Identifying families’ strengths is the first and one of the most important strategies. During the intervention (REFI), families’ support needs decreased and were alleviated, and the families’ life conditions improved. Effectiveness was found in relation to health, parenthood, the raising of and caring for children, parents’ relationships, social relations and children’s health and growth. In the future, it is needed to focus on the methodological and the ethical issues related to the preventive family nursing interventions.
Resource-enhancing Nursing at Home for Families with Small Children

Evaluation of Early Interventions
HANNA-MARI TANNINEN

Resource-enhancing Nursing at Home for Families with Small Children

Evaluation of Early Interventions

To be presented by permission of the Faculty of Health Sciences, University of Eastern Finland for public examination in Canthia auditorium, Kuopio, on Friday, October 2th 2015, at 12 noon

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ABSTRACT

Family nursing has been found to promote the health and well-being of families with small children. However, there is little empirical knowledge of resource-enhancing family nursing available. Research knowledge regarding the effectiveness of preventive family nursing early interventions also remains fragmented. The aim of this study was to describe and evaluate the resource-enhancing family intervention (REFI) in families with small children, and to assess the effects of the intervention carried out at families’ homes from the perspectives of parents. In addition, the aim was to identify and evaluate the critical methodological aspects of preventive family nursing intervention studies. This study consisted of an empirical study and a systematic review (2003–2014). The empirical study included evaluating a REFI conducted during a 19-month-period. A total of 129 family members from 30 families participated in the study. During 621 home visits, seven different intervention methods were used. Data consisted of four different types of client and service-based evaluation documents (504 pages), which were analyzed by content analysis and descriptive statistical methods. In the systematic review (N= 2077), eleven (n=11) articles were selected. Literature review data were analyzed by using inductive content analysis and an appraisal tool for evaluating intervention studies was developed.

REFI benefitted all family members. During the intervention, their support needs decreased and were alleviated, and the families’ life conditions improved. Effectiveness was found in relation to health, parenthood, the raising of and caring for children, parents’ relationships, social relations and children’s health and growth. Families experienced that they achieved more goals contributing to the family’s life than were set at the beginning of the family nursing. The results of the literature review confirmed the empirical results produced by REFI, as the preventive family nursing interventions were recognized as effective. The critical aspects of preventive family nursing intervention studies were concerned with the exact and logical use of concepts, and issues connected to establish study reporting and quality appraisal.

In conclusion, preventive family nursing interventions have been successful because they help identify and support families’ resources at an early phase, take into account the whole situation of the family, use versatile and previously tested methods and are theory-based. In the evaluation of interventions, it is important to take into account the accurate description of interventions, the long-term effects of evaluating, and all members of the family.
TIIVISTELMÄ


Preventiiviset perhehoitotyön interventiot ovat olleet vaikuttavia, koska niissä on voitu tunnistaa ja tukea perheiden voimavaroja varhaisessa vaiheessa ja otettu huomioon koko perheen tilanne. Lisäksi interventioissa on käytetty monipuolisia, aikaisemmin testattuja menetelmiä ja ne ovat olleet teoriaperusteisia. Interventioiden arvioinnissa on tärkeää ottaa huomioon niiden tarkka kuvaus, arvioinnin pitkäkestoiset vaikutukset sekä perheen eri jäsenet.

Luokitus: WY 159.5, WA 308
Yleinen Suomalainen asiasanasto: lapsiperheet; perhehoitotyö; kotikäynnit; varhainen tuki
To My Family
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Kuopio, September 2015

Hanna-Mari Tanninen
List of the original publications

This dissertation is based on the following original publications:


