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Research Article

Mothering While Living With Breast Cancer: A Qualitative Study on Challenges, Needs and Interactions With Health Care

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Background: Breast cancer is the most common cancer diagnosis among women in Sweden, and 20% of cases are women younger than 50 years. For many of these women, the diagnosis occurs during a period of active parenting, when they are responsible for the emotional and practical care of young children. This dual burden, coping with a life-threatening illness while maintaining a caregiving role, can lead to increased emotional strain, altered family dynamics and challenges in communication and support. The aim of this qualitative study was to explore the parenting experiences of women with breast cancer who have minor children, focusing on challenges, needs and interactions with the healthcare services.

Methods: A self-selected sample of 131 mothers, living in Sweden, aged 25–60 years, who were diagnosed within the past five years participated. Participants were recruited via social media, patient organizations and oncology clinics. An online questionnaire was used to collect data between January and May 2023, which consisted of, among other things, sociodemographic information and an open-ended question about parenthood. The responses to the open-ended question were analysed using conventional content analysis.

Results: The analysis resulted in five categories: a significant impact on mothering and an increased emotional burden; challenges in communication within the family; a broad range of experiences of healthcare support from significantly lacking to positive experiences; the need for emotional and practical support from family, partners, relatives and school and the emotional and social impact on the children.

Conclusion: The findings highlight that there is a clear need for more accessible and structured support from the healthcare services to address the unique needs of mothers with breast cancer and their children, ensuring better communication, psychosocial care and practical assistance throughout the illness trajectory.

1. Introduction

Breast cancer is the most common cancer diagnosis among women in Sweden, with approximately 9000 new cases annually [1]. The relative 5-year survival rate has improved from 74% to 93% in recent years [2]. The median age at diagnosis is 66 years; however, approximately 20% of cases occur in women under 50 years of age [1]. This suggests that many affected women may have minor children and that advances in treatment have enabled more prolonged survival, often with ongoing disease.

A breast cancer diagnosis poses significant physical, emotional and social challenges, particularly for younger women. Definitions of 'younger women' vary across studies. Research indicates that women aged under 35 years at diagnosis face a worse prognosis compared to middle-aged women, attributed to advanced-stage diagnoses and aggressive tumour characteristics, such as triple-negative profiles requiring intensive treatment [3]. Younger women are also more likely to experience body image disturbances [4], concerns about fertility and the effects of treatment on reproductive functions, and the need for

fertility preservation counselling [5]. Chemotherapy-induced menopause, which can be temporary or permanent, occurs in up to 50% of women diagnosed before the age of 35 years, with rates increasing with age [6]. The consequences of this include vasomotor symptoms, sexual dysfunction, weight gain and psychosocial challenges, particularly for premenopausal women [7]. Younger women report greater fear of recurrence, fatigue and body image dissatisfaction compared to older women and age-matched controls without cancer [8]. These issues often persist for years postdiagnosis [9].

For women with minor children, the emotional and physical burden of breast cancer is compounded by the responsibilities of parenting. A systematic review by Tavares et al. [10] highlighted that mothers often prioritize their parenting role over their own health, sometimes delaying treatment to avoid disrupting family routines. Maintaining daily routines, such as attending their children's activities, is a common coping strategy, although this can strain their physical capacities [11]. Another systematic review [12] found that parenting concerns are associated with increased risks of depression, anxiety and stress. Previous research suggests that cancer patients with minor children experience higher levels of psychological distress compared to those without caregiving responsibilities [13]. The same study reported that fathers with minor children may exhibit higher levels of anxiety than mothers in similar situations, whereas mothers tend to report more depressive symptoms [13]. These gendered patterns of distress point to the complexity of parenting while navigating serious illness. Although the present study focuses specifically on mothers, the literature underscores that both mothers and fathers experience heightened psychological vulnerability when they have dependent children, though the expression and type of distress may differ. Among mothers, this vulnerability may be influenced by emotional and societal expectations related to caregiving and mothering. Guilt and shame are commonly reported when they are unable to meet their children's needs due to illness or treatment. Many mothers must also adapt to a new parenting role in which family members or external support takes over some of the daily responsibilities [14].

