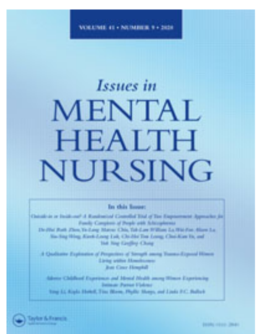

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Mental Health Professionals' Experiences with Applying a Family-Centred Care Focus in Their Clinical Work

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ABSTRACT

Family members play vital roles in supporting their young adults with mental health challenges, implying that professionals are challenged to apply a Family-Centred Care approach (FCC) in community mental health services. By applying a qualitative phenomengraphic approach, this study aimed to explore and describe professionals' experiences of applying a FCC approach. Based on data from 13 individual interviews, the descriptive categories were: *Mutual understanding*, *Facing dilemmas* and *Dealing with barriers*. Despite the professionals' expressed desires to involve the family, individual treatment and follow-up seemed to characterize their daily clinical practice, often due to the young adults' own wishes.

Introduction

Mental health professionals play a key role in supporting young adults with mental health problems in their recovery and during the treatment processes in municipalities. Mental health problems occurring during adolescence are the main causes of young adults' disabilities and represent a considerable global burden of disease (Gore et al., 2011). Likewise, these early mental health problems may entail a risk of developing mental health illness in young adulthood, as well as increasing the risk of developing somatic health problems later in life (Cunningham, Peters, & Mannix, 2013; McCloughen, Foster, Huws-Thomas, & Delgado, 2012). Considering that 10–20% of children and adolescents are affected by mental health challenges worldwide (Kieling et al., 2011), optimalizing family resources is a core issue and responsibility for both mental health professionals and national health administration. Consequently, addressing the families of young adults with mental health problems and challenges and involving them in the treatment and care of the young adult is of vital clinical importance.

The Norwegian Directorate of Health (2017) has provided guidelines in order to secure the involvement of family members and offer them support. According to these guidelines, the family and its members should be addressed in three ways: the family as a core source of information; family members as advocates for the young patient; and family as a recipient of support in terms of their own needs. The guidelines imply that the community mental health services should establish routines and systems in order to facilitate the provision of information and offer supportive and educative consultations with the young adult's family members. This implies that mental health nurses and other mental health professionals may face challenges when it comes to applying a Family-Centred Care (FCC) approach in their daily mental health services.

The challenges and experiences professionals may face in gradually adopting the FCC approach and perspectives in their daily roles and clinical work as well as in providing emotional and educative support are not adequately explored and described by qualitative research. To our knowledge, working in line with the FCC approach has received little attention in community mental health settings. Hence, this study addresses mental health professionals' experiences when applying FCC to support young adults living with mental illness and their families in a municipal mental health context.

Background

The FCC core values are *Dignity and Respect*, *Information Sharing*, and *Participating and Collaboration* (Bell, 2013; Falkov, 2012). An FCC approach implies inviting and respecting the patient's family members as partners in the caregiving (Johnson, 2000; McNeil, 2013).

The FCC perspectives further hold that the family operates as a *system*, and that the clinical FCC approach implies the provision of psychosocial support to the family as a unit or *system* rather than approaching the family members

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individually in their unique contexts (Wright & Leahey, 2012). Additionally, FCC directly and individually addresses the needs of the person suffering from mental illness as well as of family members (Falkov, 2013), since an understanding of the family as a system implies that each member of the family mutually affects each other as well as affecting the family system as a whole. In order to apply and provide the FCC, the professionals need to recognize their responsibility in assisting the patient as well as the family to cope with mental illness in a *collaborative* way.

Consequently, the concept of family is not just regarded as limited to the family as a structure characterized by blood bands (Whall, 1986), but includes significant others as part of the family. The FCC approach implies involving significant others in the patient's family system, and thereby acknowledging family members'/relatives' perspectives and knowledge in the planning and delivery of care and support (Wright & Leahey, 2012).