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## Abbreviations

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<th>Description</th>
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<tr>
<td>DHFW</td>
<td>Developmental/Health Framework</td>
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<tr>
<td>FSB</td>
<td>Family Situation Barometer</td>
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<tr>
<td>MeSH</td>
<td>Medical Subject Headings</td>
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<tr>
<td>MMN</td>
<td>McGill Model of Nursing</td>
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<tr>
<td>MRM</td>
<td>Theory of Modeling and Role Modeling</td>
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<tr>
<td>REFI</td>
<td>Resource-enhancing family nursing intervention</td>
</tr>
<tr>
<td>SURE</td>
<td>Support Unit for Research Evidence</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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1 Introduction

Family nursing aims to promote children’s favorable growth and development and supports the well-being and health of families and family members in different phases of life (Friedman 1998, Baggaley & Kean 1999, Gottlieb 2014, Halme et al. 2014, Aston et al. 2015). In addition, family nursing helps in managing families’ resources and supports dealing with different health problems by focusing on early support and emphasizing families’ resource enhancement (Häggman-Laitila 2005, Häggman-Laitila et al. 2010) and strength-based (Häggman-Laitila 2003, Gottlieb 2014, Aston et al. 2015) approaches. The aim of preventive family nursing is to identify families’ needs and their life situations (Pietilä & Häggman-Laitila 2006), support their existing internal and external resources and strengths (Gottlieb 2014, Aston et al. 2015) and promote families’ health and the quality of life in an early phase (Pietilä & Häggman-Laitila 2006) before problems become more serious and permanent. When parents are supported in an early phase, the family, including children, will benefit from the aid received (Giallo et al. 2012, Rautio 2013).

All families need support when there are concerns and problems in their family life situations. Typically, expecting and giving birth to a baby and the period when children are small bring many changes to the lives of parents and entire families (Widarsson et al. 2013, Hildingsson & Thomas 2014, Spiteri et al. 2014). The World Health Organization (WHO) emphasizes the first priority of the Health 2020 European policy framework and strategy for the 21st century investing in health through using a life-course approach and by empowering people. According to WHO, supporting good health throughout the life-course leads to an increasingly healthy life expectancy and a longevity dividend, both of which can yield important economic, societal and individual benefits.

Recently, international preventive family nursing studies have shown that the number of families in need of psychosocial support is constantly increasing. This trend raises the need for developing early support services of preventive family nursing for families. There has particularly been increased research interest in family nursing services conducted at families’ homes. Even though positive health outcomes have been linked to support from family nurses, and families have benefitted from received psychosocial support in their own homes (Kardamanidis et al. 2009, Rossiter et al. 2012, Kemp et al. 2013, Widarsson et al. 2013, Paton et al. 2013, Aston et al. 2015), little is still known about how this occurs during family nursing interventions.

In Finland, it is known that the majority of children grow and develop well. Furthermore, most families are healthy and they are coping well with their everyday lives. It has been evaluated that every tenth child is living in a family with multiple problems and approximately one-third of families is in need of additional support. Preventive family health care services are produced in municipalities and they are provided under the Health Care Act (1326/2010). The Finnish Government has given a decree (Decree 338/2011) that imposes that health counselling and physical examinations are
methodological, are at a uniform level, and take into account the needs of individuals and the population as a whole. The aim is to guarantee sufficient uniform and equal services, strengthen health promotion, intensify early support and enhance the prevention of social exclusion, target aid to those who are in need, and to reduce health inequalities (Decree 338/2011).

