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Mental health promotion as perceived by Norwegian adolescents with somatically ill parents – an interpretative phenomenological analysis

Nina Helen Mjøsund ^a, Torill Eide^b, Elin Kufås^a, Anne Faugli^a and Grethe Eilertsen^b

^aDivision of Mental Health and Addiction, Vestre Viken Hospital Trust, Drammen, Norway; ^bUniversity of South-Eastern Norway – Campus Drammen, Drammen, Norway

ABSTRACT

Objective: Having a somatically ill parent can influence adolescents' daily lives and mental health. This study aimed to explore the lived experiences of mental health promotion among adolescents with a somatically ill parent, based on a salutogenic orientation.

Methods: Individual interviews with 11 adolescents (13–18 years of age) with a somatically ill parent were conducted. The data were analysed according to interpretative phenomenological analysis.

Results: A superordinate theme, *feeling at home in a house of mental health-promoting conversations*, frames the participants' perceptions of a prominent mental health promotion experience, including decisive characteristics of the significant conversation partners and different important conversation contexts. The metaphor of feeling at home expresses that the participants ascribe the conversations taking place there as promoting mental health. The themes elucidate the superordinate theme: (a) significant conversation partners characterised by the three subthemes: (i) being available, (ii) being competent and (iii) being caring and (b) rooms reflecting conversation contexts containing four subthemes: (i) room of increased knowledge, (ii) room of disclosure, (iii) room for meeting points and (iv) room for breaks.

Conclusion: Adolescents with a somatically ill parent perceived that conversations about important topics with significant others with special characteristics in distinct contexts promoted mental health.

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Adolescent; salutogenesis; conversations; interpretative phenomenological analysis; mental health promotion

Introduction

Health professionals' duties to support minors who are the next of kin of their patients have been enshrined in the Norwegian Health Personnel Act (Ministry of Health and Care Services, 2009). As next of kin, young people themselves express a desire to talk to health professionals (Kennedy & Lloyd-Williams, 2009), so it is

CONTACT Nina Helen Mjøsund  nina.helen.mjosund@vestreviken.no  Division of Mental Health and Addiction, Vestre Viken Hospital Trust, Drammen, NO 3004, Norway

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important for health professionals to understand how adolescents experience living with parental illness to better meet their psychological and emotional needs (Phillips, 2015). Mental health promotion, as well as the prevention of adverse developments, are important in caring for offspring. Having a parent with serious neurological disease or cancer (henceforth called a somatically ill parent (SIP)) during adolescence might represent stressors that coincide with the developmental transition to increased autonomy and towards becoming more independent. The literature has shown negative psychosocial impacts, such as distress, worry, anxiety, isolation, and poorer quality of life of adolescents living with an SIP (Walczak et al., 2018). Consequently, it is important to increase the understanding of how their resources can be supported to strengthen their mental health. To ensure and promote mental health often seems to be characterised by distinct processes from those understood as the risks for mental illness (Mjøsund & Eriksson, 2021). In the present study, we applied a salutogenic perspective on mental health (Antonovsky, 1987; Keyes, 2002) to gain insights into mental health-promoting experiences from the inside perspective of adolescents.

Adolescents living with parental illness

Adolescence might be challenging because it is the period during which individuals develop an adult identity and separate from the family, becoming more independent, which might be in conflict with daily life in living with an SIP (Giesbers et al., 2010; Jansson & Anderzen-Carlsson, 2017). Some adolescents are drawn back into home at a time that would otherwise be linked to increased autonomy and self-directedness (Phillips & Lewis, 2015). Friendships are increasingly important, and having an SIP might represent an impediment to staying with friends (Eide et al., 2020).

Research on experiences of adolescents living with somatic ill parent is recommended (Phillips & Lewis, 2015). Current knowledge is dominated by studies pointing to the negative impact of parental illness on adolescents living with parental illness (Morris et al., 2016; Walczak et al., 2018). Mental problems and the developmental adjustment problems, such as adverse emotional, behavioural, social, physical and cognitive problems and posttraumatic stress, have been reported (Faugli et al., 2021; Huang et al., 2014; Phillips & Lewis, 2015; Tozer et al., 2019).

An integrative review of the literature regarding parental cancer and families with children younger than 18 years showed that the children were exhibiting more stress and psychosocial and psychological problems, as well as identifying some coping strategies (Morris et al., 2016). In the systematic review by Walczak et al. (2018), eight studies identified positive impacts and experiences with parental cancer as being a form of posttraumatic growth for the adolescents. These studies have indicated a shift in orientation from a deficit to strengths perspective in the research, where the focus is on preventing difficulties rather than just responding to them. Phillips (2015) suggested that experiences of cancer in the family also have the potential to create opportunities for growth and well-being. Mauseth and Hjälmhult (2016) identified openness within the family and outwards to network as essential for well-being. Jørgensen et al. (2021) were inspired by the social-ecological perspective on resilience and found social support, leisure time and school experiences to be positively associated with well-being.

The identified studies all applied a risk perspective and a focus on adverse development, in addition to a focus on resilience and how to prevent adverse development and health problems. However, we were not able to find studies on mental health promotion with a salutogenic orientation on how to promote the mental health of adolescents living with parental illness.