Young adults' mental illness tends to involve and affect family members' everyday lives (Lindgren, Söderberg, & Skär, 2016) and may cause change in the family system and family members' roles. Family members play a vital and crucial role in supporting their young adults struggling with mental health issues. In order to meet and prepare for these changes in their roles, family members need to acquire and to share information, gain knowledge and develop new insight in order to cope with the young adult's needs when he/she experiences mental health challenges (Rodríguez-Meirinhos, Antolín-Suárez, & Oliva, 2018). The general FCC approach may include fixed interventions geared to support and strengthen family resources when living together with persons suffering from a physical or mental illness. However, the core values of FCC are in general the same regardless of what model or interventions health professionals might apply in their FCC approach. The Family-Centred Support Conversation Intervention (FCSCI) is one such fixed or geared intervention involved in FCC. The FCSCI is outlined in order to strengthen health professionals' support when addressing the everyday life of the family. Core elements in the intervention include facilitating new beliefs and opinions and dealing with matters of concern for each family respectively. In FCSI, the relationship and collaboration between the mental health professionals and families is characterized as nonhierarchical and co-creating (Benzein, Olin, & Persson, 2015).

Several barriers are reported in the implementation of FCC. These barriers are either related to the patient, other family members, or to health professionals. Kim and Salyers (2008) have reported that the patient's refusal to involve the family or the other family members' lack of knowledge about mental illness might act as a barrier to working with families. Additionally, family members with mental health issues of their own or experiencing burn-out symptoms are recognized as major barriers. Other studies have reported that family members may perceive difficulties in participating when they are not invited into care decisions due to the legal and ethical duty to maintain confidentiality (Lindgren et al., 2016; Skundberg-Kletthagen, Wangensteen, Hall-Lord, & Hedelin, 2014; Weimand, Hedelin, Hall-Lord, & Sällström, 2011). The mental health professionals encounter barriers, e.g. they might be afraid of risking the therapeutic relationship to the patient when inviting the family to collaborate (Weimand, Sällström, Hall-Lord, & Hedelin, 2013) or experience that they do not have time to involve the patient's family due to a heavy workload (Kim & Salyers, 2008). Thus, the aim of the present study was to explore and describe mental health professionals' experiences of applying a family-centred care focus in their daily clinical work.

Method

Design

A qualitative phenomenographic approach was applied for this study. The ontological focus in phenomenography addresses human experiences and holds that the only world from which we can communicate is the experienced world. One essential feature of phenomenography is a description of the various ways in which a phenomenon can be perceived. However, this assumes epistemologically that a phenomenon can only be perceived in a limited number of ways (Marton & Booth, 1997; Sjöström & Dahlgren, 2002). In this study, the mental health professionals' experiences of a family-centred care focus is the phenomenon examined.

Research setting

Norwegian health care is organized at three main levels: national/state level, health region level, and municipality level (community level). Young adults living with mental illness who are in need of community mental health care are entitled to professional support by the mental health care services in the municipalities. These services offer them interpersonal therapy individually or/and in groups.

Mental health care in Norway is divided into child and adolescent mental health care (from 0 up to 18 years) and adult mental health care (18 and above), respectively. Young adults above 18 must formally consent to allowing their parents access to information and to be involved in the treatment they receive from mental health services. The mental health professionals in community mental health services include a range of professions with a variety of competence.

Sample and participants

The participants consisted of mental health professionals employed in mental health care in five Norwegian municipalities. Participants were recruited by their immediate manager who invited them to participate in a course addressing FCC and the Family-Centred Support Conversation Intervention (FCSCI). In total, 19 mental health professionals participated in autumn 2017 in this course. Of these 19, thirteen gave their informed consent to participate in this study. The inclusion criteria were outlined in order to secure a maximum variation in competence and experience: minimum 3-year bachelor's degree in health or social work; experience of

working in a community mental health care setting for a minimum of 1 year; experience of working with young adults from 18 to 25 years with mental health problems. The following professions were included: nurse, social worker, social educator, psychologist, occupational therapist–some of whom had further education in mental health.

The final sample consisted of three males and 10 females aged from 36 to 61 years. Everyone had further education (family therapy/mental health/cognitive therapy). Years of experience working in the municipal mental health service varied from 1–20 years (mean 6.8). The size of the municipalities where they worked differed, reflecting also the variation in the size of Norwegian county municipalities. Both urban and rural counties were represented.

Data collection

The first and last author carried out individual interviews during spring 2018. The participants were informed of the purpose of the study. The introductory interview question was: *Can you describe your experiences of working with a family-centred care focus?* In addition, follow-up questions aimed at elucidating the health professionals' experiences were asked.

The interviews were carried out at the mental health professionals' workplaces in line with their wishes and lasted between 43 and 61 minutes, with an average length of 44 minutes. The interviews were recorded and thereafter transcribed by the first author.

