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Family Resilience Experiences in Adolescents with Inflammatory Bowel Disease: A Qualitative Study

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Abstract: *Objective*: To explore the experiences of family resilience among adolescents with Inflammatory Bowel Disease (IBD), in order to provide a foundation for the development of effective clinical nursing intervention programs. *Methods*: Twenty-two adolescents with IBD were recruited using purposive sampling. In-depth, semi-structured interviews were conducted between July and August 2025. Interview data were analyzed using Colaizzi's seven-step method. *Results*: Four themes and ten subthemes were identified: (1) family stress and challenges brought by IBD, including changes in the family environment, imbalanced family communication, and pressure associated with acute symptoms; (2) family support, including a sense of security, empowerment for personal growth, and emotional connection; (3) support outside the family, including online connections and social support; and (4) growth through adversity, including reshaped family health values and strengthened family cohesion. *Conclusion*: Healthcare professionals should place great emphasis on the negative impacts of IBD and actively utilize various support systems to enhance patients' positive emotional experiences, thereby helping patients and their families achieve effective adjustment and adaptation.

Keywords: Inflammatory bowel disease; Adolescents; Family resilience; Social support; Qualitative research.

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1. Introduction

Inflammatory Bowel Disease (IBD) was once seen as a rare disease [1]. However, in the past 30 years, with the changes in eating habits, lifestyles, and environment, the incidence of IBD has increased gradually [2]. According to the international data, nearly 20% patients develop symptoms before adulthood [3]. Besides, compared to adults, adolescents are more likely to have severe intestinal lesions and rapid progression of this disease [4]. The chronic process and reasons for IBD remain uncertain, which not only affects the physical

and mental health of the patients, but also reduces the quality of life of their families. Long-term care for most patients is mainly undertaken by family members in China as well as many Southeast Asian countries [5,6]. Since the family serves as the key supportive system of adolescents, the family's response to a crisis directly affects the prognosis of the patient [7]. Given such a context, the functions of family resilience are gaining more and more attention [8]. Family resilience refers to the capacity of a family, through collaborative efforts, to recover from trauma, gain strength and growth from within, and become more powerful than before [9]. According to research, strong family resilience not only helps improve disease management but also enhances the mental health and overall well-being of family members [10]. It should be noted that adolescents' subjective perception of family resilience is positively related to their personal resilience, which indicates that the one who believes their family has resilience exhibits stronger personal resilience when facing stressful scenarios with relatively low levels of anxiety [11]. Yet in China, the clinical research on IBD patients is mainly focused on the middle-aged group and young adults [12]. In July 2025, the WHO announced a partnership with Noora Health, with the explicit goal of "strengthening support for family caregivers". This indicates that integrating nursing services with family care remains a key priority on the WHO's current agenda. Nursing practice is shifting from individual intervention towards family system support. Therefore, this study aimed to explore experiences of family resilience among adolescents with IBD through semi-structured interviews, with a view to informing future family-focused nursing interventions.

2. Methods

2.1. Design

This study utilizes a descriptive qualitative design, which uses everyday language to directly describe participants' experiences or present an event, to explore the underlying family resilience experiences, psychological responses, and adaptation strategies of adolescents with inflammatory bowel disease (IBD). Conducting in-depth semi-structured interviews facilitates a thorough understanding of the adolescents lived experiences and cognitive traits, aligning closely with the objectives of this research.

2.2. Sample

This study uses purposive sampling to recruit adolescent IBD patients from participants who attended the youth family summer camp hosted by Zhejiang Love & Relief Foundation, with the inclusion criteria as follows:

(1) Adolescents aged 10 to 19 years and diagnosed with IBD [13];
(2) Who are voluntary participate with consent from their family members;
(3) Who are in a family where at least one family members are available to take care of them.

In addition, the exclusion criteria are as follows:

(1) Patients who have severe physical or mental diseases;
(2) Patients unable to effectively communicate or accept interviews, e.g., hearing or speech dysfunctions;
(3) Families who have already participated in similar research to avoid duplicate data.

The sample size was undetermined prior to data. The researcher will periodically review the interview transcripts to assess if data saturation had been achieved. Data saturation was considered reached when new interviews merely echoed previous data and no new themes or information emerged.