A salutogenic orientation: the theoretical perspective of the study

The present study is based on a salutogenic perspective on mental health promotion, which embodies a resource-oriented and strength-based perspective on mental health (Mittelmark et al., 2017; Mjøsund, 2021). Salutogenesis refers to the origin of health (Antonovsky, 1979). Health is understood as a dynamic movement on an ease-dis/ease continuum (Antonovsky, 1979). Mental health promotion includes the strategies to promote, protect and restore mental health (WHO, 2022). In clinical practice, health professionals are encouraged to apply more holistic care based on knowledge from both the paradigms of salutogenesis and pathogenesis (Mjøsund & Eriksson, 2021).

Inspired by salutogenesis, Keyes ‘applies an operationalisation of mental health as a syndrome of symptoms of positive feelings and positive functioning in life’ (2002, p. 207). Mental health has been further elaborated as the presence of psychological, social and emotional well-being, a positive experience and not the absence of infirmity (Keyes, 2002). Emotional well-being includes perceptions of happiness, interest in life and satisfaction with life. Keyes (2002) used the term *flourishing* to describe high-quality mental health and noted the opposite position as *languishing*. Keyes (2016) used flourishing to be clear that he was discussing mental health, not merely about the absence of mental illness. Mental health is something to achieve and desire, a state where we are thriving, growing, and unfolding and experience vitality, energy and strength (Mjøsund, 2021).

Within Antonovsky’s (1987) salutogenic model of health, *stressors* are perceived as omnipresent in life. The core resources to counteract stressors are the *sense of coherence* (SOC) and *generalised resistant resources* (GRRs) (Antonovsky, 1987). SOC includes a tendency to perceive life as comprehensible, manageable and meaningful. The individual’s *access* to and *ability* to use GRRs, rather than the stressor itself, determines the persons’ health. A successful identification and mobilisation of GRRs might resolve the tension resulting from the stressors and a movement towards the ease end of health continuum is possible (Antonovsky, 1987). Our salutogenic orientation draws attention to the genesis of mental health in adolescents’ daily lives, as well as to identifying resistant resources and strategies to sustain, restore and enhance flourishing mental health.

In summary, studies have shown that living with an SIP might be a stressful situation for adolescents making them vulnerable to mental health problems. There is some knowledge about resilience and how to manage, despite a difficult situation with serious parental illness and prevent emotional, behavioural, social, physical and cognitive problems. However, knowledge of what and how adolescents themselves experience health-promoting activities is sparse. As far as we know, there are no studies exploring the experiences of adolescents with SIP from a salutogenic mental health promotion

approach. A salutogenic theoretical framework might help discover important phenomena in the daily lives of adolescents with SIP to improve health services and health outcomes.

Aim

Hence, the aim of the present study was to explore the lived experiences of mental health promotion among adolescents with SIP based on a salutogenic orientation.

Materials and methods

Interpretative phenomenological analysis (IPA) was applied as the methodological approach, as it, because of its phenomenological inheritance, aims to examine persons' lived experiences (Smith et al., 2009). IPA involves a combination of phenomenological and hermeneutic insights that are guided by the assumption that rather than 'pure experience', researchers access, and interpret the narratives that reflect the participants' attempt to make sense of their experiences (Smith et al., 2009). Finally, IPA is informed by an ideographical sensibility towards particular instances of lived experiences, highlighting that a detailed understanding of the lived experiences of a person has the power to bring us closer to significant aspects of the general (Smith et al., 2009). IPA is a suitable research approach when we have little knowledge of the phenomenon to be explored. To bring more power to the insider perspective, two adolescents with an SIP were actively involved in some stages of the research process (not as study participants but as research advisers). The involvement of research advisers with experiential knowledge on the phenomenon in question has been argued to enhance the quality of IPA studies (Mjøsund et al., 2017).

Recruitment and participants

Inclusion criteria for participation were (i) currently living with a somatically (cancer or neurological disorder) ill parent (SIP) and having done so for at least a year, (ii) being willing and able to elaborate on their experiences and (iii) being between 13 and 18 years of age.

Table 1. Characteristics of the participants.

Gender	Age	Ill parent	Parent's disorder
Boy	13	Father	Neurological disorder ^a
Girl	13	Father	Cancer
Boy	14	Mother	Cancer
Boy	14	Mother	Neurological disorder ^a
Girl	14	Father	Cancer
Girl	16	Mother	Neurological disorder ^a
Girl	16	Mother and father	Cancer and cancer
Boy	17	Mother	Cancer
Girl	17	Mother	Cancer
Girl	17	Mother	Cancer
Boy	18	Father	Cancer

^aNeurological disorders included multiple sclerosis, amyotrophic lateral sclerosis and cluster headache.

In line with IPA's ideographic commitment and aim of providing a detailed understanding of the perceptions of the participants, the sample was homogeneous and relatively small, as comprising five boys and six girls who had lived with parental illness in periods lasting from 1 to 16 years (i.e. since birth) (see [Table 1](#)).

The adolescent research advisers assisted our efforts in applying age-appropriate language to the information flyers that we distributed in two recruitment strategies. First, health professionals in services for cancer and neurology in three Norwegian municipalities and one hospital trust identified and informed patients who were the parent to an adolescent. Further, parents who had received both oral and written information informed their adolescents. The prospective participants or parents of prospective participants contacted one of the authors directly to arrange the interview meeting, resulting in nine participants. Second, interest organisations for persons with a somatic illnesses distributed information on the study to members and their families, resulting in two more participants.