Effective communication about the illness between parents and children is vital but challenging. Parents often struggle with deciding how much information to share, and when and how to express it, aiming to minimize stress for their children [15]. Parents receiving palliative care face additional barriers to discussing their prognosis with their children, often requiring detailed information from healthcare professionals in order to feel prepared for such conversations [16]. Some parents avoid talking about the illness due to denial or a belief that children will not understand, while others prioritize open communication to prevent misunderstandings. Open and honest communication fosters trust, reduces feelings of isolation and strengthens family cohesion [15]. Children who are better prepared for a parent's death experience less guilt, anxiety and hostility during grief than those who are unprepared [17]. Previous research found that while most children had been informed about their parent's illness, many still expressed a need for more information and opportunities to discuss their feelings [18]. From the children's perspective, inadequate communication about a parent's illness increases their risk of anxiety and depression [19]. Dysfunctional family systems with poor communication and low emotional engagement exacerbate behavioural and emotional problems in children [20]. Studies indicate that children often sense their parent's illness through observations of medical treatments and physical changes. If they do not receive sufficient information, they may develop fears, such as feeling responsible for the illness or worrying that they might also become ill [21].

In Sweden, the Health and Medical Services Act stipulates that healthcare professionals must consider children's needs for information, advice and support when a parent or other cohabiting adult is seriously ill [22]. Healthcare professionals are responsible for addressing parenting concerns and involving children in the care process. However, understanding mothers' experiences of their interaction with the healthcare services and their challenges in parenting is essential for identifying gaps and improving support services. Research suggests that although both mothers and healthcare professionals see the value of supporting communication with children, their views on what kind of support is needed often diverge. Mothers tend to ask for clear, practical and accessible guidance, whereas healthcare staff may focus more on general emotional support [23]. This highlights the need for better alignment between families' expressed needs and the support provided. Effective interventions require insights into what has worked well and areas where improvements are needed. Mothers have expressed a need for support in various aspects of parenting during illness, including how to talk to their children about the diagnosis and how to respond to their emotional reactions and questions. In addition, preferences have been voiced regarding the format and content of support, such as group-based interventions, flexible scheduling and access to online or individual psychological support, highlighting the importance of tailoring interventions to fit families' everyday realities [24].

However, previous research often adopts a general parenting lens without fully considering the gendered and relational aspects of *mothering* in the context of serious illness. This study is grounded in a social constructionist approach [25], where *mothering* is viewed not as a fixed biological role but as a dynamic and relational practice shaped by cultural expectations, healthcare structures and everyday interactions [26]. Within this framework, the experience of illness is not only a disruption of health but also a disruption of one's social identity as a mother [10, 27]. This perspective allows for a more nuanced understanding of how mothers interpret, negotiate and sometimes resist societal ideals of caregiving and strength while facing vulnerability. Moreover, while some studies highlight the importance of family-centred care, few have examined how mothers perceive the support they receive from healthcare professionals in relation to their parenting role. There is a need for research that centres mothers' own voices and perspectives, especially in healthcare systems where children's needs are

legally mandated to be considered when a parent is seriously ill.

This study aimed, therefore, to explore the parenting experiences of women with breast cancer who have minor children, focusing on their challenges, needs and interactions with the healthcare services.

2. Methods

2.1. Design. The study forms part of a larger cross-sectional investigation aimed at examining psychological stress, relational dynamics and parenting after a cancer diagnosis. For this specific study, an explorative and inductive design was used following the Consolidated Criteria for Reporting Qualitative Research Checklist (COREQ) [28].

