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RESEARCH

Resilience in people with severe mental illness and cancer, a qualitative study

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Abstract

Purpose The purpose of this study was to explore the lived experiences of people with severe mental illness (SMI) who are also diagnosed with cancer. The research sought to understand the lived experiences of this population, focusing on physical and mental health comorbidity.

Methods This research was underpinned by a relativist ontological stance and a constructivist epistemological position and adopted a constructivist grounded theory methodology. Research was undertaken in England and data were generated through 11 in-depth one-to-one interviews with people with lived experience of SMI and cancer. Grounded theory methods of initial, focused, and theoretical coding were adopted alongside constant comparative methods and memoing.

Results Several interrelated categories describe participants' experiences of coping with SMI and cancer. This paper focuses on one of the four categories—resilience. Resilience was derived as a main category, highlighting that people with a pre-existing SMI draw on existing strategies when diagnosed with cancer. Through this mechanism, participants' previous experiences of living with SMI shaped the way in which resilience was enacted when receiving a cancer diagnosis. Resilience was expressed through four interrelated processes: deploying known strategies, self-advocacy, finding positives, and reimagining future me. Findings resonate with existing evidence on resilience, while also offering new insights in the context of SMI and cancer.

Conclusions People living with SMI draw on established, prior strategies for resilience to support coping when diagnosed with cancer. These findings suggest that supportive care for people with SMI and cancer may benefit from taking an asset-based, personalised approach to support enactment of their existing strategies for resilience. Recognising and supporting existing strategies for resilience may improve coping and experiences of care in this population.

Keywords Cancer · Comorbidity · Coping · Oncology · Resilience · Severe mental illness

Background

Comorbidity refers to the co-occurrence of more than one illness or disease in any one person simultaneously, compared to multimorbidity in which two or more conditions coexist [1]. Alongside increasing cancer incidence, there is growing incidence of people living with co- and multimorbidity. Research indicates that worldwide, about one third of adults experience multimorbidity, increasing to more than half among those with chronic health conditions [2] this can lead to interacting symptoms and treatments for multiple long-term conditions, resulting in greater disease and care needs [3].

Cancer is one of the most significant global health challenges, presenting a significant disease burden with close to 20 million new cases of cancer in the year 2022 [4], with projections indicating that global cancer incidence is set to increase to 35 million by 2050. This growing burden of cancer should also be considered in the context of the growing burden of mental health illness. People living with severe mental illness (SMI) experience physical health inequalities and have a life expectancy 15–20 years shorter than the general population, a gap that is widening as overall

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health improvements outpace those among individuals with SMI [5–7]. People with SMI experience higher incidence of physical illness, influenced by factors such as modifiable lifestyle risks, medication-related weight gain and drug interactions, the impact of mental illness itself, fragmented care, and inequities in access to health services [8–10]. Globally, cancer, cardiovascular disease, liver disease, and respiratory disease account for a large proportion of deaths among people with SMI, highlighting the urgent need to better understand and address the impact of physical health comorbidity in this population [11].

These disparities in physical health outcomes highlight the need to better understand how people living with SMI experience physical health conditions such as cancer. A recent systematic review identified how people with SMI and cancer encounter daily life [12], difficulties were identified in navigating services for mental health and oncology, variation in decision-making capacity assessment, conflicting parity between mental and physical health in terms of care prioritisation, and reliance on informal support networks [12]. Additional qualitative studies [13, 14] have highlighted the complexity of comorbid mental illness and cancer, identifying similar challenges of fragmented service provision, and deterioration of mental illness due to a cancer diagnosis. Facilitators of positive experiences included person-centred, holistic care. Despite the emergence of the evidence base, research from the perspectives of people living with SMI and cancer remains limited.

Exploring the lived experiences of people living with SMI who are diagnosed with cancer was therefore particularly important in the current study given the limited evidence directly reflecting their perspectives [15]. While data indicate that this population face higher cancer-related mortality, greater risk of metastatic disease at diagnosis, reduced likelihood of receiving optimal treatment, and increased treatment interruptions and delays compared to those without SMI [15], little is known about how these individuals themselves experience and navigate cancer care.