Data generation – qualitative interviews

Data were generated through semistructured in-depth interviews, which, after the participants' decisions, were conducted in hospital offices ($N = 6$), library study rooms ($N = 4$) and in the participant's home ($N = 1$). Adolescents participated with their informed consent, and with written consent from parents.

The interview schedule was developed based on the aim of the study, earlier research, input from the adolescent research advisers and the authors' knowledge and experience from clinical work with adolescents (Eide et al., 2020). In pursuing the principles of informed participation and participation without parental pressure, the interviewer started each interview by informing about the study, volunteerism and the possibility of withdrawal. To promote open dialogues, questions were presented flexibly to facilitate the participant's story and focus of interest. The interviews lasted an average of 78 min and were audio-recorded and transcribed verbatim. Because we perceived the participants to be in a vulnerable life situation, they were offered professional follow-up approximately three days after their interviews. One participant accepted this offer and had one session with a child psychiatrist.

Data analysis

Inspired by IPA, the analysis was conducted flexibly, even though we followed the analytic focus and set of common processes described in steps by Smith et al. (2009). To safeguard the ideographic focus, we engaged in a close analytic reading of each transcribed interview (Nizza et al., 2021). The process of analysis was managed with the aid of NVIVO, version 12 (QSR International, 2018). The adolescent research advisers were encouraged to apply their experiential knowledge when reading and commenting on six anonymised transcripts. As examples, the young research advisers emphasised that participants seemed to prefer talking about their life situations within established relations and that knowledge about the illness is crucial for feeling good.

First, to become immersed in the data, we engaged in one transcribed interview. Second, initial notes on (i) descriptive, (ii) linguistic and (iii) conceptual levels were made. Third, we searched our initial notes for interrelationships, connections and

patterns to identify emergent themes in each interview. These were expressed as phrases speaking to the psychological essence and contained enough particularity to be grounded and sufficiently abstracted to be conceptual (Smith et al., 2009).

Fourth, we searched for connections across the emergent themes, resulting in subordinate themes. In step five, we moved to the next participant's transcript and repeated steps one to four, treating each interview on its own terms, to do justice to the IPA's ideographic commitment. This also means that we made an effort to bracket the ideas emerging from the analysis of the first case while working on the second one (Smith et al., 2009).

After completing steps one through five for the 11 interviews, we engaged in step six, which involved going through the individual case analyses to look for particularly resonant patterns of mental health-promoting experiences across them. One emergent pattern considered prominent was related to *some* mental health-promoting conversations. These conversations were identified in different forms in all the interviews. We then applied a repeated process of grouping, splitting, merging and naming the subordinate themes related to mental health-promoting conversations, ending up with a superordinate theme including two themes with accompanying subthemes.

Ethical considerations

The study was conducted in accordance with the Declaration of Helsinki (World Medical Association,), and approved by the Norwegian Centre for Research Data (project number 774320, January, 2021). In a submission assessment, the Regional Ethics Committee for Medical and Health Research Ethics concluded that the study fell outside the scope of the Health Research Act (The Health Research Act, 2008). The adolescents participated with their informed consent, and with written consent from parents.

Results

The exploration of the participants' lived experiences revealed that the adolescents with SIP perceived some particular conversations as promoting mental health. Anchored in the participants' narratives and through our collaborative process of analysis, we developed a metaphor of a house to illustrate the results (see [Figure 1](#)).

Superordinate theme

The superordinate theme 'Feeling at home in a house of mental health-promoting conversations' frames the participants' perceptions of a prominent mental health promotion experience, including the decisive characteristics of the significant conversation partners, as well as different important conversation topics. In the words of the house metaphor, *feeling at home* expresses that the participants ascribed the conversations taking place there as promoting mental health.

Two themes

Feeling at home in a house points to theme (a) 'characteristics of significant conversation partners' as being available, competent and caring and to theme (b) 'rooms representing

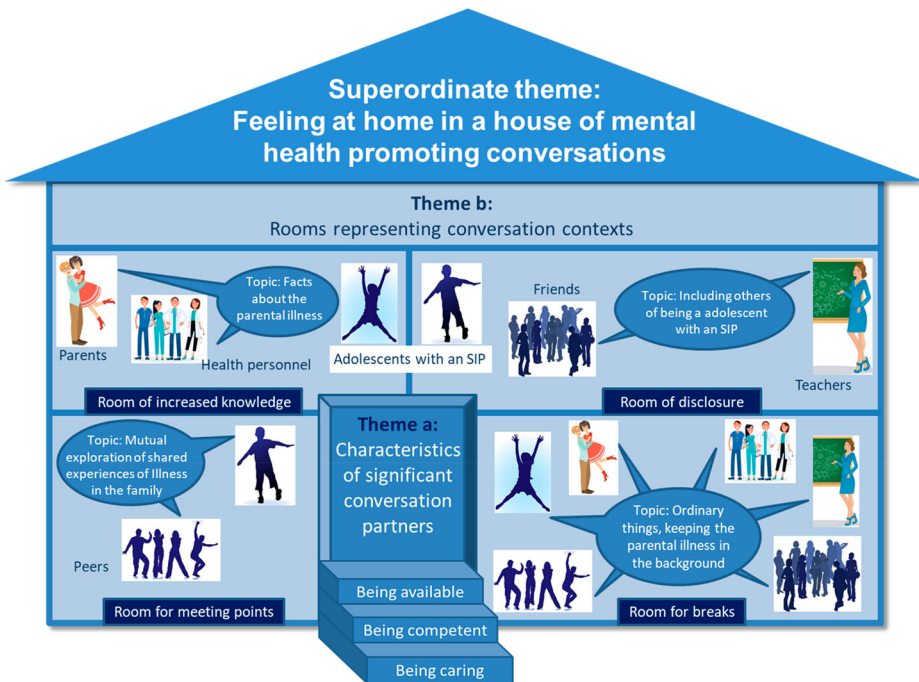


Figure 1. Superordinate theme, themes and subthemes: Feeling at home in a house of mental health-promoting conversations, included (a) characteristics of significant conversation partners, being available, competent and caring and (b) four rooms, one for increased knowledge, one for disclosure, one for meeting points and one for breaks.