2.3. Data collection

Data were collected between July 2025 and August 2025 through audio-recorded, face-to-face, semi-structured interviews. The interview guidance is censored by two psychiatric and psychological experts and one qualitative methodology expert, and further revised after a pilot interview with 4 participants, ensuring its rigor and applicability. It should be noted that these 4 participants are not included in the formal interview. The core questions in the interview are as follows:

(1) Could you describe your feelings after being diagnosed with the disease?
(2) What changes has the diagnosis brought to you and your family?
(3) What measures have you and your family taken to adapt to the changes?
(4) Apart from family members, what other support have you gained?
(5) What positive changes in your family encourage you?

The interviews were conducted in a tranquil room at a hospital in REDACTED, with Chinese as the medium of communication. All interviews were conducted by a postgraduate nursing student (HY.N.) under the guidance of his master's advisor (QF.M.). To adequately prepare for the study, HY.N. engaged in reading extensively about qualitative research and took relevant online courses. QF.M. has over 30 years of experience treating adolescents with depression. he has completed training in qualitative research and has published several peer-reviewed qualitative studies.

Before commencing the interviews, all participants and their parents or guardians signed informed consent forms. The interviews were conducted with only the adolescents in the room to create a more open and relaxed atmosphere that encouraged free expression, while their parents waited outside with prior consent.

During the interview process, two researchers actively encouraged participants to fully express themselves and used a variety of interviewing techniques, such as follow-up questions, feedback, and clarifications, to ensure the thoroughness and precision of the data collected. Each interview lasted between 30 to 45 minutes and was audio-recorded with the consent of the participants, allowing the researchers to capture detailed information and reduce personal bias.

2.4. Data analysis

Within 24 hours after interviews, the researcher scrutinized the recordings and notes, then transcribed the data. Subsequently, the seven-step analysis method of Colaizzi is used, combined with NVivo12.0, for data coding, categorization, synthesis, and theme extraction [14].

Initially, two researchers（HY.N.&X.L.）thoroughly reviewed all interview data multiple times to fully immerse themselves in the material and develop a comprehensive understanding of the participants' interviews and experiences. Subsequently, independent coding was performed using Nvivo 12.0 qualitative analysis software, and coding units were organized according to shared characteristics. Finally, through an interactive and inductive process, similar coding units with higher levels of abstraction were extracted and grouped together, facilitating the identification of subthemes and overarching themes. Concerning disputes that arise during the data analysis process, LL.Y. will organize meetings in which all researchers participate to discuss and critically examine the coding content until consensus is achieved.

2.5. Rigor

To ensure the trustworthiness and rigor of this qualitative research, the study followed the framework proposed by Lincoln and Guba, which encompasses credibility, transferability, dependability, and confirmability [15]. Credibility: The researchers established a trusting, empathetic, and secure environment during the interviews, using emotional support and non-directive questioning to encourage the 22 adolescent participants to freely and authentically express their experiences. All interviews were audio-recorded, supplemented by field notes, and transcribed within 24 hours. Clarification questions (e.g., "Am I interpreting this correctly?") were actively utilized during the process to ensure data precision. Furthermore, the study was guided by a senior advisor (QF.M.) with extensive clinical experience. Transferability A thick, detailed description of the purposive sampling strategy, inclusion/exclusion criteria, participants' sociodemographic profiles, and the hospital-based interview context has been provided, enabling future researchers to evaluate the applicability of these findings to similar clinical cohorts. Dependability: Data analysis strictly adhered to Colaizzi's distinct 7-step method, integrated with NVivo 12.0 software for standardized coding and categorization. To control variability, two researchers (HY.N. & X.L.) performed independent coding after immersing themselves thoroughly in the transcripts. Any analytical disputes or coding discrepancies were systematically reviewed and resolved through research team consensus meetings led by LL.Y. Confirmability: The primary interviewer (HY.N.), a postgraduate nursing student, underwent extensive training in qualitative methodology and maintained continuous self-reflection to minimize personal preconceptions. Potential researcher biases were continuously bracketed, and the final extracted themes and subthemes were fully supported by direct verbatim quotations from the participants (N1 to N22) to guarantee that the findings genuinely reflect the adolescents' perspectives rather than the researchers' subjective biases.