Data analysis

In this phenomenographic analysis, the idea was to explore and describe the mental health professionals' perceptions of working with an FCC focus.

A phenomenographic analysis moves from an individual to a collective awareness as a "pool of meaning" (Marton & Booth, 1997). The analysis was performed in seven steps in accordance with Dahlgren and Fallsberg (1991):

1. Familiarization: The transcriptions were thoroughly read in order to establish an overall impression of data and to become familiar with the data material.
2. Condensation: Short and representative statements corresponding with the aim of the study were identified. These statements were inserted into tables, with clear identification of those who had made the statement.
3. Comparison: This step implies a preliminary analysis of each mental health professional's predominant way of understanding the phenomenon: "Working with a family-centred care focus." The main concern at this step was to find similarities and differences within the statements.
4. Grouping: Answers which appear to be similar were grouped, and these groups were further compared to ensure that each had a unique character and the same level of description.
5. Articulating: At this step, a preliminary attempt was made to describe the essence of the similarities and variations within each group of answers.
6. Labeling: The various groups were denoted by constructing a suitable linguistic expression for each descriptive category and identifying concepts that best represent the findings.
7. Contrasting: The descriptive categories and concepts obtained were compared in respect of similarities and differences in order to avoid overlap.

Steps 3 to 5 were repeated several times, and the analyses were concluded when new concepts no longer emerged. We arrived at three descriptive categories, comprising six concepts.

The categories were systemized in what is termed horizontal outcome space (Uljens, 1989). See Table 1.

Ethical consideration

The mental health professionals were given oral and written information before consenting. All participants gave their written consent, and they were informed that the material would be treated confidentially (World Medical Association, 2018). Ethical guidelines for research ethics with respect to confidentiality, integrity and voluntariness of the participants were followed throughout the study. Approval was given by the Norwegian Center for Research Data (NSD), Ref: 54962.

Findings

Experiences of working with a family-centred care focus from the perspective of mental health professionals revealed three descriptive categories: *Mutual understanding*, *Facing dilemmas and Dealing with barriers* comprising six concepts, two of which were related to each category respectively. Categories and concepts are illustrated in Table 1.

The participants revealed that the young adults' difficulties and reasons for searching for help and support varied considerably. As the young adults often lived together with their family while receiving treatment and follow-up support, family involvement was a core issue. For the

Table 1. Mental health professionals' experiences of applying a family-centred care approach in their clinical work.

Descriptive categories			
Conceptions	***Mutual understanding***	***Facing dilemmas***	***Dealing with barriers***
	Arriving at a mutual understanding of the young adults' mental health problems	Facing dilemmas when implementing family-centred ideas	Dealing with reluctance when attempting to involve the family
	Arriving at a mutual understanding of collaborative family support	Facing dilemmas in balancing needs and offering support	Dealing with prejudice as a barrier in reaching out

participants, this imposed a responsibility and a need to include and offer support and collaborative strategies in a variety of ways. The participants experienced challenges, dilemmas and barriers when addressing the young adults and their families with a family-centred care focus.

Mutual understanding

When getting to know the young adult's family, the health professionals gained a deeper understanding of the patient's everyday life and the core challenges. This deeper understanding often implied initiating different strategies in order to help the young adult and the family to arrive at a mutual understanding of the young adult's mental health struggle and what challenges the family themselves experienced. Arriving at a mutual understanding was experienced as the turning point for applying psychoeducative strategies, such as conveying knowledge to foster psychological insight and reflections that might be supportive for the family as a whole

The category comprises the concepts "Arriving at a mutual understanding of the young adult's mental health problems" and "Arriving at a mutual understanding of collaborative family support".

Arriving at a mutual understanding of the young adult's mental health problems

The young adults struggled with their mental health challenges in a variety of ways and in a number of different life situations. Arriving at the best possible way to support them was, therefore, a core clinical aim for the mental health professionals. They described how they quite often experienced that family members only grasped the young adult's mental health struggle to a minor degree or did not fully understood the young adult's mental health problems. Moreover, family members, despite their good intentions, had quite unrealistic expectations of what the young adult was able to handle–something that might even exacerbate the young adult's feeling of helplessness, as expressed by the following quote: "Even the best intended parental engagement distresses these young adults."