2.2. Data Collection and Participants. Participants were recruited through self-selection. An open invitation to participate in the study was distributed between January 25 and 31 May 2023, via social media platforms and by patient organizations and oncology clinics in Sweden. Women who met the inclusion criteria and were interested in participating accessed the survey through a link and gave informed consent before completing the online survey. The survey was hosted on Uppsala University's survey tool REDCap [29, 30] and was accessible via the project's website (https://connectedprojektet.com), where information about the study and the research team was also available. The survey consisted of questions regarding sociodemographic information (e.g., educational background, employment status, family information, details of cancer diagnosis), anxiety (GAD-7), depression (PHQ-9), post-traumatic stress (PCL-5) and psychological distress (DASS) (this will be presented in other papers). The survey also included three free-text questions regarding parenting, relationship with partner and mental health. Of these three questions, the one used for this study was: '*Is there anything more you would like to share about your parenting experience in relation to your cancer diagnosis?*'. Before this question, four close-ended study-specific questions regarding support to the mother and her child/ren were asked (see Table 1).

The inclusion criteria for this study were participants who defined themselves as women, were aged between 25 and 60 years, had been diagnosed with breast cancer within the past five years, and had at least one child under the age of 18 years. Of the 406 individuals who completed the online survey, 388 were women. Of these, 131 met the criteria for this study of having been diagnosed with breast cancer within the past five years and having answered the open-ended question about parenting in the context of their illness, which constituted the primary data source.

2.3. Ethical Statement. The study was approved by the Swedish Ethical Review Authority (Registration number 2022-03088-01). Participants signed informed consent in REDCap before starting the survey.

2.4. Data Analysis. Sociodemographic data were analysed using descriptive statistics with SPSS statistical software (IBM SPSS Statistics for Macintosh, Version 28.0. Armonk, NY: IBM Corp) by two of the authors (AW; MA). Free-text responses were analysed using conventional content analysis [31], which allows for the inclusion of all participant data without being constrained by pre-existing knowledge or frameworks. The main analysis was carried out by two of the authors (MA; RE), and the process began with an initial reading of the data to gain an overall understanding of the content. The text was then reviewed word by word to identify key concepts relevant to the research question. These concepts were condensed into meaning units and the meaning units then formed the initial codes. The generated codes were reviewed and grouped into subcategories based on thematic similarities. Subcategories were subsequently analysed to identify patterns, similarities and differences and were then aggregated into broader main categories. Each main category represents a central theme recurring across the subcategories it encompasses. After completing the initial coding, the data were re-examined to confirm that the codes accurately represented the original text and to identify any aspects that had been overlooked. To enhance the validity of the findings, representative quotes from participants were included in the results to substantiate the categories and subcategories.

Although sociodemographic information was collected in the survey and four questions regarding support to the mother and her child were asked, the present study focuses on the narrative data provided in response to the open-ended parenting question. The background variables were not included in a broader qualitative analysis.

3. Results

3.1. Sample Characteristics. A total of 131 mothers with breast cancer who had minor children participated. Their mean age was 45.6 years. About half of the mothers had two children (52.7%), followed by one child (21.4%), and three children (19.1%). Most mothers (69.5%) had more than 3 years of university education and worked full-time (57.3%). One-third (31.3%) were on sick leave. Most mothers (77.9%) were in a couple relationship. About one-third of the mothers (33.6%) had been diagnosed less than a year prior to inclusion, just under half (44.3%) between one and 2 years prior, and a fifth (22.1%) between three and 5 years prior. Most were still undergoing treatment (68.7%), and a small proportion had incurable cancer (12.2%). A history of mental health problems was reported by more than one-third of the mothers (40.5%). Of the 94 mothers who reported needing support, almost half (45.7%) had been offered help, and half (48.9%) had actively sought support on their own. As for the children, in more than a third of the cases (41.2%) the healthcare services had offered, or partially offered, support for the children, according to their mother (for more information, see Table 1).

