions, and contact information.

Nurses can also make caregiver distress visible. A brief question such as 'How are you managing personally?' can signal that the caregiver's well-being matters. If the caregiver reports severe sleep loss, panic, hopelessness, or inability to cope, the nurse can facilitate referral rather than assuming that families will seek help on their own. This is especially important because some carers may feel that acknowledging personal difficulty is inappropriate when the child is the one with cancer.

Care coordination is another important nursing contribution. Families can become overwhelmed when instructions from different professionals are not synchronized. Nurses can help reconcile information, clarify follow-up schedules, ensure that social-service referrals are completed, and identify when the family is uncertain about next steps. In geographically dispersed regions, even small improvements in coordination can prevent unnecessary travel and reduce costs.

The nursing role also includes advocacy at the system level. Repeated patterns observed across families—transport problems, delays in obtaining assistance, common misunderstandings, or gaps in temporary lodging—should be communicated to nursing leadership and hospital administration. Individual compassion is valuable, but recurring structural problems require organizational responses. The study's eventual authentic findings could therefore support both bedside interventions and service redesign.

Finally, nurses should recognize caregivers as knowledgeable partners. Families know the child's normal behavior, preferences, fears, and subtle changes. Respecting this knowledge can strengthen clinical assessment and trust. Partnership does not mean transferring professional responsibility to the family; it means combining clinical

expertise with the caregiver's intimate knowledge of the child. This balance is central to family-centered pediatric oncology.

5. Summary of Findings, Conclusions, and Recommendations

A. Summary of the Study

This study was designed to explore the lived experiences of family members who serve as carers of children with cancer in Eastern Visayas. It is grounded in hermeneutic phenomenology and is concerned not merely with identifying caregiving difficulties but with interpreting what these experiences mean within the family, cultural, material, and healthcare contexts in which they occur. The central question asks for the meaning and essence of caregiving, while seven corollary questions examine emotional and psychological realities; physical and daily care demands; financial and geographic conditions; family and social disruption; communication and decision-making; coping and resilience; and changes in identity, time, future, and perceived support needs.

B. Summary of Illustrative Findings

1. The essence is holding the family together while living in uncertainty. Caregiving is experienced as continuous responsibility in which love, vigilance, sacrifice, fear, hope, family obligation, material constraint, and interaction with the healthcare system are carried at the same time.
2. Emotional experience is nonlinear. Diagnosis disrupts ordinary expectations, and fear can return with new symptoms, laboratory results, admissions, or changes in treatment. Hope is actively maintained through relationships, faith, information, and attention to short-term milestones.
3. Caregiving is embodied and continuous. Family carers experience fatigue, altered sleep, symptom-monitoring responsibilities, cognitive load, travel, and the transformation of household routines into treatment routines. Competence grows over time but does not necessarily reduce responsibility,
4. Financial toxicity and geography are central to the caregiving experience. Direct and indirect costs, transportation, lodging, lost income, and dependence on assistance can influence treatment sustainability, dignity, relationships, and emotional well-being.
5. The entire family system is reorganized. Roles are redistributed, siblings may receive less parental attention, employment is disrupted, and relationships may strengthen or become strained. Caregiving is therefore a collective family process even when one person is the primary carer.
6. Communication functions as safety. Clear, repeated information and respectful relationships with clinicians help caregivers act confidently and participate in decisions. Poor communication intensifies uncertainty. Over time, caregivers become advocates and translators between the medical system and family life.
7. Coping is supported by family, faith, community, peer relationships, problem-solving routines, information, humor, and small opportunities for rest. Resilience is a dynamic process and should not be confused with absence of distress.
8. Caregiving reshapes identity, lived time, and the future. Carers may discover new strength while mourning suspended roles and plans. They identify a need for coordinated practical, financial, informational, psychosocial, spiritual, and transition support.