The family members' sharing of their daily challenges often improved the professionals' understanding of the complexity in the family struggle. Having this information was helpful in making decisions about treatment and follow up in order to ensure the best possible care for the young adult. This was particularly important in the early stages of severe mental illness, when the young adults sometimes struggled to recognize, understand and verbalize their feelings and experiences related to the variety of signs and symptoms. In these situations, the families at times assisted the young adult to articulate and express themselves when sharing valuable information in order to arrive at a mutual understanding of what was at stake. This was expressed as: "Information the young adult doesn't share with us, like his/her strange behaviour that is not yet clear to the young adult him/herself."

Arriving at a mutual understanding of collaborative family support

The young adults' descriptions of their struggle and challenges living with mental illness in many different life situations were issues they brought to the collaborative therapeutic conversations with the mental health professionals. In order to establish a mutual understanding of optimal support, collaborative discussions on how to establish routines and introduce meaningful activities and engagement in the young adult's everyday life were experienced as important. Likewise, involving the immediate family and more distant family members in the collaborative work was a core issue in assisting them to better understand the young adult's struggle.

When sharing information about the young adult's struggle, the parents themselves also shared how they tended to feel insecure about how to initiate and perform the best supportive strategies for their son or daughter, leaving the mental health professionals somewhat puzzled as to how to arrive at optimal family support; "What kind of support do these families actually need in order to grasp their children's mental health struggle?"

At times, it also became obvious that the family members themselves were in need of supportive conversations for their own sake, especially concerning struggling and coping with relational challenges. These experiences might be expressed as follows: "How should we actually support them then, these parents?"

The participants in the study acknowledged that in reality the *family interrelated throughout the* lifespan, and that receiving support from professionals was only for a short and limited time: "A conversation with me lasts for 45 minutes, while the rest of the day and the week they operate as a family." However, collaborating with the family implied getting to know them better, and this led to improved confidence in conversations when unforeseen issues popped up: "At times, the meetings are really to clear the air, and at times there is a need for meetings where there are some 'blow outs.' However, we do manage, and are able to cope with such things."

Finally, arriving at a mutual understanding of the family's supportive needs also implied considering the strong family ties beyond the financial and relational ties, and their daily life struggle: "I see more love than I expected." In this perspective, family members' vital information about the young adult was also highlighted and valued by the participants in the study. The sharing of everyday family life stories gave the mental health professionals valuable information that was brought into the therapeutic conversations, and helped them to understand and arrive at collaborative supportive strategies.

Facing dilemmas

The participants in the study experienced that changes in their professional practice when working with family-centred ideas and extending their family concept and understanding of what might be understood as a family, could foster a variety of dilemmas and difficult choices. These dilemmas included dilemmas related to extending the family involvement as well as choosing between whether to address the

young adult individually or the family as whole, depending on what was experienced as most appropriate in the given situation. The category comprises the concepts "Facing dilemmas when implementing family-centred ideas" and "Facing dilemmas in balancing needs and offering support."

Facing dilemmas when implementing family-centred ideas

The participants in the study clearly expressed that they acknowledged the family as a whole and as a reciprocal system. They also said that understanding who was considered to belong to a family was somehow new and unfamiliar to them and they experienced this to some extent as a strange way of thinking and working with families: "It's a little hard for me to bring in an 'outsider,' and to involve persons who do not even belong to the patient's immediate family."

The participants also revealed that they actually would like to involve the family more although this was not reflected in their current practice. However, their professional inner motives and intentions for working in a more family-centred manner were present in their professional thinking and reflections, and this was expressed as follows: "Maybe we have made ourselves somehow exclusive and unapproachable. The more we welcome and appear available, the more the patients wish to involve their family members."

However, despite these reflections on the importance of involving the family, the most common treatment and follow-up of the patient still seemed to be meeting the patient individually 1 hour per week or less often. The participants revealed that they felt that involving the family as a whole was more time-consuming than the individual follow-up that represented their ordinary practice.

Facing dilemmas in balancing needs and offering support

The participants often faced situations where it was not always obvious who needed mental health support the most—the young adult or some of the family members or even the family as a whole. At times, family members who themselves struggled with mental health issues were quite unable to support their young adult. In other cases, family members' own mental health struggle might even worsen the young adult's situation. This implied that when facing dysfunctional families, it was crucial to assess and decide whether the best way to support the young adult was to assist him/her in establishing a proper psychological and/or physical distance to the parents. In some cases, close family members themselves struggled with mental health problems to a degree that they were unable to fulfill their roles as supportive grown-ups for the young adult. These experiences were typically described as follows: "Maybe a good solution for the young adult at times is to create some distance to their family. Yes, I simply think that when the family appears dysfunctional, it's appropriate to refer to another treatment".