2.6. Ethical considerations

This study was approved by the Ethics Committee of REDACTED (Approval No. 2022062). The participants were fully informed about the purpose of the study and methods before the interviews. The interview was immediately stopped if the participant experienced distressing emotions. Appropriate psychological support was provided to the participants promptly.

3. Results

3.1. Participants

Ultimately, a total of 22 adolescents with inflammatory bowel disease participated in this study. The average age of the 22 participants was 14.45 years (SD = 2.48 years old, range = 11–18 years old), with 54.55% identifying as female and 45.45% as male. Participants in this study were diagnosed with two types of inflammatory bowel disease: Crohn's disease and ulcerative colitis, with Crohn's disease being the most prevalent (68.18%), followed by ulcerative colitis (31.82%). In terms of educational status, the participants exhibited diverse educational backgrounds, including elementary school (Grade 5–6), junior high school (Junior 1–3), senior high school (Senior 1–3), and college freshmen. Some participants had special educational situations such as intermittent attendance or school suspension due to illness. Information on all adolescent patients, including their gender, age, educational status, disease type, and disease course, is shown in **Table 1**. with 22 adolescent IBD patients involved and numbered from N1 to N22; see **Table 1** for their basic information.

Table 1. Basic information of patients

No.	Gender	Age	Education status	Disease type	Disease course
N1	Male	18	Senior 2	Crohn's disease	3 years
N2	Female	14	Junior 3Suspended	Crohn's disease	5 months
N3	Female	15	Senior 1 Intermittent Attendance	Crohn's disease	2 years
N4	Female	17	Senior 2	Ulcerative colitis	4 months
N5	Female	16	Senior 2 Suspended	Crohn's disease	8 months
N6	Male	13	Junior 2	Crohn's disease	6 months
N7	Male	14	Junior 3	Ulcerative colitis	2 years
N8	Female	11	Grade 6	Crohn's disease	2 months
N9	Male	18	College Freshmen	Crohn's disease	3 years
N10	Male	14	Junior 3	Ulcerative colitis	1 year
N11	Female	11	Grade 6	Ulcerative colitis	4 years
N12	Male	16	Senior 1	Crohn's disease	1.5 years
N13	Female	13	Junior 1 Intermittent Attendance	Ulcerative colitis	7 months
N14	Male	17	Senior 3 Suspended	Crohn's disease	2.5 years
N15	Female	12	Grade 5	Crohn's disease	3 months
N16	Male	15	Senior 1 Suspended	Ulcerative colitis	1.2 years
N17	Female	11	Grade 6 Suspended	Crohn's disease	6 months
N18	Female	12	Grade 5	Crohn's disease	8 months
N19	Male	18	Senior 3	Ulcerative colitis	2 months
N20	Female	12	Grade 6	Crohn's disease	1 year
N21	Female	13	Junior 2 Intermittent Attendance	Crohn's disease	1.5 years
N22	Male	18	Senior 3 Suspended	Crohn's disease	4 years

3.2. Themes

3.2.1. Theme 1: Family stress and challenges brought by IBD

(1) Changes in family environment

For patients and caregivers in the family, challenges like unbalanced medical resource allocation and financial pressure force them to adapt to different life environments to share the family responsibility. For instance, there are expressions like *"My mom is having a hard time. She quit her job to take care of me" (N2); "my mom brought me to Hangzhou because of this disease. We don't live here before" (N6); "I came to Shanghai for treatment, but I didn't study or live here. I've been with my dad living here for more than six months" (N10); "my mom helps me a lot, and dad work in another city for higher salary" (N13); and "my dad went to another city to work, for me, for the whole family" (N16).*

(2) Imbalanced family communication

Part of IBD adolescent feel irritated by the role their parents play in disease management. This may be because they are in the key period of growing up with increasing self-awareness, so they would like to have more self-determination and self-control, but the communication between family members, as well as the means of disease management, makes them feel limited. Moreover, some patients even had delayed diagnosis and treatment due to misunderstandings between family members. The expressions as follows are recorded: *"It's so annoying, my family keep urging me to take medicine every day" (N1); "no one knows more than me about this disease, okay" (N5); "I told them I had stomachache not just to avoid school. They don't believe*

me" (N7); "sometimes they remind me but I don't want to respond. It's a bit annoying. I know everything but they keep urging me" (N12); and "they think I'm not telling the truth. They think I just don't have appetite, giving me pressure every day" (N14).