Depending on the service provider, two different concepts, ‘family counselling’ and ‘family nursing’ have been used to refer to the concept of offering assistance to families (Seppänen et al. 2010, Järvinen et al. 2012). Families are assisted in different contexts, such as in nursing, social work, day care centers, institutions and home care, as well as in churches, organizations and as a part of voluntary work. Assisting families is classified as conducting preventive work, crisis management and rehabilitation (Järvinen et al. 201). In all these approaches, offering assistance to families has been family-centered and resource-oriented. Nearly all Finnish families with small children are clients of maternity and child health clinics where health promotion is based on a family-centered and resource-oriented working method and using dialogue in interaction with parents. These services are classified as preventive child welfare (Child Welfare Act 417/2007, Social welfare Act 1301/2014). Trained public health nurses or midwives work in maternity and child health clinics. Services are targeted to pregnant women, families expecting a child, and children under school age (0–6 years) and their families. Family nurses working in connection with maternity and child health clinics are specialized and educated in providing family nursing in families’ home. Their work involves giving support to parenting and skills related to caring for and rearing children, as well as strengthening family’s social networks and parents’ relationship as a couple. Despite the national recommendations for preventive family nursing services in Finland, there are still many municipalities without early support services, such as home services for families with small children, peer activities for parents or children and young people, and low-threshold meeting places or family counselling in the child health clinic context (Paavola et al. 2010). In addition, most families need resource-enhancing and psychosocial early support conducted in their own homes, a service which child health clinics do not offer (Häggman-Laitila 2003, Häggman-Laitila et al. 2010).

The aim of this study was to describe and evaluate the resource-enhancing family intervention (REFI) in families with small children, and to assess the effects of the intervention carried out at families’ homes from the perspectives of parents. In addition, the aim was to identify and evaluate the critical methodological aspects of preventive family nursing intervention studies. This dissertation belongs to the field of preventive family nursing research, which emphasizes early support. Although the concept of preventive family nursing interventions realized at home has been established, literature on the topic and information on effectiveness of these interventions remains fragmented. In this study, the word ‘family’ is used to refer to families with at least one child 0–6 years of age, or families expecting a child. ‘Family nurse’ refers here to a nurse who has specialized in and received education on family work. There is still little empirical knowledge on how nurses working in a home context develop relationships with families,
what methods they use to enhance families’ resources and how such relationships affect families’ health outcomes.
2 Family nursing for families with small children

The literature searches of this chapter two were conducted in two phases. In the first phase, an electronic and manual literature searches focused on the theoretical basis of family nursing and resource-enhancing family nursing. Scientific articles, textbooks and other publications in the field of family nursing and preventive family nursing were used. Literature searches were conducted on international and national databases were conducted using free search words and without determining any limitations. In addition, reference lists of selected articles and information from the Statistics of Finland were used.

In the second phase, searches were focused on interventions in family nursing conducted in families with small children. Four international databases, CINAHL, PubMed, Scopus and Web of Sciences were used with following restrictions: i) studies were published between 2010 and 2014 (in order to obtain the latest information), ii) they were written in English and iii) available as full texts. The following search phrases were used for the texts: *(family nurs*) AND *(intervent*) AND *(parent* OR mother* OR father*) AND *(child* OR baby* OR children*). Selection of articles was based on inclusion and exclusion criteria. Inclusion criteria were as follows: studies i) represented family nursing, ii) were focused on families with small children, and iii) included an intervention. Exclusion criteria were as follows: interventions were i) conducted only by volunteers or peer supporters, ii) described the topic insufficiently, or iii) only reported on the development process of the intervention. There was one further exclusion category, iv) studies written by the current author (Tanninen et al.). In total, the searches resulted in 384 publications. The articles were selected in stages based on titles, abstracts and full texts. (Figure 1)

![Figure 1. Selection process for original family nursing intervention studies](image-url)
2.1 DEFINITIONS OF FAMILY AND WELL-BEING OF FAMILIES

The definition of family has changed over time because of different societal and cultural contexts (Yesilova 2009) and varying definitions of its form and structure (Nätkin 2003, Castren 2007). The family has been understood as the basic unit of society (Marin 1999, Friedman et al. 2003, Yesilova 2009). Even though it has received criticism (Paajanen 2007, Yesilova 2009), the most common definition of family refers to the combination of parents, i.e., mother and/or father with a child or children (Friedman et al. 2003, Åstedt-Kurki et al. 2008). Currently, the comprehension of family has been diversified from this view of a nuclear family to include different combinations, such as single-parent families, reconstituted families and families with same-sex parents. (Statistics Finland 2013, Lammi-Taskula & Karvonen 2014).