conversation contexts'. In each room, significant conversation partners conversed with the participants about one of the following topics: facts about the parental illness, including others about being an adolescent with an SIP, mutual exploration of shared experiences of illness in the family, and talking about ordinary things while keeping the parental illness in the background.

Theme a) Characteristics of significant conversation partners

The metaphor of a house of mental health-promoting conversations includes an entrance for significant persons with specific characteristics (Figure 1). The participants described several persons holding important roles in their everyday lives: parents, grandparents and extended family members, teachers, coaches in leisure activities, schoolmates and friends. Being an adolescent with an SIP also leads to important meetings and dialogues with health professionals at their parents' healthcare institution, as well as the school nurse. Additionally, several of the participants talked about acquaintances they met at summer camps and weekend meetings for children and adolescents with an SIP arranged by patient interest organisations. Some participants described that long lasting friendship arose there. Former and current friends who had experiences with an SIP or an ill grandparent took on a different meaning and the participant's and the friend's common situation received increased importance. These significant others have been termed peers.

The participants described three characteristics of significant conversation partners (subthemes) that seem to be crucial for mental health-promoting conversations, as illustrated by the doorsteps in [Figure 1](#). The content of these subthemes sometimes overlap, reflecting that human experiences and conceptions are interwoven with each other.

The first subtheme (i) characterises the importance of **being available** for conversations. To be available includes *being inviting* in terms of actively and regularly and taking initiatives for conversations. A boy said, ‘My teacher, with whom I had a close relationship, he was always there, asking me how I was doing (...). I really appreciated that’. The possibility of declining invitations, either explicitly or subtly, was another aspect of availability. A girl described a friend who let her decide whether to talk about parental cancer: ‘Like others, she asks how my mother is doing. Then, if I say “She’s fine”, she says, “Okay”. Then, we talk about something else, like boys or sports’.

Being available also meant being *easy to reach*, for example, from the everyday settings of the participant. One girl preferred talking with the school nurse because it meant that conversations were ‘just something I did when I was at school, and it makes it a bit more everyday like’. In contrast, crossing the town for meetings with a health professional represented a burden to her because the trip was an indicator of her extraordinary life situation. Being available could also mean *responding positively* to conversations initiated by the participants. One boy said about his friend, He listens to what I have to say if I feel bad. Moreover, if I say, ‘I’m feeling bad today, can we do something?’ Then he answers, ‘Yes, of course’. The participant’s description of his friend’s response – immediate and affirmative – emphasised that he valued friends who responded positively to his initiative without hesitation. Another participant emphasised the importance of being available *frequently* when he spoke of the school nurse:

She was there only on Mondays. So I did not have a school nurse to talk to if I felt bad on a Wednesday. It didn’t help that she would be back next Monday because it would have passed by then.

Another nuance of being available was about *openness*. Even though the topic could be painful or challenging for both the parents and their offspring, the participants appreciated openness. Thus, the feeling of always having such access to talk openly with close family members was emphasised. One boy highlighted that, generally, his family culture of openness strengthened his feelings of safety and inclusion:

My mother’s side of the family is very open—we talk about everything. There are no secrets in the family. Everything is open. If you want to know something, you get to know it. I am very comfortable with my family.

The second subtheme (ii) characterises the significant conversation partners **being competent**. Significant conversation partners with *professional knowledge*, who had information about the situation of the participant contributed to mental health promotion by how they applied their professional knowledge to the conversation. One girl described a conversation she and her younger sister had with a nurse when she was 13 years old – a conversation that made her less nervous about their father’s forthcoming, extensive operation. Her story highlights the importance of health professionals who apply professional competence regarding relevant medical issues, as well as their ability to explain it in a realistic, yet positive, way to children and adolescents:

We spoke a lot, and she gave us small storybooks with happy endings, like ‘Dad at the hospital’. Then, she told us about the operation and explained all sorts of things that would be different after the operation. So we were well prepared.

Competent significant others are informed about an adolescent’s situation with an SIP. Another nuance of competence is to be informed and hold *holistic knowledge* about the adolescent’s family and school situation, as well as more specific information about the ill parent. This was illustrated by a school nurse, who applied her knowledge of the participant’s mother and his situation. The boy explained that his mother had problems with pronunciation because of her illness. He perceived that people incorrectly assumed that his mother also had problems understanding and that they, accordingly, would often modulate their voice, applying simplistic, childish words when speaking to her. In contrast, the school nurse at an end-of-term celebration ‘spoke to my mom like she spoke to other parents. She was herself. I really liked it’.