Table 1: Characteristics of the mothers, their illness, family and support.

	Number (*n*)	Percentage (%)
Age		
< 40	21	16.0
40–50	82	62.6
> 50	28	21.4
Mean, SD	45.6	6.1
Time since diagnosis		
< 1 year	44	33.6
1–2 years	58	44.3
≥ 3 years	29	22.1
Mean, SD	1.4	1.3
Cancer status		
Incurable		
Yes	16	12.2
No	115	87.8
Completed treatment		
Yes	41	31.3
No	90	68.7
Civil status		
In a couple relationship	102	77.9
Single mother	29	22.1
Occupation		
Working full-time	75	57.3
Working part-time	27	20.6
Parental leave	1	0.8
Sick leave	41	31.3
Educational level		
Secondary school	13	9.9
University education < 3 years	18	13.7
University education > 3 years	91	69.5
Other education	9	6.9
Numbers of children		
1	28	21.4
2	69	52.7
3	25	19.1
4	6	4.6
5	2	1.5
Missing	1	0.8
Mean, SD	2.2	1.0
Age of the youngest child Mean, SD	10.2	4.8
Need for support as a mother		
Yes	61	46.6
Partly	33	25.2
No	37	28.2
Offered support by healthcare services		
Yes	17	18.1
Partly	26	27.7
No	51	38.9
Missing	37	28.2
Mothers seeking support on their own		
Yes	46	48.9
No	48	51.1
Missing	37	28.2
Children offered support by healthcare services		
Yes	32	24.4
Partly	22	16.8
No	77	58.8
History of mental health problems, mothers		
Yes	53	40.5
No	78	59.5

3.2. Mothering While Living With Breast Cancer. The analysis resulted in five categories: (1) impact on mothering and emotional burden, (2) challenges and strategies in family communication, (3) varied experiences of healthcare support, (4) emotional and practical support from family, partners, relatives and school, and (5) children's varying responses to their mother's illness.

3.2.1. Impact on Mothering and Emotional Burden. A frequently recurring theme was the intense emotional challenges the illness evoked in mothers. These emotions included fear of death and cancer recurrence, as well as anxiety, grief and worry about their children's future in the event of death. This concern was particularly pronounced when the father was absent. One mother wrote '*You are so terribly afraid of dying, not for your own sake, but because of what will happen to the children if I'm no longer there*' (49 yrs, child aged 16). Many mothers reported feelings of guilt, perceiving that they had, in some way, ruined their children's childhood. They felt that the illness had deprived their children of a secure and stable childhood, forcing them instead to accompany their mother on a challenging and demanding journey through her illness. Feelings of failure were also common, with mothers feeling defeated by the fact that they had been diagnosed with breast cancer while caring for minor children, as one mother wrote '*It's hard having an 18-month-old when you can barely cope with the illness. You felt like you were a bad parent for not having the energy to play or pick up from preschool,* for example' (32 yrs, child aged 4).

The illness, and in some cases the treatment, was described as an energy-draining process. Many mothers reported feeling physically and mentally fatigued, which affected their ability to meet their children's emotional and practical needs, as one mother described: '*I've been tired because of the treatment and I felt like a failed parent. The treatment has taken away so many parts of my identity and one of them is my role as a mother, which I was unable to take on during much of the chemotherapy. It was a huge sadness for me*' (36 yrs, children aged 2 & 17). According to the mothers, sensitivity to infections during treatment and other side effects further contributed to diminished energy levels. One mother shared that her children had to move to their father's home because of her poorly condition. Another explained how she had to prioritize caring for her younger child because she lacked the energy to care for both children simultaneously, meaning the older child received less attention.