Understanding how people with SMI experience cancer is therefore essential. One concept which may offer some insights into how to improve supportive care for people with SMI and cancer is *resilience*. There is growing recognition that resilience could be an important factor in cancer care, potentially influencing how people cope with the challenges of illness and recovery [16]. Resilience encompasses assets and capabilities that support positive adaptation in the face of adversity especially through mental, emotional, and behavioural flexibility and adjustment to external and internal demands [17, 18]. Resilience is shaped by multifaceted constructs that can either facilitate or impede its development, such as social support, environmental conditions, stigma, and family and community dynamics [19, 20]. The topic of resilience has been explored in the field of oncology, where it is recognised as a protective factor against psychological distress, contributing to enhanced quality of life and improved clinical outcomes [21, 22]. However, there is a paucity of literature exploring its role in relation to the comorbidity of SMI and cancer. With the growing incidence of people living with a long-term condition [23], the probability of experiencing multiple conditions is increasing; therefore, understanding the mechanisms and potential advantages of resilience in this context could be beneficial.

The aim of this study was to explore the lived experiences of people with SMI who are also diagnosed with cancer. In the absence of a universally accepted definition of SMI [24, 25], seminal papers [26–28] were used to develop a working explanation. The resultant definition of SMI for the purpose of participant recruitment in this study was:

> Experiencing emotional, behavioural or mental health problems, other than addiction and developmental issues that substantially limit one or more major life activities and has a service duration of two years or more. Individuals should also be accessing services related to their mental health.

Methods

Aim

The aim of this study was to explore the lived experiences of people with SMI who are also diagnosed with cancer. The research sought to understand the lived experiences of people with a pre-existing SMI who receive a diagnosis of and treatment for cancer, focusing on physical and mental health comorbidity.

Design

This research was underpinned by a relativist ontological stance and a constructivist epistemological position and adopted a constructivist grounded theory methodology [29]. The research was undertaken in England and data were generated through 11 in-depth one-to-one interviews with people with lived experience of SMI and cancer. Grounded theory coding methods of initial, focused, and theoretical coding were adopted alongside constant comparative methods and memoing [29]. Patient and public involvement (PPI) supported the development of the research materials and informed study conception and dissemination. Mental health and cancer professionals reviewed study materials and provided feedback on terminology and content. Subsequently, two separate PPI groups based in England reviewed study materials and the interview topic guide. Feedback received was focused on language clarity and the way in which SMI was described, leading to modifications to the recruitment materials and the interview topic guide. Input was received from people living with cancer, and from people living with SMI. An interview topic guide was developed and revised between interviews; for example, as a result of some early coding, it became apparent that the point of diagnosis was important to participants, and the topic guide was edited to add an open question specifically about experiences of cancer diagnosis.

Data collection

Purposive sampling was used to recruit adults (18 +) with lived experience of both SMI and cancer. Recruitment took place within England through the National Health Service (NHS) and voluntary organisations focused on cancer or mental health. Eligible participants had a SMI of more than two years' duration and a cancer diagnosis confirmed between six months and ten years prior to the study. Exclusion criteria included being under eighteen, lacking capacity to consent, current inpatient status, detention under the Mental Health Act [30], or not living independently (people living in supported independent living environments were eligible to participate). Recruitment materials followed plain English summary guidance [31], with ethical approval granted by Sheffield Hallam University and the NHS Health Research Authority. Potential participants who expressed interest were contacted for an initial discussion to explain the study and confirm eligibility. Expressions of interest were sent directly to the researcher by the potential participant or via a health professional on behalf of a potential participant. Those choosing to participate returned signed consent forms before interviews were scheduled. All interviews were conducted by LC, a female doctoral researcher and a registered health professional with a background in oncology and experience of qualitative research. An additional post-doctoral researcher with experience in mental health was present at the start of interviews for confirmation of consent as per the requirements of ethical approval. The participant and interviewer spoke via telephone prior to the interview to discuss the content of the participant information sheet and the consent form, the researcher explained the aims of the research and outlined that the study was being undertaken as a PhD study. Single participant interviews lasted between 45 and 90 min and were undertaken as either a telephone or video call at the preference of each participant. Interviews were conducted using a guide that was tested with patient and public involvement groups. Interviews were recorded and transcribed verbatim.