Peers appeared to be informed by their own experience and *experiential knowledge*, thereby recognising the needs of the participants. This knowledge promoted conversations in which the participants could focus on exploring and expressing their experiences rather than worrying about the feelings and needs of the other. The participants described how their peers expressed their competence through being calm and truly understanding. When asked how she knew that peers really understood, she answered, ‘It relates to them not being taken aback when I talked about it’. With calm, casual intonation she imitated a peer who had said, ‘Yeah, I remember’ when she spoke of the parental cancer. In contrast, she used dramatic intonation when imitating the response of a friend: ‘Oh, my God!! I don’t get how you could live with that!’ The participant summarised, ‘I prefer talking to someone who doesn’t get like, overwhelmed’.

The participants perceived that the calm intonation, as illuminated in the quotes above, contributed to connectedness. Similar experiences confirmed feelings of community and understanding. There was no need to explain issues like treatment or to verbalise feelings or thoughts of concern. One girl described a conversation with a peer:

We did not have to show compassion, in a way, because we knew that the other knew what it was like and that the other cared. So, we could just talk without worrying that we weren’t showing enough sympathy for the other.

The participants also described meeting others who were perceived as non-competent to be included in health-promoting conversations. Therefore, they did not tell everybody about their parental illness. One girl explained, ‘If everybody knew about my ill mother, I constantly would be faced with, “Are you okay?” Then, it would have affected me all the time’. Others highlighted that they avoided or delayed telling new acquaintances about their parental illness because they feared reactions like shocked outbursts, being pitied or being perceived differently than others. One girl explained why she did not inform classmates at her new school about her mother’s illness: ‘When people think about me, I don’t want their first thought to be my sick mum. Even though it’s an important part of my life, it doesn’t define me as a person’.

The third subtheme (iii) illuminated the characteristic of the significant conversation partners **being caring**. The participants described mental health-promoting conversations with significant conversation partners who were caring and supportive, in addition to knowing the situation of the adolescent with an SIP. The following quote illustrates

how the participant perceived that the nurse truly cared for her and her sister and responded to their unique needs:

She did not talk to us as if she was obligated to do so, but as if it were for *us*, like she *wanted* to help. There was no distance, like You are the children of the patient, and I am the one working here. It was as if she took extra responsibility; she made us feel really close.

When the participant was asked how she ‘knew’ that the nurse wanted to help, she said the following:

She used words that were not medical words. It was more like words that my parents would have used. She did not sit at the other side of the table; she sat next to us. She looked at the storybook with us and showed us pictures of things, like medical equipment. She used things that were a bit childish, to make it funny, kind of, and not scary.

That the nurse spoke ‘like a parent’ and that she sat down to look at the books with them was perceived as both a caring attitude and action, leaving the participant with a feeling of familiarity and inclusion, even though both the topic and setting of the conversation was unaccustomed to her.

One participant contrasted friends perceived to be preoccupied with their own feelings with a friend who facilitated a conversation in which the experiences of the participant were at the centre:

She asked me, ‘How is your father? Any news? How are you?’ She was interested and asked questions. Most of my other friends, as I understand it, are scared, too. They are afraid of saying the wrong thing or upsetting me. She was not afraid because she wanted to understand. I found that very comforting.

The quote highlights friends who were constructively curious and emotionally calm based on their understanding of the illness situation. Some of the participants made their point by describing the opposite situation: conversations that often meant mental health drainage. Including friends in their story of being an adolescent with an SIP could make some friends wrapped up in their own feelings or needs, or in assumptions of what having an SIP must be like.

The participants also described mental health promoting conversations with dedicated teachers. One boy said the following about his teacher, whom he had known for years:

When he learned about my mom, it seemed important to him to be someone that I could talk to if I wanted to. It was important for *him*, to be there for *me*. That was valuable to me.

Caring teachers adapted obligations to the individual situations of the participants. The adolescents and teachers negotiated and customised a plan, including permissions to take hours or days off or to skip or defer homework or tests. One girl explained why she appreciated this flexibility: ‘It meant a lot. It gave me the feeling that they wanted to make school as good as possible for *me*’.

Theme b) Rooms representing conversation contexts

In the words of the house metaphor, the rooms reflect those contexts in which conversations about different topics took place between the adolescents and significant others. The contexts were constituted by the persons present and the four topics (subthemes) they conversed about – who talks with whom about what. Additionally, the context

includes feelings of an atmosphere of openness and connectedness. The significant others were bringing their competence and caring attitude and affected the atmosphere in a way that facilitated health-promoting conversations.

Subtheme (i) includes **facts about parental illness** (Room of increased knowledge, as shown in [Figure 1](#)). The participants described talking with parents or health professionals in this room. They described that learning about the parental somatic illness, that is, treatment, prognosis and hospital equipment, meant mental health promotion through experiences of having information and being prepared. Next, this meant strengthened comfortable feelings, reduced painful feelings and increased ability to support the ill parent. One participant described that she felt less afraid and worried because of learning from her mother about the treatment situation:

As we knew what treatment was like, my brother and I did not think, ‘Now, there are 15 doctors standing there, staring down at our mother’s breast, trying to figure it out’. It was not like that. She went to the hospital, sat down, and then she got two fluid bags in here, in her vein. It took about 2 hours, and she was reading magazines while it happened. Then she was free to leave.

The contrast between the scary idea of numerous doctors standing, staring down at the breast without knowing what to do and the calm reality of the magazine-reading mother illustrated the extent to which her fears and worries diminished.