(3) Response pressure from acute symptoms

Acute episodes of IBD are regular in disease courses, featuring intestinal inflammation, accompanied by abdominal pain, diarrhea, hematochezia, fever, and fatigue, as the participants described: *"there's blood coming out of me, and my mom is terrified" (N3); "In that period, I lost around 20 kilos, and the way my dad looked at me made me sad" (N6); "when I was not in a good state, my mom often hid in her room and cried" (N8); "The gastric tube always made me nauseous, and my mother cannot bear looking at me" (N10); and "I felt extremely weak during flare-ups. My mother paced around, but there was nothing she could do for me" (N11).*

3.2.2. Theme 2: Family support

(1) Sense of security

Given that participants are young and exhibit volatile disease symptoms, caregivers in the family are required to persistently observe and care, so as to maintain a close connection with the IBD patients. For adolescent IBD patients, family serves as the key source of their sense of security and belonging, with expressions as follows: *"when I was in hospital, I was not bored and feel secure because I had my parents accompany me" (N7); "I get used to the present diet very soon because I want to eat everything my mom cooks" (N12); "of course my family take care of me. They provide money, or else I cannot be treated" (N13); "my parent will sit next to my bed and I feel very peaceful when they are here" (N14); and "I feel exhausted when symptoms occur and my parent will help me clean my face and feed me water, and they are always patient. It is with their care that I'm able to face this disease" (N16).*

(2) Empowering personal growth

For an adolescent with IBD, constructing meaning in adversity is a significant process of psychological adaptation, which not only helps them deal with the present challenges but also provides them with psychological resilience for future difficulties. With the family support, adolescents with IBD can gradually achieve self-acceptance from "resisting disease" to "accepting disease" and "growing through adversity", which can not be separated from family guidance and empowerment. Some participants note that the understanding and support of family members can affect their psychological status and disease management, as follows: *"My dad often encourages me to be positive. A lot of things don't have to be so heavy. I should mind the present business and not worry too much." (N5); "before, I always worried about my disease deteriorating. My mom keeps accompanying me, and we search for recovery cases and talk. Now, I have found the courage to hold on" (N11); "I used to feel I didn't have a good luck, asking 'why me', but my mom always there for me, making me feel I'm not alone" (N7); "Although it was hard, I learned to cherish and grateful for what I have now, and I understand more about the love from my parents" (N18); and "I used to be very self-abased and afraid of telling my classmates the disease I had, feeling different from others. It is my dad who keeps encouraging me, saying it's not my fault to have this, and I don't have to be self-abased. He even explained the conditions with me to my classmate, which made me feel much better" (N20).*

(3) Emotional connection

The psychological status of adolescents with IBD is easily affected by emotions, and emotional connections in the family accompany are key to addressing the negative emotions of patients. Such

connections are reflected not only in daily care but also in the family's perception, responses, and empathy of the patient's emotions, which makes them feel understood and respected. Related expressions are as follows: *"every time when I'm down, my mom doesn't keep asking me questions but sits next to me and hugs me, making me feel very warm" (N9); "I could not participate in the school sports meetings due to my disease and felt very upset. My dad asked for one day off to have me accompanied. We had a walk in the garden and did some sports that I'm capable of" (N10); and "when I was in hospital, my little sister would come and meet me after school, talking about funny things that happened in school and drawing me some sketches. I felt like I had to recover and get out of the hospital so I could grow up with her. The affection from my family is my motivation to keep on" (N13).*