C. Conclusions

1. First, family caregiving in pediatric cancer is best understood as a whole-life experience rather than a discrete set of tasks. The modeled analysis indicates that emotional, physical, financial, relational, and spiritual dimensions are inseparable in everyday life. A change in one domain can quickly affect the others. This supports family-centered models of care that assess the caregiving situation broadly rather than limiting attention to the child's biomedical treatment.
2. Second, uncertainty is the central experiential condition around which caregiving is organized. Families cannot fully predict treatment response, complications, costs, transport difficulties, or the duration of disruption. Effective healthcare support cannot remove all uncertainty, but it can reduce avoidable uncertainty through clear information, reliable contact pathways, continuity, anticipatory guidance, and coordinated referrals.
3. Third, caregiver distress should be treated as a legitimate consequence of the caregiving situation rather than as personal weakness. Fear, anxiety, exhaustion, grief, and ambivalence can coexist with strong commitment and resilience. This conclusion is consistent with systematic evidence documenting psychological strain among caregivers and with phenomenological evidence describing resilience as an evolving process.
4. Fourth, financial and geographic conditions are not external to pediatric cancer care. They are part of treatment feasibility. In a region composed of islands and geographically dispersed communities, transport, lodging, food, missed work, and indirect expenses can shape the family's ability to remain connected with specialized services. Financial toxicity therefore deserves early and repeated assessment.
5. Fifth, the family is a caregiving system. The primary caregiver's capacity depends on who cares for siblings, who earns income, who makes decisions, who provides transportation, and who offers emotional support. Family assessment should therefore include both visible and less visible contributors to care.
6. Sixth, communication is a clinical intervention in its own right. Families need understandable, repeated, honest, and compassionate information. Trust grows when healthcare professionals listen, acknowledge uncertainty, and respect caregiver observations. Nurses have a particularly important role because of their frequent contact with families and their capacity to translate medical information into actionable home-care guidance.

7. Seventh, coping is strengthened by resources. Faith, family support, community networks, peer connection, practical organization, and psychoeducation can help caregivers continue, but these strategies should not be used to excuse structural barriers. Resilience should be supported rather than demanded.
8. Finally, a responsive caregiver-support system should be longitudinal and coordinated. Needs change from diagnosis to active treatment, repeated hospitalization, recovery, survivorship, or palliative phases. The most appropriate model is therefore not a one-time orientation but a pathway that reassesses needs and connects families with relevant services throughout the child's cancer journey.

D. Recommendations

1) For the Pediatric Oncology Unit and Nursing Service

Develop a structured caregiver-support pathway beginning at diagnosis. The pathway should include caregiver-needs screening, symptom-management education, teach-back, clear emergency contact instructions, psychosocial screening, and referral mechanisms. Nursing documentation should include not only the child's clinical status but also major caregiver barriers that can affect continuity of care.

2) For Nurses

Use repeated, plain-language education rather than one-time information delivery. Assess what the caregiver already understands, invite questions without judgment, provide written or digital instructions, and use teach-back for high-risk symptoms. Nurses should also ask about sleep, exhaustion, emotional distress, family support, and transport difficulties when these issues may affect safe home care.

3) For Physicians and the Multidisciplinary Oncology Team

Strengthen family-centered communication by explaining uncertainty honestly while preserving realistic hope. Ensure consistency of messages across team members and include carers in decisions in ways that respect family preferences and cultural norms. Complex conversations should ideally include nursing and psychosocial professionals so that families have opportunities for follow-up clarification.

4) For Hospital Social Work and Patient Navigation Services

Implement early financial-risk and access screening. Families traveling from Samar, Biliran, or distant areas of Leyte should be assessed for transportation, lodging, meal, and employment-related needs. Social workers should maintain an updated map of PhilHealth benefits, local government assistance, charitable resources, and temporary housing options, and should help families complete requirements before crises develop.

5) For Hospital Administration

Consider creating a pediatric oncology family navigator or designated caregiver-support coordinator. This role can reduce fragmentation by linking families with nursing education, social work, psychology, financial assistance, lodging, spiritual care, and survivorship resources. Administrative support should also include family-friendly scheduling and systems that reduce repeated paperwork and unnecessary travel.

6) For Psychosocial and Mental Health Services

Normalize caregiver psychological support as part of routine oncology care. Brief distress screening can identify caregivers who need additional assessment. Psychoeducation, peer support, counseling, and referral should be available across the treatment trajectory. Interventions should recognize that anxiety and fatigue may recur around major clinical transitions.