Data analysis

Grounded theory analysis consisted of initial, focused, and theoretical coding. Analysis was undertaken by the lead researcher (LC), with testing of concepts through regular supervision meetings with two experienced post-doctoral researchers. The analysis was inductive, with concepts, sub-themes and themes developed through engagement with participant experiences described during interviews. Initial coding was undertaken line by line for the first three interviews and paragraph by paragraph for subsequent interviews. Following Charmaz [29] and adapted from Glaser and Strauss [32], the process emphasised coding actions in the data to remain close to participants' accounts and reduce researcher assumptions. Gerund coding was used where appropriate to preserve participants' experiences and encourage analytical progress [29, 33]. In vivo coding was also adopted to retain participants' own language [34], with some codes later elevated to subcategories. Together, these approaches facilitated constant comparison within and across interviews and supported the early movement from codes to concepts.

Focused coding drew on the most significant initial codes to develop more conceptual understandings of the data. This stage involved iterative revisiting of transcripts, memos, and audio recordings to refine codes and test their explanatory value and to integrate significant patterns across interviews. Finally, theoretical coding was undertaken to integrate categories and examine their relationships. Saturation was judged to have been achieved when no new data emerged, categories were fully developed, and relationships among categories were clearly established [35]. This point was reached following eleven in-depth interviews with participants living with SMI and cancer, confirmed through diagramming, memoing, and iterative revisiting of data.

Consistent with a constructivist epistemology and grounded theory methodology, a reflexive approach was adopted throughout the study. Reflexivity was supported through regular supervision meetings, audio, and written memoing, enabling the exploration of early concepts and the transparent documentation of analytic decisions. This approach helped to challenge assumptions and ensured that findings were grounded in participant experiences while acknowledging the researcher's interpretive influence.

Ethical considerations

Ethical approval was obtained from Sheffield Hallam University (ER5430039), NHS Health Research Authority London-Surrey Research Ethics Committee (20/HRA/3177) and local research and development teams across four NHS Trusts in England. Participants were provided with information sheets and written consent obtained before interviews were undertaken. To maintain confidentiality and anonymity, participants were given a randomly generated name as a pseudonym, used throughout the study.