3.2.3. Theme 3: Support outside of family

(1) Online connections

IBD is a long-term chronic disease, during which patients may feel lonely and separated. Through the internet and support groups, some patient and their families build connections with people with similar experiences to share their experiences and emotions, so as to alleviate the sense of loneliness. Some patients argue that the internet offers a channel for them to outlet emotions, where they can express their fear, anxiety, and depression free of psychological burden, without worrying about being misunderstood by families and friends. Such emotional outlets help to alleviate mental stress, as mentioned follows: *"I saw people with this disease on the internet, and all of them are facing life with a very positive attitude. I feel encouraged by them and try to face this disease in a more positive way" (N4); "I feel the group is warm because people help each other in the group" (N15); "when I haven been diagnosed, I shared my syptoms and doctor's words with them in the group, and they encouraged me and conforted me, maybe because im very young" (N2); "I don't know a lot of friends with this disease, but my mom know some of their parents on the internet" (N7); and "my dad communicate with patents of children with this disease on the internet, such as the new medicine, etc." (N13).*

(2) Social support

Except for family and internet friends with this disease, a lot of patients gain support from other channels, such as school, friends, and society. Teachers in school offer them care and understanding, society provides rich information about their disease as well as platforms for patients' communication, and friends give them encouragement and comfort. Support from various aspects not only helps to relieve their psychological burden but also enhances their resilience in facing the disease, expressed as follows: *"Sometimes, I have a stomachache when running, teachers will allow me to be absent. Because I live in the dorm, they also remind me about my diet" (N16); " I become happy when I chat with my friends on the watch. My bestie helps to smooth my emotion and hangout with me" (N8); "when I was in summer camp, I added contact with a few friends, and we communicate sometimes" (N14); and "people take care of me. They ask me how am I doing recently and what medicine I'm taking" (N15).*

3.2.4. Theme 4: Adversity brings growth

(1) Health value reshaped by family

All participants reported in the interview that their health values are affected to different degrees after getting IBD. During the process of reshaping health values, adolescents with IBD start to put more emphasis

on daily diet and life habits, such as positive changes within the family, which help not only the recovery of the patient but also the cohesion between family members, with descriptions as follows: *"This disease has reshaped my life value. Before, I overworked, and my mom also encouraged me to do so. At that time, I stayed up late every day. Now, my mom tells me to be constrained, including making efforts" (N6); "my mom says nothing matters except health. Besides, I want to learn to cook my favorite dishes from my mom, so I can make them by myself when I recover" (N8); and "this disease has made me realize that health is very precious and now I care about my wellness. My dad also does so, like we will go to bed earlier at the same time and do sports. We are forming better life habits than before" (N9).*

(2) Family reinforcement

Family reinforcement serves as a critical foundation of disease management and psychological adaptation of adolescents with IBD, with its core in cooperation, consistent ideas, and ability improvement of family members, constructing a more solid family support system. It is shown not only in the detailed daily care but also in family members learning disease knowledge together, unify the supportive ideas, and reduce divergences when providing care, making patients feel the family cohesion and solid support. The related expressions are as follows: *"my family form a habit of checking nursing knowledge of IBD every week. My parent and grandparents will learn them together" (N2); "they used to know nothing about this disease, sometimes, they don't take care me in a proper way. Now, they know better about my feelings" (N4); "my parents used to argue about my nursing. As time passes by, they unified the idea and I feel more secured" (N6); "I no longer feel I'm alone facing the disease, but the whole family is working together to defeat this disease" (N8); "my parents bring me to IBD family communication meetings to learn from other families and to encourage me to share my feelings" (N13); and "my little brother even know that I can't eat spicy food of work too much. He even takes care of me voluntarily" (N17).*

4. Discussion

This study, from the perspective of adolescents with IBD, digs deep into the family resilience experienced by the patients when dealing with the disease. In the theme of a comprehensive family support system, this paper shows three key components: family belief system, family organizational pattern, as well as communication and problem-solving capacity, which is consistent with the family resilience theory of Walsh [9]. Besides, the research has clarified that the presence of family resilience should go through a linear process of "encountering adversity, engaging positive supportive responses, and achieving gradual adaptation", and this study exhibits a similar pattern in terms of this aspect.