The structure of the family can be defined from various perspectives. Usually, family refers to a group of individuals who are related to each other through different reasons, such as blood ties, marriage or adoption, and carrying out the function of family can occur interdependently, and through mutual relationships and role-bonded relationships. Thus, the family has been understood as a personal issue and defined according to families’ personal views. The family has been considered to include the individuals that each family wants it to include (Castren 2007), and emotional intimacy has been considered to have an even more important role than legal or biological ties (Friedman et al. 2003, Yesilova 2009). Most people appreciate their family and consider it an important part of their lives (Paajanen 2007).

A family consists of individuals who are married, cohabiting couples or those living in a registered partnership, and parents who have children together or the children of one of the spouses. In addition, the family refers to single parents with their children, childless married and cohabiting couples, and couples in registered partnerships. Children have been understood to include persons less than 18 years of age. (Child Welfare Act 417/2007, Statistics Finland 2013). At the end of the year 2013, 39 per cent of the populations were families with children. The most common family type among married couples was still family with children, which covered 60 per cent of families. In total, there were 576,000 families with children living in Finland. The number has decreased from the previous year by 2,700 families. Finnish families have in total 420,412 children under school age. On average, families have 1.84 children and 2.77 family members. (Statistics Finland 2013).

Families’ well-being consists of several issues, and their health and well-being situations vary (Haataja 2009, Kaikkonen et al. 2012, Lammi-Taskula & Karvonen 2014). The same family concerns and problems as currently were already highlighted ten years ago; for example, parents had increased support needs related to parenthood, social networks, family members’ mental health problems and parents’ substance abuse issues. In addition, issues such as increasing immigration, poverty in families, family violence and divorces were identified (Ministry of Social Affairs and Health 2004). Currently, regardless of the fact that the majority of Finnish children grow, develop and live in good conditions, a significant part of families are suffering from cumulative problems, and families’ needs for support of social and health care services have increased (Perälä et al.
Parents still have a number of everyday concerns to which they would like to get support from professionals. Family income differs between families’ (Haataja 2009, Kaikkonen et al. 2012), and nearly half of the parents in families with small children have had concerns about their financial situation. The number of families at risk for poverty has increased due to different changes to life situations, such as when parents’ socioeconomic situation weakens because of unemployment, when there is a greater number of children in the family and when there is an infant in the family, which often results in one of the parents leaving work to be on a family leave (Salmi et al. 2009, Sauli et al. 2011). In addition, some families’ may struggle with poverty. This is emphasized especially in single-parent families. (Haataja 2009.) Parents who are working have experienced increasing amounts of stress in their everyday lives. It is noteworthy that parents’ work with busy schedules, working overtime and fixed-term employment limit children’s right to care and protection. (Perälä et al. 2011, Lammi-Taskula & Karvonen 2014).

Parenting has also changed during the time period. Ten years ago, there was emphasis of challenging aspects regarding parents’, especially mothers’, feelings of loneliness and fatigue. In addition, parents felt uncertainty related to parenting and role conflicts. (Ministry of Social Affairs and Health 2004.) In recent years, parents have experienced the loss of moderation in conflict situations with their children and they might have felt feelings of inadequacy as parents. Mothers appear to have more concerns for parenting and family’s everyday life than fathers (Perälä et al. 2011, 2013). In addition, higher immigration rates and families’ lack of social support networks have increased needs for family services (Haataja 2009, Castaneda et al. 2012). More than a third of parents have been concerned for in their relationship as a couple. There is discontent due to lack of shared time with one’s partner and dissatisfaction with sex life. One mother in ten expressed dissatisfaction with the amount of time spent together with her partner, and eight percent of them were very dissatisfied with their sex life with their significant other (Kontula 2009).