Results

Sample characteristics

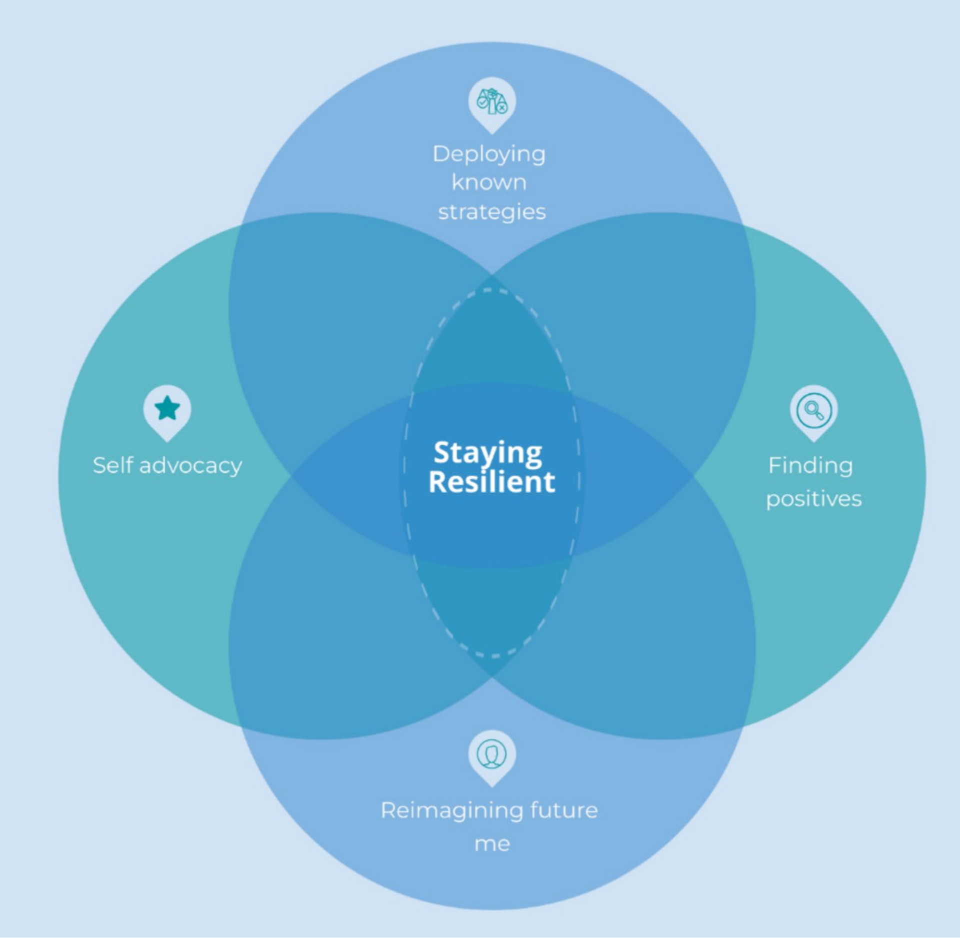
People with lived experience of cancer and SMI (n = 11) participated in one-to-one interviews to explore their experiences of receiving a diagnosis of and treatment for cancer, and life with their comorbidity. As required by the ethical review process, demographic data obtained from participants was kept to a minimum to maintain their confidentiality and anonymity, and details of cancer and SMI were not collected. All participants were understood to be white British citizens. Individuals that self-identified as male or female were included in the study, with most participants identifying as female. When participants disclosed their age, they represented people in the 30–39, 40–49, 50–59 and 60–69 age groups.

Staying resilient

Several interrelated categories describe participants' experiences of living with SMI and cancer. This paper focuses on the category of resilience. Resilience was derived as a main theme, highlighting that people with a pre-existing SMI draw on existing coping strategies when diagnosed with cancer. Through this mechanism of drawing on existing strategies, participants' previous experiences of living with SMI shaped the way in which resilience was enacted when receiving a cancer diagnosis. Participants described their preparedness for experiencing a diagnosis of and treatment for cancer alongside their pre-existing SMI, as well as the ways in which they responded to and navigated this experience. Across participants' descriptions, processes of resilience were evident, reflected in the use of strategies to support coping, or where strategies could not be enacted, the factors leading to fragility. Staying resilient is explained through four subcategories of deploying known strategies, self-advocacy, finding positives, and reimagining future me (Fig. 1).

On receiving their cancer diagnosis participants reported that they had *deployed known strategies* for resilience by building on their prior experiences. Understanding the impact of a major life event on their mental health, participants described how they attempted to *self-advocate* at the time of their cancer diagnosis and treatment. Additional resilient strategies enacted by participants involved

Fig. 1 Staying resilient category and subcategories



identifying and *holding on to positive factors* and *reimagining a future me.*

Deploying known strategies

In response to receiving a cancer diagnosis, participants described how they attempted to deploy strategies for resilience to aid their coping with the major life event of a cancer diagnosis. Participants were often aware of their behaviours and explained how they had meaningfully and intentionally adopted these strategies. On other occasions, participants explained behaviours of deflection whereby they described masking of their feelings where they tried to hide their true feelings about their situation in public situations to support coping.