Another girl highlighted that, after learning about the competence of health professionals and modern treatment, she was given hope and, thereby, could support her mother. She described a cherished morning: ‘I said to my mom, “It *will* be fine. Dad *will* survive. Because we have very capable nurses and doctors today”. My mum didn’t expect me to say something like that, so it became, well, quite a touching morning’. Her voice indicated that supporting her mother made her feel proud.

Subtheme (ii) describes the action of **including others about being an adolescent with an SIP** (Room of disclosure, as shown in [Figure 1](#)). In this room, the participants talked with their teachers and friends. The participants described that they, sometimes with support from parents or health professionals, included others in their story of being an adolescent with an SIP. Mental health-promoting aspects of those conversations included experiences of being looked after because of responses from the person who was included, for example, hugs or offerings of practical support. The conversations also appeared to be experiences of relief to the participants because they meant that they could avoid potential misunderstandings, for example, regarding needs or behaviours. One boy described that including his teacher in the story of the parental cancer meant experiences both of relief and of being looked after – the conversation contributed to the replacement of sanctions by support when he had trouble concentrating. He said that including teachers was important because ‘then they would know why I was sad and didn’t pay attention. Oftentimes, you are told off and stuff for not paying attention, and then, you get even sadder. Instead, they helped me’. Being at school is an important setting for the participants; thus, awareness was paid to contextual factors to reduce stressful situations.

The third subtheme (iii) concerns the **mutual exploration of shared experiences of illness in the family** (Room for meeting points, as shown in [Figure 1](#)). In this room, the participants talked with their peers about shared and individual experiences. Some

participants highlighted that this mutual exploration of somatic illness in the family promoted belonging:

It feels really good to be with them because I feel that I can give something to them, and I get something in return. I am sharing my latest stories with them and telling them what has happened (...). Then, they give me their stories in return, of course, so that I'll know what's new for them. And if I've experienced the new things they've gone through, I can share my experiences. And if they've experienced what has just happened to me, then they can tell me about it.

The experiences of belonging are underlined by the words *give*, *get* and *share*, which indicate that the conversations were perceived more as an exchange of gifts than as an exchange of information with the participant. The participants perceived these conversations with peers as mental health promoting in terms of giving comfortable tranquillity and belonging.

The fourth subtheme (iv) elucidates the contexts in which conversing about **ordinary things, keeping the parental somatic illness in the background**, took place (Room for breaks, see [Figure 1](#)). In this room, all the significant conversation partners being available, competent and caring could talk with the participants. The participants' narratives illustrated that conversing about ordinary things and keeping the parental somatic illness in the background represented mental respites and protection from uncomfortable feelings. One boy described why he was glad his friends did not ask him about his ill mother: 'It's lovely not to have to think about it when I am with others'. Keeping the parental illness in the background enabled conversations about ordinary things, like common interests or funny incidents, which meant mental health promotion in terms of being 'recharged'. One girl highlighted how 'small things' like a compliment included in the conversation 'recharged' her because it made her happy. She elaborated on the value of compliments: 'It makes my day easier; it gives me extra energy and motivation to – well, be myself'.

The participants enthusiastically described the value of conversing about ordinary things with both parents and family members, teachers, peers and health professionals. Still, friends seemed especially important in this room. One girl highlighted that conversations with the extended family would often turn to the subject of her ill mother. Accordingly, conversations with her friend were important because, in those conversations, the maternal illness could really stay in the background. Still, she perceived that her friend recognised her challenging life situation: 'She is a friend at my own age, which means we can talk about other things. So it is like a break, while at the same time, she's aware of my situation'.

Discussion

The results have revealed several experiences that the young people described as health promoting; at the same time, it is interesting to note that these experiences were accompanied by specific characteristics of the contexts in which the experiences occurred. The adolescents described the promotion of mental health as bringing them comfort, having good feelings of connectedness, community and familiarity, being prepared and informed, being supported and having value for others, and getting more

energy and motivation. Based on the theoretical underpinnings of the present study, we interpret these expressions of views as compatible to flourishing – the pinnacle of good mental health (Keyes, 2016). The adolescents put into words what brought about their positive feelings (emotional well-being) and how to be functioning well (psychological and social well-being), which constitute flourishing (Keyes, 2002; Mjøsund, 2021). The participants' stories revealed that mental health was also promoted when they experienced reduced negative feelings, leading them to become less worried, afraid, nervous and less alone.

These mental health promotion experiences of the participants were conditioned by the superordinate theme: *feeling at home in a house of mental health-promoting conversations*. Adolescents with an SIP perceived conversations about different topics with available, competent and caring significant others taking place in different conversation contexts to be promoting mental health. The metaphor feeling at home accommodates psychological, social and emotional well-being, which is, flourishing mental health (Keyes, 2002). Seen in light of Antonovsky (1987), these conversations provided the adolescents GRRs, which might counteract stressors arising from parental illness. Then, the tendency to perceive life as comprehensible, manageable and meaningful can be strengthened and a movement towards the ease end of the mental health continuum is possible (Antonovsky, 1987).