3.2.2. Challenges and Strategies in Family Communication. Communication emerged as an important aspect impacting mothers' experiences of parenting. Some families had adopted a strategy of open communication, where parents honestly shared information about the illness and its current status, encouraging family members to discuss and ask questions. One mother stated that she chose to inform her children about the risks of cancer spreading in order to prepare them for a potentially worse outcome. This approach allowed the family to be pleased when the healthcare professionals gave them better news than what the family had talked about and prepared themselves for: '*My husband and I have been open with our children about what has happened, what is happening, and what will happen due to my cancer. We don't want them to create their own version of reality, so we've encouraged them to share everything they feel from day one. All questions and emotions are okay*' (40 yrs, children aged 9, 10, 13 & 16).

At the same time, many mothers described difficulties in communicating appropriately with their children. These challenges were partly due to the child's age, as the mothers struggled to convey such serious information in a way that a young child could understand. In addition, it was difficult to determine how much information the children needed, especially when the illness had reached an advanced stage, as one mother described: '*It's hard to explain to a 5-year-old why mum is losing her hair, is sick,* etc.*, in a way that they can understand*' (48 yrs, children aged 5 & 17). As a result, some mothers chose to hide their emotions or condition to avoid worrying their children. Some mothers had required, or expressed a clear need for, support from healthcare professionals in order to feel better equipped to talk with their children and handle their reactions: '*I wish there had been information and advice on how children might react and how best to respond, what to say and what not to say*' (48 yrs, child aged 16).

3.2.3. Varied Experiences of Healthcare Support. Many mothers reported a need for various forms of support from healthcare professionals, such as someone who could talk to their children, support for their partner and psychological help for themselves as sick parents. At the same time, many mothers shared positive experiences where they had received help for themselves and their children. These were, for example, that their children had been involved during the course of the illness, that they themselves had received psychosocial support when needed, and that both they and their partner were provided with written material or referred to digital resources to guide them in their conversations with their children about the illness. This support was appreciated and deemed sufficient. Some mothers found it easy to access proper support when they requested it, as one mother wrote '*I really appreciated that the healthcare staff involved my children in the process. The children were able to visit the hospital and attend chemotherapy and radiation treatments, and we even received children's books about breast cancer. I felt that the healthcare staff were very positive about the children being involved and that they treated them with incredible care!*' (38 yrs, children aged 3 & 8).

At the same time, some mothers were critical because their role as parents had not received sufficient attention during interactions with healthcare professionals. They pointed out that this topic—parenting—should have been addressed at an early stage during the illness. Some described how they had not received person-centred care and felt that they were treated in just the same way as much older women without young children. One mother wrote '*There was an almost comical inability from the healthcare staff to address*

this. During my first appointment, I remember filling out a questionnaire about whether I had children and if I was worried about their future. The doctor then commented that I 'seemed like someone who wanted to talk about everything', and that was the only time parenting was ever brought up during my years in oncology care' (49 yrs, child aged 18).

Some mothers also described how difficult it was for a sick mother to seek and obtain the help needed for both herself and her children. Support was not offered automatically or as part of standard routines, so the mother became responsible for reaching out to various services and requesting help herself. This was an overwhelming task, particularly for someone who was sick and exhausted. Some reported that, despite their requests, their children did not receive any support: '*I wish there had been some kind of guideline about 'this is how we involve children', a recommendation, or perhaps a standard option for the children to accompany a parent to a treatment session. I felt lost with regard to knowing how much to share with my child and how to involve them'* (42 yrs, child aged 11). Others described how they only received brochures with general information about parenting, materials they considered to be insufficient. The mothers felt that, on their own, they could not provide their children with the sense of security they needed when they themselves were so unwell and afraid. Suggestions from mothers included having a children's representative (Swe: *Barnombud*) available at the oncology units or receiving concrete information giving advice and tips about how to involve children during treatment, and others suggested family counselling sessions. Some mothers also experienced that the availability of support varied depending on where in Sweden they lived.