7) For Spiritual Care and Community Partners

Offer spiritual support when desired and collaborate with faith communities without assuming that all families use religious coping. Community organizations can assist with transport, meals, lodging, and family respite. Partnerships should be coordinated to protect privacy and avoid making families repeatedly retell painful circumstances to different agencies.

8) For Family Support Programs

Include siblings and secondary caregivers. Provide age-appropriate information for siblings, encourage realistic sharing of responsibilities, and help families identify backup caregivers who can learn key routines. This reduces overdependence on one primary caregiver and creates opportunities for rest.

9) For Nursing Education

Strengthen pediatric oncology content on family-centered care, caregiver assessment, communication under uncertainty,

Table 12
FAMILY-Care support pathway components

Component	Purpose	Key activities	Responsible persons	Indicators
F - Family needs screening	Identify risks early	Assess distress, support network, siblings, transport, finances, caregiver health	Nurse, social worker	% screened within first two visits
A - Accessible information	Reduce avoidable uncertainty	Orientation, symptom cards, teach-back, emergency contacts, preferred language	Nurse, physician	Teach-back completion; caregiver-reported clarity
M - Material and mobility support	Address financial/geographic barriers	Transport/lodging referral, financial navigation, appointment coordination	Social worker, navigator	Referrals completed; missed visits related to access
I - Integrated psychosocial and spiritual care	Support emotional and meaning-related needs	Distress screening, counseling, peer support, chaplain/spiritual referral	Psychologist/counselor, chaplain, nurse	Referral uptake; caregiver distress follow-up
L - Linking family roles and respite	Prevent overload of one caregiver	Map secondary caregivers, sibling support, respite planning	Nurse, social worker	Backup caregiver identified; respite plan documented
Y - Year-round/trajectory follow-up	Recognize changing needs	Reassess at treatment transitions, relapse, survivorship, palliative care	Multidisciplinary team	Needs reassessment at milestones
CARE - coordinated advocacy, resources, and education	Keep services connected	Named contact, referral tracking, MDT case review for high-risk families	Navigator/team leader	Referral closure rate; caregiver satisfaction

financial toxicity, cultural humility, trauma-informed practice, and supportive care. Student nurses should learn that the family's capacity to carry out care is part of treatment safety.

10) For Local Government and Regional Health Systems

Explore transport support, temporary accommodation, referral coordination, and decentralized follow-up where clinically appropriate. Regional solutions are especially relevant because Eastern Visayas is geographically dispersed. Policies that reduce unnecessary travel can decrease both financial and physical caregiver burden.

11) For Future Research

Conduct the planned interviews and analyze the authentic transcripts using the hermeneutic procedure described in section 3. Future studies may compare experiences across provinces, caregiver roles, phases of treatment, and public versus private treatment settings. Mixed-method studies can subsequently quantify the prevalence and predictors of burdens identified qualitatively, while intervention studies can test caregiver-navigation, psychoeducation, financial counseling, or tele-support programs.

E. Proposed Output: FAMILY-Care Support Pathway for Pediatric Oncology

Based on the synthesis, the study may propose a practical FAMILY-Care Support Pathway. The name emphasizes that pediatric cancer treatment is sustained by a family system and that support should be embedded in routine care rather than offered only after a crisis.

F. Implementation Considerations

Implementation should begin with a small pilot in the pediatric oncology service. Existing staff roles should be mapped before creating new tasks. Some components, such as teach-back and transport screening, can be integrated into routine nursing assessment; others may require formal referral agreements with social work, psychology, charity partners, and local government units.

The pathway should be adapted to the languages used by families. Educational materials can be developed in Waray-Waray, Filipino, and English, with attention to health literacy and the emotional context in which information is received. Materials should be concise and action-oriented rather than dense. The goal is to support decision-making, not to overwhelm caregivers with technical detail.

Evaluation should combine service indicators with caregiver feedback. Missed visits, emergency calls related to unclear instructions, referral completion, and caregiver-reported understanding can provide practical monitoring data. Brief qualitative feedback should also be collected because a pathway may look complete administratively while still feeling fragmented to families.

The proposed pathway should not replace individualized clinical judgment. Some families will need intensive psychological or financial support, while others will need primarily information and coordination. A flexible stepped-care approach is more consistent with the varied needs identified in the literature and the phenomenological commitment to context.

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