Mental health-promoting conversations

The present study adds knowledge about the importance of conversations, not any conversations, but the active ingredients in particular conversations that can promote mental health for young people living with an SIP. The importance of open communication about parental illness has been discussed (Clemmens, 2009; Faugli et al., 2021; Finch & Gibson, 2009; Huang et al., 2014; Jørgensen et al., 2021; Kennedy & Lloyd-Williams, 2009; Kristjanson et al., 2004; Maynard et al., 2013; Phillips, 2015; Walczak et al., 2018). Noteworthy here is that the key factor in the present study was not just open communication: it was conversations about different topics of importance for the adolescents with available, competent and caring significant others.

Studies have reported that the information and support needs for adolescents with parental illness have been poorly met or these individuals do not have access to information they want (Huang et al., 2014; Kristjanson et al., 2004; Tozer et al., 2019). Poor communication and uncertainty are associated with poorer coping and worse psychosocial outcomes (Walczak et al., 2018). Improving communication within and outside the family system, here aiming to offer reflective space for adolescents, is considered beneficial (Kennedy & Lloyd-Williams, 2009; Tozer et al., 2019). Communication, as assisted by health professionals, is seen as a key element in supporting young people and is important for family well-being and adjustment (Mauseth & Hjälmhult, 2016; Morris et al., 2016).

Being available, competent and caring conversation partners

The participants' stories revealed the importance of being available, competent and caring as essential features of a conversation partner who had the potential to bring

about mental health promotion. First, inherent in being available is the responsibility to actively initiate a conversation and take the time to ascertain how the adolescent is coping. The participants appreciated the positive and frequent attention of significant others and their sensitivity to timing. This corresponds with other studies arguing for a conversation to be genuine, direct and offered a number of times at the right timing (Kristjanson et al., 2004; Maynard et al., 2013). Teens with a mother with breast cancer called for health professionals who were straightforward and ‘checking out’ their needs individually (Kristjanson et al., 2004).

Second, the participants described meeting a competent conversation partner as helping in understanding and being adequately prepared for upcoming anticipated demanding situations related to the parental illness as a mental health-promoting experience. To be prepared for treatment procedures and side effects, as well as to understand the hospital environment and medical equipment, was appreciated. As described in the studies of Giesbers et al. (2010) and Tozer et al. (2019), competent health professional conversation partners are proactive, know their information needs and have knowledge about the parental situation. Huang et al. (2014) concluded that the information should contain all aspects of the parental illness – both physical aspects and psychological reactions of both children and parents induced in the situation. In the present study, theoretical, professional and lived experiences, together with the health professional’s ability to customise the knowledge, were highlighted as valuable. This was also claimed in another study (Kennedy & Lloyd-Williams, 2009), which stated that communication involves more than the giving of factual information: it also includes support and involvement and the adaption of information in an appropriate way to age and individual situation.

Third, our results showed that, when the caring conversation partners are supportive and offer sincere empathy, this is accompanied with a health-promoting experience. We interpret this result as being strengthened by the results from a study among adolescent children of women with breast cancer that characterised caring persons as being genuine, warm and honest, followed by an understanding non-judgmental tone (Kristjanson et al., 2004). Additionally, several studies have shown that relationships marked by care, trust and support from parents, peers and other significant persons might fulfil emotional support (Huang et al., 2014; Jansson & Anderzen-Carlsson, 2017; Kristjanson et al., 2004), as well as safeguarding and regulating children’s emotions during times of adversities (Faugli et al., 2021).

In line with Antonovsky (1987), in being available, competent and caring, significant others might become a GRR to resolve and manage the tensions arising from the illness situation in the family. Within the salutogenic orientation, this means fostering coping and movement towards the ease end of the health continuum (Antonovsky, 1987), as well as bringing about positive feelings and positive functioning, which constitutes flourishing (Keyes, 2002).

The importance of peer support

The importance of parents, as well as teachers, school nurses, health professionals, friends and peers, as significant conversation partners was also confirmed in the research (Finch & Gibson, 2009; Giesbers et al., 2010; Huang et al., 2014; Kennedy & Lloyd-Williams, 2009; Kristjanson et al., 2004). Having positive relations with others is important

for mental health because it promotes psychological well-being (Keyes, 2002). Several studies have justified the importance of social networks and healthy relationships in the adjustment of young people to parental illness (Clemmens, 2009; Giesbers et al., 2010; Phillips, 2015). Seeking support have been reported as a coping strategy (Walczak et al., 2018) and is a vital element of well-being (Phillips, 2015).

We wanted to pay particular attention to the role of peers. In the present study, the adolescents described how talking with peers, someone who had experienced the same or similar situations, made them feel mentally strengthened. Talking with peers provided the possibility to mutually explore experiences and connect and gain information on how to tackle the situation in the family. Spending time together with peers also provided a sense of hope because their experiences represented other new ways of coping in the same situation. Corresponding experiences of emotional support from friends and peers have been reported in the literature (Jansson & Anderzen-Carlsson, 2017; Kristjansson et al., 2004; Maynard et al., 2013).

Additionally, the participants felt less alone and were given an opportunity for reciprocal support where they could offer and receive. Maynard et al. (2013) argued that being able to offer support back to others with parental illness might provide a sense of meaning and purpose to what they had been through.

According to Finch and Gibson (2009), the reciprocity and genuine sense of connection in peer relationships can facilitate a mental space of emotional support, reflecting and correcting, helping them feel understood. In other words, it is a way forward to promote coping and well-being. This is also consistent with Mjøsund et al. (2015), who argued that the social domain of life is one of four domains that nourished mental health. This finding is understood in light of Antonovsky's model of health (1987), in which peers seem to contain features that make them become a GRR for the participants. We assess peers as becoming a resource to counteract some of the stressors that accompany the situation with an SIP (Mittelmark et al., 2017; Mjøsund & Eriksen, 2021).