> "I didn't really react, by this time, I kind of knew what they were going to say. I don't know, I'm not very emotional. Or at least I might seem to deal with things, but I'm very good at hiding it" Judy
> "I can be quite withdrawn, on the other hand I can be very upbeat and it's just a front, you know…people think I've got my act together when actually I'm quaking in my boots." Lisa

Participants sometimes placed their own circumstances in perspective by referring to others whom they perceived to be in more difficult situations. This process involved deflecting attention away from their own illness and reframing their experience in relation to others, helping to manage the emotional impact of their cancer diagnosis. By considering others in worse situations, participants described being able to express gratitude, maintain perspective and keep their mental health balanced. This form of reframing was evident when participants spoke about people in their social networks who were facing adversity.

> "...she is desperate for help with her son and she was asked was he self-harming and was he suicidal and she said 'No' and they said, 'Well he doesn't get any help' and she said, 'Does that mean I have to wait till he overdoses and maybe dies?'" Amanda

People with SMI and cancer in this study also described emotional detachment. That is, a known response in SMI, where individuals remove the connection with their emotions [36]. It could be that this strategy was formed from previous learned behaviours, drawing on prior strategies used to cope with stress.

> "I don't think so, I think it is just in a little compartment somewhere." Judy
> "It's a defence mechanism; it's just a feeling of doom and gloom at time to be honest with you although I try to ignore it. I don't know how to put it into words, it's basically fear, terror." Lisa

For some participants, the emotional detachment appeared to delay their emotional response to the cancer diagnosis. While participants sometimes described initially responding in a controlled or positive way, the emotional impact of the cancer emerged later. The emotional detachment functioned as a short-term coping strategy that allowed participants to manage the immediate stress of the diagnosis, although for some this resulted in a delayed impact of the cancer diagnosis on their mental health. After describing her initial response to her cancer diagnosis as positive, one participant continued to describe the impact on her mental health:

> "So, it was almost a positive thing, it really was. My whole experience was pretty positive, and I felt for the first time this is why I have got full ownership of this, and I am not even going to tell anybody…" Angela

> She later explained:

> "I remember just long periods of just lying in bed counting seconds thinking will I get through the next second, for hours on end. When I think back to that mindset it was really, really tough to come out of the other end and then I would get out of that and then the next wave would come over…I have always had suicidal ideation even as a child. I am very familiar with it and know how to control it… my suicidal ideation suddenly went away …and it was the very next day, the first time in my life I was self-harming, cutting…" Angela

Self-advocacy

Self-advocacy was discussed by participants in their attempts to access support for their mental health following their cancer diagnosis, specifically where access to help proved challenging. This was a common occurrence, most significant in instances where participants tried to access specialised mental health support because of their cancer diagnosis.

> "So also, I explained that I wanted help, and I made sure that I asked very quickly and early on, because I was kind of aware that it was kind of fairly problematic knowing, you know...and I raised it at I think my second oncology appointment..." George
> "Midway through my chemotherapy I was told it was going to be stopped, so just a few weeks earlier they were saying to me that this drug was going to help prevent my cancer recurring sooner and then so many

> weeks and it was, they were no longer going to continue with it, so obviously that weekend it caused a mental health crisis and I rang up the hospital, asked for more help from the MacMillan nurse…" Maggie

Participants described self-advocating outside of the health system through decisions about disclosing their cancer diagnosis to others. For some, sharing information with family, friends, or employers enabled them to access support. For others, deliberately choosing not to share their diagnosis was also important. Controlling disclosure allowed participants to have some agency and perceived stability.

> ""Well, and I chose not to tell my family. So, there was --- knew obviously, my partner, and I said I'm not going to tell them until I know I've got a date and exactly what's happening. So that was quite difficult, but it was the right thing to do…" Jennifer

Participants also described self-advocacy through decisions about how they would respond to their cancer diagnosis in their everyday lives. Some described making intentional changes to aspects of their lifestyle, including the prioritisation of modifiable behaviours.