3.2.4. Emotional and Practical Support From Family, Partners, Relatives and School. In many of the responses, the partner was identified as an important source of support, contributing to the family's ability to function despite the impact of the illness. One mother described: '*I have a supportive husband; without him, it would have been much harder to manage parenting*' (51 yrs, child aged 16). Many also described being dependent on help and support, primarily with practical matters, from family members or close relatives who stepped in to assist: '*I get a lot of help from my parents,*for example*, with dropping off and picking up at preschool [. . .] my mother-in-law is also helpful*' (32 yrs, children aged 3 & 4). Some mothers also described the positive effects of the illness, where both the mother and the children became closer to each other, and the children provided emotional support to the mother during her illness. One response included this reflection about the children: '*. . .like a shield, helping me pull myself together, think ahead, find meaning, love, joy, and take care of myself*' (53 yrs, child aged 18).

Single mothers, which was about one-fifth of the participants in the study, described how being a single mother with breast cancer was particularly burdensome, especially without a partner or relatives nearby to provide support, one mother wrote '*You feel very alone as a cancer patient, especially as a single parent. In reality, only my child has truly seen how unwell I've been, while I tried to keep my spirits up. I didn't want to show it, but my child still understood*' (49 yrs, child aged 14).

In some responses, the children's schools were mentioned. School staff had been involved and active in many cases. In one instance, it was school staff who informed the children about their mother's illness. Many mothers mentioned that school nurses and counsellors had played a role in identifying the children's emotional well-being and providing them with psychosocial support. One mother explained: '*The school supported my daughter incredibly well, and that was very touching!*' (38 yrs, child aged 10). At the same time, there were calls for more engagement and assistance from schools. This included providing more support to the families, although the mothers reported that the school staff did not always have time for this. Some mothers wished that the school staff had offered more active guidance about accessing other resources to support their children, as one mother described: '*The school gave me phone numbers for healthcare services and names of various initiatives, but you still need to have the energy to call and figure out what is the right kind of help. I didn't manage to do that'* (49 yrs, children aged 6 & 9).

3.2.5. Children's Varying Responses to Their Mother's Illness. The prominence of the children's experiences in the mothers' responses was particularly notable. Many of the mothers described how their children had been negatively affected, both socially and mentally. Socially, some children had been bullied by other children because of their mother's cancer. Others had been prevented from socializing with friends during their mother's cancer treatment due to the high risk of infections, as one mother wrote '*Due to concerns about infections when my immune system was severely weakened by the treatments, we kept both children home from school. It went well, but it probably wasn't much fun for them not being able to see their friends'* (54 yrs, child aged 17). Mothers also described that mentally, many children had been affected in the form of changed behaviour, increased isolation and mental health struggles, with some mothers reporting that these effects only became apparent long after the onset of the mother's illness. In a few cases, it was mentioned that the diagnosis had triggered fear in the children, particularly if they had previously encountered cancer or death within the family or their social network. One mother described the experience as follows: '*Last autumn, my daughter started asking if I could die. She catastrophizes and went through a period of compulsive thoughts, believing she had developed serious illnesses herself*' (40 yrs, child aged 9).

Some mothers described that various forms of support and interventions could have prevented the negative consequences for their children. Several suggested that their children would have felt less alone if they had been able to meet other children who had parents with cancer or had been offered someone to talk to regarding the illness: '*I would have liked the healthcare service to offer family*

meetings or child support. I think the children need to talk about all their worries with an independent person' (51 yrs, children aged 16, 16 & 18). A few responses also noted that the COVID-19 pandemic had meant limited opportunities for children to meet other families or accompany their mothers to hospital visits.

At the same time, some mothers reported that their children had coped relatively well and were not significantly affected by the situation. In many of these cases, this was attributed to the mother's illness being less severe. This could have been, for example, because the mother managed her treatment without severe side effects, allowing her to remain more present in her children's daily lives. Alternatively, it could have been because she received hopeful news, such as that her cancer was curable, which created a sense of security for the children, who believed their mother would recover. One mother wrote '*I managed the treatments relatively well, which made our daughter calmer. Maybe even a bit too calm at times since she didn't always consider what I could or couldn't handle'* (49 yrs, children aged 14 & 16).