When meeting families with high levels of conflict, the participants in the study had to balance their conversations in order to ensure that the young adult and the family members were addressed in a caring way. This was actually experienced and regarded as a balancing art. However, in these situations the participants also perceived that some of the young adults as well as their family members became more aware of their own strengths and resources. This new awareness could be applied as a new way of thinking and behaving in their domestic situation: "They have been made aware of things that haven't earlier been expressed at home."

Dealing with barriers

The participants in the study experienced that they had to deal with a complexity of barriers when trying to reach out to the young adult in need of mental health support and involve their families. These barriers limited their opportunities to facilitate optimal collaborative mental health services between the young adult and the family members. The barriers implied balancing between different strategies or just having to deal with the fact that reluctance and prejudice actually were hindrances that were impossible to overcome. This category comprised the two concepts: "Dealing with reluctance when attempting to involve the family" and "Dealing with prejudice as a barrier to reaching out".

Dealing with reluctance when attempting to involve the family

The participants dealt with young adults who were unwilling to involve their family or their parents. They experienced that the young adults at this stage of life often wanted to define themselves as independent despite living together with their family. They wanted to manage on their own and establish their own lives. Some of the young adults also expressed their reluctance to be a burden to their parents. In these cases, the health professionals revealed that the parents were not aware that their young adult actually received mental health services from the municipality. They considered that this often complicated their best intentions to invite the parents to collaborate. In order to solve these challenges, some participants had made an agreement with the young adult that a parent might participate at least for a few minutes in each conversation, since "They often only need the parents to drive them for the appointment we have." In other situations, the parents were in touch with mental health professionals just for a preliminary conversation after the young adult's first hospital stay. In such situations, the young adult's mental health problems could no longer be hidden for the parents.

The professionals also related reluctance to take part in conversations to the young adults' fear of being blamed or having feelings of guilt. Likewise, parents' refusal to participate in their young adults' treatment and care was experienced: "They are afraid of being accused of not being a good parent, and then be the cause of the son or daughter's mental health problems."

Dealing with prejudice as a barrier in reaching out

The parents and young adults struggle with prejudice and the fear of stigmatization associated with psychiatry or mental health illness. This was experienced as a barrier in the establishment of a supportive and trusting relationship, underlining the difficulty of establishing a collaborative mental health practice. According to the health professionals, just imagining themselves sitting in the waiting room and making it visible to others that they had a mental health problem was a barrier for the young adults. For young adults from non-Norwegian cultures, it was not even an option for the health professionals to get involved in their family affairs and challenges, due to the former's fear of stigmatization. Consequently, these families rather dealt with their problems alone. Regardless of cultural background, however, the participants in the study found that in some cases, family members did not want to be involved in anything that might be associated with psychiatry or mental health. In fact, just informing some parents that their young adult had a mental health problem, was considered a barrier: "Many parents will be reluctant to hear what I have to say or to take on board that their child has a mental health problem. They will have to adjust dreams and life aspirations for their child, which represents a long-lasting process of sorrow."

Fortunately, opposite experiences were also shared. The younger generation was experienced as having a more positive attitude toward receiving help from the mental health services than the older generation, as illustrated by the following: "Parents nowadays are more open and willing to seek help from mental health services than earlier generations. Maybe there is less shame attached to getting mental health assistance."

Discussion

The findings in this study offer valuable information on how mental health professionals experienced working with a family-centred care (FCC) approach in their daily clinical work. The three main categories: *Mutual understanding; Facing dilemmas; and Dealing with barriers* convey the mental health professionals' experiences. The findings illustrate in various ways how the mental health professionals perceived their practice in the frame of an FCC approach. In the following, the findings will be mirrored against the core values of FCC and relevant research. The summarized core values in FCC are Dignity and Respect, Information Sharing, and Participating and Collaboration (Falkov, 2012; Bell, 2013).