> "It did feel quite different when I came out… but I also felt kind of liberated, stopped smoking and drinking for about 4 months" Judy

These actions enabled participants to position themselves as active agents in how they managed their cancer diagnosis, supporting their resilience while navigating their cancer diagnosis and SMI.

Finding positives

While the long-term negative effects of a cancer diagnosis had led to a mental health crisis and suicidal feelings for many participants, earlier in their care pathway, they searched for and held on to positivity.

> "… and then, I was looking as far as the consultant that diagnosed me, he said this is entirely curable, and I just clung to that one phrase throughout… was always offered to me that surgery would cure it, it was absolutely curable by surgery alone…" Judy
> "Well, all he said to me when I sat in front of him was, I'll give you a better quality of life, and that's all he said… he said we can give you an operation and that will give you a better quality of life." Michael

Participants described how their cancer diagnosis initially resulted in a more optimistic outlook. Short-term reprioritisation of modifiable risk behaviours or a change to focus on the cancer rather than other complex life factors enabled participants to identify positive aspects of their cancer diagnosis.

Considering the longer-term positive impact of cancer, participants described how this had affected their perspectives on their relationships, self-esteem, and work.

> "So, it's given me a power and openness to do that. You know, calling out a lot of bad behaviour at work and you know, I've found my strength from it as well, because you know working for --- is --- , you know, there is so much crap thrown at you…" George

Participants also discussed cancer as an opportunity to take control of their life, including lifestyle changes and relationships. Feeling liberated or embracing the cancer led to short-term behaviour change but also helped refocus priorities over the longer term. In situations where participants found their comorbidity challenging in the longer-term, adopting a positive outlook where possible remained a strategy used to support their resilience and enable coping. Drawing on their experiences of having long-standing mental illness equipped participants with their own mechanisms that they felt were successful.

> "I like to sit in a cafe and just have a cup of coffee watching people go by… I like to find something, try and find something positive for each day, can I draw this, can I go here…" Lisa

Participants used the cancer diagnosis as an opportunity to pause, reset, and reprioritise. They felt able to do this given their perception of the short-term nature of their cancer in many cases.

Reimagining future me

Participants explained how their comorbidity impacted on their identity and the future. This started with recognition of a changing identity, describing how they planned to build a new existence, or describing a *new me* or accepting *this is who I am now*. Identity change after a cancer diagnosis is a known phenomenon [37, 38], often but not always associated with the physical changes that occur because of a cancer diagnosis or treatment.

Early in interviews, participants described the origins, manifestations and management of their SMI and the impact on their lives during which many referred to their identity. Participants also discussed cancer in the context of their SMI and revisited the notion of identity. Here they explored a changed identity emerging from their comorbidity and questioned what this meant for their future. Even in the absence of a clear vision for how this might look, participants were aware of changes that occurred because of their comorbidity.

Being labelled as a person with cancer was not a significant area of focus for participants, except in relation to their place of work. Participants that described this had also raised the issue of labelling in relation to their mental illness.

> "I was at a focus group we were running with colleagues… but we didn't have enough patients, so they asked if I would play the role, not play the role but be a patient for the purposes of that session, take off my work hat and be a patient. And I was really, really upset, and it caught me completely off guard…" Jennifer

Cancer was a turning point for many participants, a moment to pause and refocus and make decisions about the future.

> "I am here yeah, because of my cancer diagnosis and that, that is kind of a major point I think for me, in my life...and that has been a massive change and a shift in me personally and I think professionally…" George
> "It's quite hard because since --- my life has been cancer related so who I am now is a very different person to who I was, so I suppose I am a bit more outgoing now…" Maggie

Revisiting their identity and subsequently creating a new me and building a new existence was a strategy used by participants, drawing on their ability to find positives in times of adversity.

Discussion

Resilience among people with SMI and cancer in this study was enacted through a series of interrelated strategies encompassing deploying known strategies, self-advocacy, finding positives and reimagining a future self. These subthemes collectively highlight how prior experience with SMI shaped responses to a cancer diagnosis.