4. Discussion

This study explored the parenting experiences of mothers with breast cancer during their illness trajectory. The findings show that the disease challenges parenting in several ways, describing a significant impact on mothering and an increased emotional burden, challenges in communication within the family, a broad range of experiences regarding healthcare support, from significantly lacking to positive experiences, the need for emotional and practical support from family, partners, relatives and school, and the emotional and social impact on the children.

The findings of this study underscore how the mother's dual role as a parent and a patient can create feelings of inadequacy and guilt, aligning with previous research on parenting and serious illness, where parents struggled to balance the illness and their parenting role [32, 33]. Previous mental health issues, reported by 41% of mothers in this study, may have amplified the expression of complex and negative emotions. The results indicated a need for psychological support for mothers with breast cancer. Psychosocial interventions, including psychoeducation, have been evaluated and shown positive effects. Parents with cancer who participated in interventions involving psychoeducation, skill-building and communication strategies reported reduced worry about the impact of the illness on their children and increased confidence in balancing their parenting role with the demands of their illness [34].

This study also highlighted the significant impact interactions with healthcare services have on the mothers' parenting experiences. Some received good guidance and support, while others found the support from healthcare services to be insufficient. The need for support from healthcare professionals is evident in previous research [15]; however, this need is not always met, as also shown in this study. The topic of parenting is often avoided or overlooked by healthcare professionals, with parents reporting that it was only addressed if they initiated the discussion. Some mothers had to explicitly request support or raise the topic of parenting during their interactions with healthcare professionals. This has also been found in previous research, showing that healthcare staff rarely proactively inquire about parenting [35]. Mothers may feel that they do not receive person-centred care, as their specific needs are not acknowledged, exacerbating feelings of loneliness and helplessness [10]. A study by Franklin et al. [36] on healthcare professionals' experiences revealed that time constraints, heavy workloads and lack of competence—feeling that they lack the right tools—contribute to avoiding discussions about parenting. However, healthcare professionals have a legal responsibility under Swedish healthcare law [22] to address parenting and include children, which was not always the case in this study. The findings therefore indicate gaps in meeting these responsibilities. This study serves, therefore, as a reminder of this responsibility and emphasizes the potential for healthcare staff to do more to support mothers with breast cancer.

The uncertainty about whether to talk about the illness and create an open dialogue or to avoid the topic to prevent potential stress can be a struggle for some parents, as seen in the results of this study, which aligns well with previous research [17, 23]. Previously reported barriers to communication include the child's age and cognitive development, with parents sometimes choosing to talk more about the illness and give more information if the child is older and presumed to have a better understanding of illness and death [10, 17]. This is consistent with this study, where some mothers reported difficulty knowing how to talk to young children who were considered to lack an understanding of the illness and the family situation as a whole. Parents sometimes choose to withhold certain details or delay information to avoid causing the children stress, with some opting not to inform them until the illness becomes palliative [15]. The varying approaches to communication in this study could be due to the inclusion of mothers having different medical statuses, ranging from those in remission to those receiving palliative care. The disease stage may significantly influence the difficulty of discussing the illness. Advanced and incurable stages of breast cancer may make communication more emotional compared to when the illness is treatable. On the other hand, this may not always be the case, since palliative care can often provide more psychosocial support for mothers. Evaluated interventions which aim to facilitate family communication have been examined in Sweden within palliative home care [37] where the results have shown these to be helpful based on parents' and children's experiences and needs [38–40]. Offering mothers, and families, such support is especially important, since less than half of the mothers in this study had been offered support by healthcare professionals. Routinely incorporating evaluated interventions that facilitate communication within oncology care settings could be one way to support mothers in their parenting.