Mutual understanding

A core issue in the mental health professionals' experiences when working clinically with a FCC approach was arriving at a mutual understanding of the young adult's mental health problems and approaching the family in a collaborative way. This implies that these findings are in line with the core value—information sharing in FCC. The findings concerning arriving at a mutual understanding are also supported by findings from Hoadley, Smith, Wan, and Falkov (2017). These authors have underlined the importance of understanding the patient's symptoms and relationships, which implies daring to face the family's own difficulties when assisting them in their struggle. Our findings also illustrate how the sharing of everyday family life stories might offer valuable information in the therapeutic conversations and that these shared stories helped the professionals to understand and arrive at collaborative supportive strategies. The importance of arriving at a mutual understanding of the patient's condition when making good clinical decisions as regards patient treatment and care is also highlighted in other studies (Ewertzon, Andershed, Svensson, & Lützén, 2011; Skundberg-Kletthagen et al., 2014; Weimand et al., 2011).

In the process of arriving at a mutual understanding and maintaining dignity and respect, it is of vital importance for the mental health professional to acknowledge the family's unique perspective and to be a non-judgmental collaborator (Benzein et al., 2015).

Arriving at a mutual understanding also implied sharing information, and helping family members to gain knowledge and develop insight concerning mental health issues.The participants described how the family members felt insecure when it came to understanding and supporting their young adult, and how in some cases their lack of insight into mental illness might exacerbate his/her difficulties. These findings are supported by the conclusions reported in a systematic mixed studies review addressing the support needs of families in which there are adolescents with mental illness (Rodríguez-Meirinhos et al., 2018). These authors reported that family members were in need of reliable information about mental health conditions, possible treatments, and what resources and services might be available for them and the patient. This sharing of information is vital in order to assist and support the family members to better understand the young adult's symptoms, thereby enabling them to discriminate between normative behavior and behavior arising from the mental illness.

It is anticipated that improved FCC competence among mental health professionals might lead to positive attitudes and greater confidence when meeting the families of persons suffering from mental illness (Marshall, Bell, & Moules, 2010). The health professionals' competencies regarding working with families are found to positively influence their attitudes toward involving the family (Landeweer, Molewijk, Hem, & Pedersen, 2017).

Facing dilemmas

The mental health professionals faced various dilemmas when striving to establish and work in line with the FCC approach, especially as regards the family-centred perspectives and the balance between various needs and ways of offering support. Despite working individually, the professionals tended to adopt a mindset whereby the family was regarded as important. This concurs with the findings of

Sveinbjarnardottir, Svavarsdottir, and Saveman (2011) who found that mental health nurses who had knowledge and training in respect of working with families, regarded the families as less burdensome. This change in attitude further enabled them to think more positively about including the patient's family.

The findings further illustrate, however, how the participants in the study respected each patient's privacy and allowed them to retain their autonomy, in particular when dealing with young adults who did not want to involve or inform the family. The mental health professionals also revealed an attitude of respect toward the families and recognition of their importance. However, they considered that it was challenging to put in place a trustful relationship that showed respect for the young adults' choices if this was the opposite of what they considered to be the best possible care and treatment, for example involving the family.

At times, high family conflict levels forced the mental health professionals to balance their sharing of information in order to ensure that the young adult and the family members were addressed in a respectful and caring way. In other cases when the family attended the conversation with the young adult, the professionals experienced that the conversation facilitated by the professionals served to "clear the air" for the family members since they expressed a lot of frustration. Conversations were also helpful for the professionals in identifying family resources and strengths, which were of great importance both for the young adult and the family members. This entails that the healthcare professionals felt comfortable when facilitating sessions in which family members needed to ventilate emotions. Offering an open minded and listening attitude by bringing in an outsider's perspective, is reported to help the patient and the family members to narrate and ventilate their problems more easily (Benzein et al., 2015).

Dealing with barriers

The mental health professionals dealt with barriers related to balancing and choosing strategies when the young adult was reluctant to involve the family, and when prejudice and the patient's fear of stigmatization hindered them from reaching out to him/her. The findings clearly revealed how the family's dignity was an overall major concern for the mental health professionals and how they strived to safeguard the patient's dignity when facing prejudice and stigmatization. They also seemed to be well aware of prejudice and stigmatization as hindrances to help seeking and sharing information in therapeutic consultations. How prejudice and stigmatization may act as barriers to help seeking or delay help seeking is also well documented both on an individual and societal level (Schnyder, Panczak, Groth, & Schultze-Lutter, 2017). For this reason, the professionals actively took the lead. Showing good attitudes is reported to be important when patients may feel labeled as outsiders due to how they are treated by mental health providers (Gullslett, Kim, & Borg, 2014).