People living with SMI in this study endured SMI for significant periods of time. Except for one, all participants referred to their teenage or early adulthood years when describing the onset or first awareness of mental illness. Many received specialist inpatient care during these periods of their lives and described oscillations in stability of their mental health over time. This changeable and long-standing nature of mental illness means that inevitably people with SMI had experienced major life events, and grappled with these alongside their mental illness. It is possible that such prior experiences developed resilience strategies in this population to support coping.

People with SMI and cancer described masking their emotions as a strategy for coping with the stress of a cancer diagnosis alongside SMI. Sometimes intentional and at other times unconscious, this behaviour involved dismissing or suppressing emotions during interviews or in daily life, echoing Tobin and Begley's [39] term the "dismissive mantra." Masking was also evident when participants encountered information they did not want to acknowledge, aligning with Miller et al.'s (2021) definition of masking [40] as concealing feelings to avoid harm. In this study, masking operated as a coping strategy to manage overwhelming emotions, consistent with Lazarus and Folkman's (1984) stress and coping framework [41]. Alongside short-term masking, some participants described longer periods of emotional retreat, which may reflect learned coping behaviours or the effects of treatment. This resonates with research on emotional dysregulation in SMI [36] and the use of withdrawal or suppression as adaptive strategies under stress [42].

Another resilient strategy participants employed was deflecting attention away from their own illness by focusing on others perceived to be in worse circumstances. Deflection, masking, and emotional retreat can be collectively understood as forms of denial, a coping mechanism widely discussed in both cancer and mental health literature [43–45]. While denial is often described as maladaptive [46], in this study it appeared to function adaptively, helping individuals protect themselves from the immediate emotional impact of comorbidity. Although participants did not explicitly label their coping as denial, their accounts are consistent with theories framing denial as both a conscious and unconscious protective process [43–45].

Self-advocacy was described as both essential and challenging for participants navigating cancer care alongside SMI. Within the health system, participants sought mental health support, though these efforts did not always achieve the intended outcomes. Outside the clinical context, self-advocacy involved selective disclosure of diagnosis to family, friends, or employers, enabling participants to exert control over their circumstances. For some, conceptualising cancer as temporary compared to the long-term trajectory of SMI fostered a sense of control and advocacy. Existing literature identifies self-advocacy as central to self-management in SMI [47] and mental health recovery [48] as well as decision-making [49, 50]. However, existing oncology frameworks [51] do not account for the unique challenges posed by comorbid SMI, suggesting a need for adaptation in future research. In this study, self-advocacy was an important strategy for resilience, particularly in efforts to access mental health care and manage disclosure.

The findings of this study both align with and extend the existing evidence base relating to SMI and cancer. Previous research has predominantly focused on disparities in clinical cancer outcomes and access to care for people with SMI, including delayed diagnosis and increased cancer-related mortality [52, 53]. More recently, there has been an increase in lived experience research, highlighted through the systematic review by Glasdam et al. [12], identifying challenges in navigating fragmented services, managing complex physical and mental health needs and reliance on informal support networks. These findings were also reflected in the current study.

However, this study adds an original contribution to the evidence by demonstrating how people with a pre-existing SMI respond to and manage their cancer comorbidity. Previous studies have focused on unmet need; in contrast, these findings outline how people with SMI can draw on prior experiences of living with their mental illness to enact resilience in the context of their cancer diagnosis. The identification of resilience as a dynamic and enacted process, shaped by the prior experiences of people with SMI, provides new insight into how coping can be supported in people with comorbidity through a focus on asset-based care. Recognising the ways in which SMI lived experience can inform adaptive responses to a cancer diagnosis would allow emphasis on an individual's strengths, capabilities and resources—which were described in this study through the interconnected resilient strategies. To support coping in this population, the strengths, capabilities and resources of each individual should be explored and enabled through asset-based, personalised care and a shift away from a paternalistic model of healthcare delivery. Asset-based care may enhance the ability to navigate complex care pathways and support more effective coping for people with SMI and cancer.