While this study focused on the mothers, they frequently mentioned their children in their responses which suggests a mutual relationship between the well-being of the parent and the child. Many mothers reported that the illness had

negatively affected their children. The significant impact of a parent's cancer on children has been explored in previous studies [41, 42]. Behavioural changes, such as children becoming withdrawn and isolating themselves, are described as ways of coping with the difficult situation of having an ill parent [17]. This aligns with the findings in this study, where mothers described how children reacted with fear and signs of distress, and that their social lives were affected. At the same time, the findings also raise concerns about potential role reversals, where children may take on emotional responsibilities beyond their developmental capacity. While closer relationships can provide support, they may also place unintended pressure on the child to act as a source of strength or comfort for the parent. Previous research has described this phenomenon as 'parentification', which can impact children's psychological well-being over time [43]. Such dynamics underline the importance of offering children external psychosocial support, so they are not left to manage their concerns or their parent's emotional needs on their own. Furthermore, this study captured the perspectives of parents, not the children themselves. This means that the findings may not fully reflect the children's own experiences. A Swedish study on children and adolescents who had lost a parent to cancer showed that parental proxy assessments of their child's psychological health differed from the children's self-reports, with children rating their own health worse than their parents did [44]. To better understand the children's experiences and draw more reliable conclusions, future studies should include the children's voices.

4.1. Strengths and Limitations. This study has some limitations that must be taken into account when interpreting the results. One is that the one question this study is built around was part of a longer, demanding survey that included numerous questions and instruments. This may explain why some responses were brief and lacked nuance. Another limitation is the requirement of the participants in the survey to have language skills in Swedish. Consequently, mothers who did not speak Swedish were not reached, also reflected in the sociodemographics of the sample, which show a homogenous population with a majority of highly educated mothers participating. Furthermore, most mothers were in partnered relationships, which means that the perspectives of single mothers are underrepresented in this study, indicating that further studies should focus on this group. There was also a low representation of mothers with incurable cancer, which may be because lower disease burden creates a greater motivation to participate. It is also likely that parenting experiences differ depending on the child's age and developmental stage. However, as investigating this was not the aim of the study and would have required a different study design and analytical approach, for example mixed methods, we did not group responses based on the age of the children. Still, the wide age span (0–18 years) in the sample suggests that the findings reflect a broad range of parenting challenges. Future studies may benefit from explicitly examining how experiences differ between parents of younger versus older children. This study exclusively explored mothers with breast cancer who have minor children, so the findings are not intended to be transferable to all parents with cancer. The results may also vary in countries with family structures and functioning, and healthcare services that differ from those in Sweden. The study included mothers who had various treatment statuses and illness trajectories over the past 5 years. This variation could influence their physical and psychological state, with differing needs and experiences depending on their medical condition. On the other hand, this diversity is a strength, as it offers broader representation. Another strength is that the study includes a Swedish population with mothers from multiple regions of the country, providing results that may better capture the voices of this group compared to research limited to one particular area of Sweden.

While the findings largely confirm what has been shown in previous studies, this also strengthens it across time and international contexts. The results reinforce that mothers with breast cancer continue to experience emotional strain, communication challenges and insufficient support in health care, despite documented knowledge of these issues in earlier research. The study thereby highlights a persistent gap between what is known, and what is acted upon. Conducting confirmatory qualitative research remains important in drawing attention to patterns that are not unique to specific contexts, but rather reflect common aspects of mothering through illness, regardless of the country or healthcare systems.

5. Conclusion

Mothers with breast cancer face significant emotional and practical challenges in balancing their own health needs with their role as a mother. Adequate support from family, healthcare professionals and social networks is crucial for both the mothers and their children. There is a clear need for more accessible and structured support to address the needs of mothers with breast cancer and their children, ensuring better communication, psychosocial care and practical assistance throughout the illness trajectory.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

Conflicts of Interest

The authors declare no conflicts of interest.

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