Despite an expressed desire to involve the family, this did not necessarily reflect the health professionals' clinical practice. Several barriers to involving the family members in participation and collaboration were described. Involving the whole family was for some perceived as more time-consuming, since individual follow-up of the young adult represented the ordinary practice of the participants in this study. This has been previously reported by Kim and Salyers (2008), who reported that heavy workload might be a barrier to involving the patient's family. Despite the common understanding of the importance of assessing the needs of the affected family and addressing the family as a system, the participants most often addressed the patients individually. There is good evidence to say that inviting the family to participate and collaborate is helpful for the person suffering from mental illness and may also reduce the stress burden for the other family members (Yesufu-Udechuku, Harrison, & Mayo-Wilson, 2015).

The relationship between the young adult and the mental health professionals may sometimes be fragile and should be carefully and sensitively fostered in a respectful manner, since the risk of a reluctant young adult dropping out of care if pushed to involve their family, was always there. The risk of adolescents dropping out is also reported in another Norwegian study. Here, adolescents reporting mental distress also reported a more difficult relationship with their parents, and they were less likely to seek help from their parents, friends or other adults compared to adolescents who were not mentally distressed (Moen & Hall-Lord, 2019).

Methodological considerations

Concerning the trustworthiness (Polit & Beck, 2012) of the study, the following factors were important. The sample represented a variation in terms of age, education and number of years in the mental health services. According to Dahlgren & Fallsberg, 1991, this is essential in phenomenographic studies in order to be able to capture the variation of the phenomenon. All the interviews were initiated by one main question. Moreover, the interviews were carried out by the first and last author and may have resulted in some differences in the way the informants were addressed. However, both researchers had experience of the relevant research context. The first author transcribed all the interviews and all authors were involved in the various steps of the analysis in order to reach consensus. Quotations were used to strengthen the conceptions and the descriptive categories.

Conclusion

The findings revealed that the mental health professionals' experiences of applying a family-centred care approach in their daily clinical work entailed: *Mutual understanding, Facing dilemmas*, and *Dealing with barriers.* The findings revealed that the professionals in general worked in line with the FCC values. The mental health professionals strived to adopt a respectful attitude when meeting both the young adults' difficulties and the complexity of the family challenges when working to arrive at a mutual understanding. They faced both dilemmas and barriers in their ambitions to

involve the family and address the family as a whole and as a system. Despite the expressed desire to involve the family, individual treatment and follow-up seemed to characterize their daily clinical practice, often due to the young adults' own wishes.

Recommendations for clinical practice

Based on the findings, clinical practice is challenged to work on establishing a mindset whereby the family is regarded as a resource with important skills and life experience. The clinical field should also be aware of the dilemmas and barriers when attempting to implement an FCC approach. Cultural change takes time, and good leadership that addresses cultural change is needed when implementing FCC values and family system perspectives.

The variety in the mental health challenges and life context of the young adults implies that it is important to be flexible and offer individualized support and follow-up when that is considered the best choice. Establishing a strong working and collaborative alliance with the young adult cannot be underestimated.

The findings suggest that mental health professionals should hesitate to apply fixed interventions before having assessed what families might benefit from, for example a fixed family support intervention such as FCSCI. The findings further confirm that establishing a family-centred care focus must be embedded in the working culture and context. These core working values must be fostered both in the individual mental health professional and at an institutional level in order to ensure that this unfolds as a general clinical practice.

Recommendations for further research

Researchers are challenged to initiate and perform intervention or action research studies addressing the benefits or effects of implementing a family-centred approach whilst also exploring contextual issues that can act as a facilitator of, or barrier to, success.

The findings from the present study may further inspire researchers to gain an in-depth understanding of how parents can best learn to understand their young daughter or son suffering from mental health illness and be able to offer them wholehearted support. Future studies should preferably be longitudinal and offer qualitative and quantitative evidence on how a family-centred approach may vary across a part of the life span.

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Authors' contribution

All authors contributed in study design, data analysis and manuscript preparation. The first and last author collected data. All authors have reviewed this final version and agreed upon it.

Ethical approval

Approval was given by the Data Protection Official (NSD) Ref 54962.

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