2.2 FAMILY NURSING APPROACHES

Family nursing has been approached from different perspectives in different times. Definitions have varied depending on authors, time of publication and current tendencies. According to the literature, family nursing has been approached from such theoretical perspectives as salutogenesis (Antonovsky 1996, Lindström & Erickson 2005), strength-based approach (Gottlieb & Rowat 1987, Feeley & Gottlieb 2000, Gottlieb & Gottlieb 2007, Gottlieb 2014), developmental and social learning theory (Friedman 1998, Wright & Leahey 1990, 2005), and system theory as a family health system (Anderson & Tomlinson 1992, Denham 1999, Anderson 2000, Denham 2002, 2003a, 2003b). (Table 1.) The approaches provide information on family nursing. They give conceptual frameworks for evaluating family situations and health promotion to families. Some approaches focus on
health and well-being and also on the resources of families. Collaboration between families and professionals has also been mentioned.

**Table 1. Theoretical and conceptual approaches applied to family nursing**

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Approach</th>
<th>Description of approach</th>
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| Antonovsky 1996, Lindström & Erickson 2005 | Salutogenesis | • The key question is: “why do people stay healthy”. Health is seen as a process and as a movement in a continuum (dis-ease – ease)  
• The key factor is to be able to use and re-use resources for the intended purpose.  
• The ability to comprehend the whole situation and the capacity to use the resources available was called sense of coherence (SOC).  
• The family members’ and families’ internal and external resources are in focus as well as the interactions between people and their context. |
| Gottlieb & Rowat 1987, Feeley & Gottlieb 2000, Gottlieb & Gottlieb 2007, Gottlieb 2014 | Strength-based approach | • The individuals’ or family’s capacities, competencies, resources and strengths are in focus.  
• Family nursing has the goals of promoting health, empowerment, self-efficacy, hope, facilitating healing, and alleviating suffering by creating environments that work with and strengthen families’ capacities for health and innate mechanisms of healing.  
• Essential element of enhancing resources is the collaborative relationship. |
| Friedman 1998, Wright & Leahy 1990, 2005 | Developmental and social learning theory | • Families are considered from three aspects: i) individual person is the focus of the family, family can be seen as a factor in their background; ii) a family can be considered as the sum of its component parts and be understood and studied through individual family members, and iii) a family as one undivided entity.  
• All families have resources, but the experience of illness may hinder their ability to see available resources.  
• The aim of family nursing is to improve family’s health and well-being, in collaboration with professionals. |
| Denham 1999, 2002, 2003a, 2003b | System theory | • Family health includes the systems, interactions, relationships and processes, including four perspectives: i) the absence of illness or disease, ii) the ability to actively engage in life, iii) a balance among multiple family-life dimensions and iv) holistically with physical, and emotional, social, spiritual and ecological dimensions.  
• Family routines are an important aspect of family health which is linked to family health and discussion focuses on how they evolved, ways they were modified over time, and how families recreated them when stress and change were encountered. Routines provide a structural perspective for assessments, interventions, and outcome evaluations related to health and useful to nursing practice. |
| Anderson & Tomlinson 1992, Anderson 2000 | System theory, focusing on family health system (FHS) | • Family health system (FHS) focuses on collaboration with the family toward improved health and well-being, offering an integrated way to examine family dynamics, strengths, and concerns in both health and illness across the life span.  
• FHS offers a holistic perspective in examination, assessment, and care delivery for families and focuses on the five realms (interactive, developmental, coping, integrity and health process) of family life that comprise family health. The goal for intervention in family health includes an optimal response on each of the five realms.  
• Family health promotion, maintenance and restoration focuses on the interactions in the family unit and the enhancement of interactive, coping, developing, integrity and lifestyle and health components that compose a healthy family life. |