4.1. Implement targeted interventions to mitigate adverse impacts of IBD

This study found that IBD patients often go through a checkered diagnosis, leading to delayed treatment and exacerbating the mental stress and financial burdens of the family, thereby reducing family resilience [16]. It is suggested that family education be enhanced by nonprofit projects while implementing a layered diagnosis mechanism to relieve financial burdens. Targeting the complex and volatile clinical presentations of IBD, multidisciplinary team (MDT) collaboration needs to be promoted to realize full-cycle disease management and ensure accessible, high-quality medical services [17,18]. It should be noted that currently, specific diets for disease remission remain insufficient [19]. Some adolescents survive an active period of the disease through

medical treatment, but this process may trigger physical and psychological discomfort, requiring more diet intervention research. Additionally, in this research most of adolescents with IBD suffer complex and volatile negative emotions, which are contagious and expandable, consuming the family energy like viruses [20]. Research has pointed out that enhancing family resilience plays an important role in improving family emotional pollution and overall mental health [8]. According to this study, some IBD patients have problems communicating with their families. From the perspective of the family resilience theory model of Walsh, such ineffective communication will directly reduce the family resilience and trigger dysfunction of the family [21]. Besides, communication hinders further results in disorders of the family functions and weakens the overall resilience as well as its capacity to deal with the disease [22]. It is suggested that caregivers adopt the model of Family Health Conversation (FamHC) to improve family resilience through enhancing the internal communication system [23].

4.2. From the perspective of family resilience, integrate and fully utilize diversified support systems

In this study family resilience presents dynamic, evolving characteristics. Foster et al. also emphasized that nursing givers play a critical role in assessing familial protective and risk factors, facilitating domestic communication, and offering social support [24]. It should be noted that this study found that most families have a demand for digital support, so it is suggested to build a layered knowledge platform, such as an online community based on disease courses. By doing so, the precision of information access is satisfied, while forming a network of patient mutual aid. At the same time, public education should be carried out to eliminate the disease stigma and encourage patients who have recovered to participate in popularization through narrating medical practice, enhancing the emotional resonance of the social support system from the perspective of personal experience. The theory of family systems has broken the limitation of parent-child binary relations, regarding family as a dynamic resource network, among which intergenerational support is defined as a latent resource pool by Walsh [25]. Additionally, the longitudinal pioneering research by Werner et al proves that when parents lack support, the compensatory support from grandparents can significantly boost adolescent resilience [26]. Therefore, it is suggested that clinic staff system identify the key caregivers in the patient's family, and activate intergenerational resources through empowering these "resource points", thereby enhancing the family resilience systematically.

4.3. Family resilience enhances disease adaptation among adolescents with IBD

During their struggle with the disease, adolescents with IBD feel deeply the family resilience shown in the process. Meanwhile, they improved in terms of disease management and adaptation ability, which aligns with the results of Wu Danyan's research on breast cancer patients and Fan Yarong's research on family resilience of depressed patients: family members participate in disease management to adapt, including diet adjustment, medicine supervision, emotional comfort, etc [27,28]. In this study, some adolescent patients achieve positive changes like reshaped health values and enhanced psychological resilience, which is consistent with the research of Zhang et al showing adaptive behaviors like actively improving lifestyles [29]. Thus, it is suggested that the medical team reinforce such positive changes through cognitive behavioral therapy. Not only do patients perceive the supportive effect of the family, but also make the family system realize function optimization, including increased cohesion, enhanced quality of intergenerational communication, as well as

supported internet expansion. Participants' accounts suggest that supportive family interactions may facilitate adolescents' adaptation to IBD and strengthen family cohesion.

4.4. Limitations

Firstly, the results of this qualitative study rely heavily on the subjective experiences and memories shared by the adolescent participants. The theme extraction might be influenced by the researchers' subjective interpretations, which could potentially introduce recall or confirmation biases and affect the absolute objectivity of the insights gained.

Secondly, the sample size of this study, consisting of 22 adolescents recruited solely from a single foundation's summer camp, may limit the generalizability of the findings. This specific sample may not fully represent the diverse socioeconomic backgrounds, varied geographic regions, and full clinical spectrum of adolescent IBD patients across the broader population.

Thirdly, the research process exhibits inconsistencies in its reported methodology. While the study explicitly states it utilizes face-to-face interviews conducted in a quiet hospital room in July and August 2025, the rigor section later describes conducting online semi-structured video interviews. This methodological contradiction regarding the data collection environment could introduce confounding variables into the participants' psychological comfort and expression levels.