The findings of this research highlight how people with SMI draw on multiple strategies to support coping following a cancer diagnosis, offering practical implications for supportive care. Participants' prior experiences with SMI contributed to deploying known strategies such as masking or emotionally retreating, which supported coping in early stages of their cancer pathway. The importance of self-advocacy was evident in participants' efforts to navigate cancer care, seeking psychological support and through their approaches to selective disclosure. Participants also described finding positives by reframing challenges or focusing on others who perceived to be in worse circumstances and reimagining a future self by maintaining hope and a sense of control when diagnosed with cancer. The provision of supportive care for people with a pre-existing SMI may benefit from taking an asset-based approach to care, to value what matters to people as individuals and what their strengths are, alongside their needs. This could allow people with SMI to build on the coping strategies and strengths that they already have when entering a cancer care pathway. Personalised and asset-based approaches to care would adapt available support to individual needs, taking into consideration their history, approaches to coping, and their needs; this could also support access to advocacy or peer support services. Supporting shared decision-making in people with SMI and cancer enables individuals to self-advocate and maintain some aspects of control. Open dialogue between people with SMI and cancer about their SMI, and by providing a single point of contact across services could also improve care and avoid the potential issue of fractured liaison between services leading to delays in care and delayed access to specialised care which can be detrimental to coping in this population.

Study limitations should be acknowledged. The COVID-19 pandemic necessitated remote interviews, limiting the ability to observe nonverbal cues that might have enriched the data. Secondly, due to ethical approval requirements and the need to protect participant anonymity, detailed demographic information and specific cancer or SMI diagnoses were not collected. This limits the study's capacity to provide deeper insights into the experiences of people with SMI and cancer, as subgroup analyses could not be conducted. However, the study's original aim did not include exploring variation within subpopulations, and it is acknowledged that potential heterogeneity within this population warrants further investigation in future research. The research did not directly compare the experiences of people with a pre-existing SMI and cancer to those with cancer but without SMI, therefore it is not possible to compare if the findings are unique to this population. However, the research highlights important ways in which prior experiences of SMI informed coping and resilience in the context of cancer, offering novel insights for understanding and supporting this population.

Conclusion

This study addresses a critical gap in understanding resilience among people living with comorbid SMI and cancer. Whilst interest in co- and multimorbidity resilience is increasing, limited evidence exists on how individuals navigate the intersecting challenges of mental and physical illness. The findings contribute to this emerging field by describing the personal tools and adaptive strategies that individuals draw upon, aiming to remain resilient, offering new insights into how resilience is experienced in this complex context.

Awareness that a person in the oncology setting has a pre-existing SMI is a vital step toward addressing persistent disparities in cancer outcomes in this population. The strategies for resilience identified in this study illustrate how people with SMI and cancer aim to sustain their engagement in care. Incorporating these strategies into person-centred, asset-based care models may strengthen the ability to cope and help narrow the gap in cancer outcomes in this population. Clinically, this research highlights opportunities to develop interventions that actively build resilience as part of routine cancer care and reduce health inequalities in people with cancer and SMI.

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Author contributions Laura Charlesworth was involved in the study's conception, design and analysis and writing and critical revision of the article. Russell Ashmore supervised the design, implementation and analysis of the research and was involved in writing and critical revision of the article. All authors read and approved the final manuscript.

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Data availability No datasets were generated or analysed during the current study.

Declarations

Ethical approval Approval was obtained from Sheffield Hallam University (ER5430039), NHS Health Research Authority London-Surrey Research Ethics Committee (20/HRA/3177) and local research and development teams across four NHS Trusts in England. The procedures used in this study adhere to the tenets of the Declaration of Helsinki.

Consent to participate Informed written consent was obtained from all participants.

Competing interests The authors declare no competing interests. LC is currently Deputy Associate Editor at Supportive Care in Cancer (cancer disparities special collection); however, as an author of this submission, they had no role in the handling of the manuscript through the editorial or peer review process.

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