Significant conversation topics – talking about ordinary things

In the present study, experiencing moments of ordinary daily life and talking about things unrelated to their parent's illness were perceived as mental health promoting. The participants appreciated having mentally and physically breaks from the parental illness, having mental respites and shielding themselves from uncomfortable feelings promoted their mental health. This insight stresses the importance of including normal and ordinary daily life matters in conversations to promote mental health. As Maynard et al. (2013) claimed, creating normalcy is one essential coping strategy. Family members, friends and the school system might provide a sense of normalcy, offering distance and time away from the parental illness (Kristjansson et al., 2004; Maynard et al., 2013).

The participants perceived it to be good for mental health to share information and talk about parental illness; however, it was also important sometimes to keep the illness in the background. The participants' experiences were in accordance to Finch and Gibson's study (2009) that described how adolescents living with parental cancer also appreciated a sense of normality and the opportunity to detach themselves from

what was going on at home. Living as normally as possible might promote coping in times of adversity (Maynard et al., 2013), and one way to achieve this might be to preserve a shifting perspective, as thoroughly described in the shifting model of chronic illness (Paterson, 2001). The model illuminates a continually shifting process in which the illness or well-being is in the foreground in the person's daily life in different situations. The perception of mental health promotion in the present study showed that the adolescents seemed to 'charge their batteries' by maintaining some sense of normality to promote their mental health by seeking out conversations with significant others holding some essential qualities and, at the same time, being aware of supporting contexts.

Clinical implications

Health policies in the Nordic countries require all health professionals to encourage support for the children of patients with all types of illnesses (Skogøy et al., 2018; Specialized Health Services Act, 1999). Legal protection is important; however, research has shown it was only partly implemented in clinical practice (Stavnes et al., 2022). Quality improvements based on lived experiences from young people themselves are needed to inform health professionals to secure support for families with parental illnesses. The results of the present study have informed health professionals about how adolescents with an SIP's mental health can be promoted when communicating with them.

Health professionals will be in a position to facilitate family interventions that can provide parents and adolescents with a venue to communicate and process the impact of illness on their lives, as claimed by Phillips and Lewis (2015). The present study has revealed that relational and communication skills intertwined with knowledge about the psychological and developmental age of the patients' offspring are crucial in the promotion of mental health for adolescents with an SIP. Furthermore, a clinical message from the present study is to encourage adolescents to be aware of their own needs and look for friends and other significant others that promote feelings of rest, comfort and well-being.

The knowledge from the current study may contribute to an increased attention to the importance of acknowledging the significance of peers and making space and venues for conversations with other young people in the same situation. Weekend gatherings or summer camps for adolescents with an SIP, that is, arranged by patient-interest organisations, are settings that seem to have great potential for facilitating mental health promotion for young people with some common experiences.

Limitations of the study and future research

We have investigated a small number of adolescents born and raised in a Western culture. Future research should add the experiences of young people with other cultural backgrounds to be included in the knowledge base of mental health promotion for young people with an SIP. Likewise, there is a need to further investigate mental health promotion among children and adolescents with other types of parental illnesses other than somatic illnesses. There may be differences in experiences of mental health

promotion depending on a chronic or acute illness, how long the parent has been ill, whether the disease has a fatal outcome or not and different types of addiction and use of illegal drugs by the parents.

Conclusion

The experiences of adolescents living with a somatically ill parent have illuminated the mental health promotion potential in specific conversations. Significant others who were available, competent and caring participated in conversations on different topics. Some conversations with parents and health professionals provided information about the parental somatic illness, while other conversations aimed to include others, typical teachers, schoolmates and friends in the situation of living with an SIP. The participants described the benefits of sharing experiences with peers and the usefulness of talking with someone who has mutual experiences of illness in the family. Finally, conversations about ordinary things, keeping the parental illness in the background, were perceived as promoting mental health.

In the present study, the salutogenic theoretical approach to mental health promotion has nuanced the knowledge of adolescents living with somatically ill parents. What decreases the bad does not necessarily increase the good. Based on salutogenesis, mental health is seen as something positive, a condition to achieve and desire to promote and protect. The significance of conversations for the promotion of mental health was supported by the literature. Theoretical different approaches gave more similarities than differences. Translated into clinical practice, our findings validate existing knowledge and can provide an important message that specific conversations can improve mental health and protect unwanted development.

However, the present study has provided in-depth knowledge on the qualitative aspects of communication. Ideas and some recommendations are suggested for the adolescents themselves and their families, as well as with school and health professionals, peers, leisure activity leaders and other significant persons to guide their actions on an individual level. The findings might guide structural interventions in health services to enable health personnel to fulfil the intention of the law and provide knowledge on the features of mental health-promoting conversations. The findings might further inspire patient-interest organisations and other communities in promoting the mental health of adolescents with an SIP. Aiming to prevent mental problems and promote mental health seems to require similar interventions for adolescents with an SIP.

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Data availability statement

Data are not available because of ethical restrictions. Because of the nature of this research, the participants of this study did not agree that their data would be shared publicly, so supporting data are not available.

ORCID

Nina Helen Mjøsund  <http://orcid.org/0000-0001-5070-6835>

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