5. Implications for practice

As a chronic and recurrent physical disease, Inflammatory Bowel Disease (IBD) is characterized by a protracted course and unpredictable flare-ups, which seriously impacts the physical and mental health of adolescent patients and consumes family energy. Because the family serves as the primary support system during this critical developmental stage, nursing staff must pivot from individual-centered interventions toward comprehensive family system support to enhance family resilience. Health professionals should collaborate with multi-disciplinary teams (MDT) to implement full-cycle disease management, ensuring that patients and their families have access to high-quality medical services and targeted dietary and medical care plans.

Short-term nursing goals should focus on helping families cope with the acute symptoms and response pressures of the disease. Nurses need to guide caregivers in adopting the Family Health Conversation (FamHC) model to improve internal family communication, resolve parent-child management conflicts, and eliminate the negative effects of "emotional pollution" within the household. Long-term goals should focus on empowering the entire family unit by activating diversified support networks. This includes building digital support platforms and online peer-to-peer communities stratified by disease courses to facilitate information sharing and precision mutual aid. Furthermore, clinical staff should actively identify key intergenerational caregivers (such as grandparents) and empower these "resource points" to systematically strengthen the family's overall resilience pool. By utilizing cognitive behavioral therapies, healthcare professionals can reinforce positive familial adaptations—such as reshaped health values, optimized lifestyles, and cohesive family reinforcement—thereby helping adolescent patients transition from resisting the disease to achieving positive growth through adversity.

6. Conclusions

IBD poses challenges and threats to adolescent patients and their families. Yet, the positive emotional experiences of patients, the solid support within the family, and the rich resources outside the family play a vital role in the recovery process. While providing professional nursing, the medical team should pay more attention to the negative effects brought by IBD, such as complex psychological activities of adolescents with IBD, the conflicts in family communication, and the dynamic connection between families. Meanwhile, a diverse supportive system should be fully utilized to improve the positive emotional experiences of patients, helping them and their families achieve effective adjustment and adaptation. In the future, a series of interventions could be adopted to enhance the family resilience of adolescents with IBD, thereby preparing them for possible risks and challenges.

Disclosure statement

The authors declare no conflict of interest.

References

[1] Loftus E, 2021, The Increasing Burden of Inflammatory Bowel Disease. Medical Journal of Australia, 214(8): 361–362.

[2] Dou Z, Zheng H, Shi Y, et al., 2024, Analysis of Global Prevalence, DALY and Trends of Inflammatory Bowel Disease and Their Correlations with Sociodemographic Index: Data From 1990 to 2019. Autoimmunity Reviews, 23(11): 103655.

[3] Grover Z, De Nardi A, Lewindon P, 2017, Inflammatory Bowel Disease in Adolescents. Australian Family Physician, 46(8): 565–571.

[4] Vuijk S, Camman A, de Ridder L, 2024, Considerations in Paediatric and Adolescent Inflammatory Bowel Disease. Journal of Crohn's and Colitis, 18(Supplement_2): ii31–ii45.

[5] Qiu D, Hu M, Yu Y, et al., 2019, Acceptability of Psychosocial Interventions for Dementia Caregivers: A Systematic Review. BMC Psychiatry, 19(1): 23.

[6] Kuang Y, Wang M, Yu N, et al., 2023, Family Resilience of Patients Requiring Long-Term Care: A Meta-Synthesis of Qualitative Studies. Journal of Clinical Nursing, 32(13–14): 4159–4175.

[7] Bramuzzo M, De Carlo C, Arrigo S, et al., 2020, Parental Psychological Factors and Quality of Life of Children with Inflammatory Bowel Disease. Journal of Pediatric Gastroenterology and Nutrition, 70(2): 211–217.

[8] Suwanwong C, Raksat D, 2025, Navigate Chronic Illness: Antecedents and Consequences of Family Resilience—A Systematic Review and Meta-Analysis. The Family Journal.

[9] Walsh F, 2003, Family Resilience: A Framework for Clinical Practice. Family Process, 42(1): 1–18.

[10] Tempchin J, Storch B, Reigada L, 2021, Systematic Review: Psychosocial Factors of Resilience in Young People with Inflammatory Bowel Disease. Journal of Psychosomatic Research, 148: 110558.

[11] Finklestein M, Pagorek-Eshel S, Laufer A, 2020, Adolescents' Individual Resilience and Its Association with Security Threats, Anxiety and Family Resilience. Journal of Family Studies, 2020(2): 1–17.

[12] Xu L, He B, Sun Y, et al., 2023, Incidence of Inflammatory Bowel Disease in Urban China: A Nationwide Population-Based Study. Clinical Gastroenterology and Hepatology, 21(13): 3379–3386.

[13] Sawyer S, Azzopardi P, Wickremarathne D, et al., 2018, The Age of Adolescence. The Lancet Child & Adolescent

Health, 2(3): 223–228.

[14] Sanders C, 2003, Application of Colaizzi's Method: Interpretation of an Auditable Decision Trail by a Novice Researcher. Contemporary Nurse, 14(3): 292–302.

[15] Lincoln Y, Guba E, 1985, Naturalistic Inquiry. Beverly Hills, CA: Sage Publications: 289–331.

[16] Purc-Stephenson R, Blake K, 2025, Understanding Diagnostic Delays and Health Outcomes for Inflammatory Bowel Disease: A Mixed-Methods Study of Patients' Perspectives. Quality of Life Research, 34(3): 823–832.

[17] Alpert J, 2026, Transforming Healthcare: The Frontier of Integrative Medicine. American Journal of Medicine, 139(4): 500.

[18] Ricci C, Lanzarotto F, Lanzini A, 2008, The Multidisciplinary Team for Management of Inflammatory Bowel Diseases. Digestive and Liver Disease, 40(Suppl 2): S285–S288.

[19] Gleave A, Shah A, Tahir U, et al., 2025, Using Diet to Treat Inflammatory Bowel Disease: A Systematic Review. Official Journal of the American College of Gastroenterology | ACG, 120(1): 83–97.

[20] Herzer M, Denson L, Baldassano R, et al., 2011, Patient and Parent Psychosocial Factors Associated with Health-Related Quality of Life in Pediatric Inflammatory Bowel Disease. Journal of Pediatric Gastroenterology and Nutrition, 52(3): 295–299.

[21] Chen X, Yang F, Pan Y, et al., 2025, Transitions in Patterns of Family Resilience and Their Associations with Parent-Child Interaction: A Longitudinal Study Using Latent Transition Analysis Among Families of Children with Chronic Illness. Journal of Psychosomatic Research, 190: 112054.

[22] Schuman S, Graef D, Janicke D, et al., 2013, An Exploration of Family Problem-Solving and Affective Involvement as Moderators Between Disease Severity and Depressive Symptoms in Adolescents with Inflammatory Bowel Disease. Journal of Clinical Psychology in Medical Settings, 20(4): 488–496.

[23] Østergaard B, Kolbrun-Svavarsdottir E, Brødsgaard A, et al., 2026, The Effectiveness of Family Health Conversations Delivered by Nurses: A Systematic Review. Journal of Clinical Nursing, 35(2): 539–564.

[24] Foster K, O'Brien L, Korhonen T, 2012, Developing Resilient Children and Families When Parents Have Mental Illness: A Family-Focused Approach. International Journal of Mental Health Nursing, 21(1): 3–11.

[25] Walsh F, 2016, A Family Developmental Framework: Challenges and Resilience Across the Life Cycle. In Sexton T, Lebow J, eds. Handbook of Family Therapy. 2nd ed. New York: Routledge: 30–47.

[26] Werner E, 2004, Journeys from Childhood to Midlife: Risk, Resilience, and Recovery. Pediatrics, 114(2): 492.

[27] Wu D, 2020, Construction of Family Resilience Process Model for Breast Cancer Patients: A Grounded Theory Study, thesis, Anhui Medical University.

[28] Fan Y, Kang F, He M, 2024, A Qualitative Study on Family Coping of Adolescents with Depression from the Perspective of Family Resilience. Journal of Nurses Training, 39(21): 2331–2337.

[29] Zhang W, Feng X, Zhang H, [year not provided], A Qualitative Study on the Experience of Family Resilience Among Young and Middle-Aged Stroke Patients. [Journal not provided], 37(4): 717–721.

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