Nursing models such as Erickson et al.’s (1982) Theory of Modeling and Role-Modeling (MRM) and the McGill Model of Nursing (MMN) emphasize strengths and place strengths as a core concept (Gottlieb & Rowat 1987, Feeley & Gottlieb 2000, Gottlieb 2014). MRM synthesizes concepts from several theories, including those of psychosocial development,
human needs psychology, and stress-adaptation to examine the health of individuals across the life span in a range of clinical practice settings. MRM names the five goals of nursing interventions as building trust, promoting client’s positive orientation, promoting client’s control, affirming and promoting client’s strengths, and setting mutual, health-directed goals. (Erickson & Swain 1982.) Of these two models, the McGill Model of Nursing (MMN) focuses on health and provides a theoretical basis for resource-enhancing family nursing (Feeley & Gottlieb 2000). Health, family, collaboration and learning are the salient features of the MMN (Gottlieb & Rowat 1987). The MMN is based on ideas of whole person care, patient-centered/family-centered care and empowerment, whereas the Developmental/Health Framework (DHFW) provides substantive knowledge underlying whole person care (Gottlieb & Gottlieb 2007.) Together, the MMN and DHFW provide a comprehensive, integrated model to guide everyday nursing practice. There is a basic assumption that all individuals and families possess strengths, potential, and resources. In other words, there is a presumption that families have the requisite resources and abilities to develop themselves and solve their problems.

2.3 RESOURCE-ENHANCING FAMILY NURSING

2.3.1 Family resources in focus
Family resources vary in different life situations. Resource-enhancing nursing is one of the family nursing orientations which aims to help families identify their resources and strengths and use these resources to cope with and develop their individual family members and the family as a unit. Together, the family nurse and the family set goals and devise means for achieving these aims by building on the family’s strengths and resources. (Gottlieb & Rowat 1987, Gottlieb 2014).

Family resources can be divided into internal and external resources (Feeley & Gottlieb 2000). Internal resources consist of the physical and mental health, self-esteem, knowledge and skills, problem solving abilities and optimistic attitude towards future of family members, particularly parents. External resources comprise different dimensions of social support, i.e., emotional, cognitive, concrete and mental support. Emotional resources, on the other hand, consist of proximity, care and appreciation. They may manifest as empathy, sympathy, listening and positive feedback. Cognitive support consists of information and counselling. Concrete support may involve doing things for the person, modifying their environment or arranging financial support. (Feeley & Gottlieb 2000).

Feeley and Gottlieb (2000) found four different types of strengths that enable individuals and/or families to cope with life challenges, create changes and develop themselves: (a) traits that reside within an individual or a family (optimism, resilience), (b) assets that reside within an individual or a family (finances), (c) capabilities, skills, or competencies that an individual or a family has developed (problem-solving skills), or (d) a quality that is more transient in nature than a trait or asset (motivation). In contrast, potentials are precursors that could be developed into strengths.
2.3.2 The contents of the resource-enhancing orientation

Enhancement and collaboration between a family nurse and parents

In the nursing process, three strategies are implemented: identifying resources and providing feedback, developing resources, and calling for resources (Feeley & Gottlieb 2000). In resource-enhancing family nursing, identifying families’ strengths is the first and one of the most important strategies, because it can potentially produce many diverse beneficial outcomes (Feeley & Gottlieb 2000). However, strengths need to be recognized by both family nurse and the family. Family members can use the identified resources to shape the course of their life, to manage and interpret stressful factors, to regulate their need for support and to find explanations to their life events.

The nature of the nurse-family relationship is collaborative (Gallant et al. 2002, Gottlieb 2014). Good working collaboration between family nurse and family is considered pivotal for the success of resource-enhancing discussions (Benzein et al. 2008, Rossiter et al. 2012, Paton et al. 2013). The aim of the collaborative relationship is to support families to recognize and utilize their existing resources and to find new resources throughout therapeutic discussions (Häggman-Laitila et al. 2010). In the collaboration, the family’s expertise is appreciated and trusted. The family nurse observes and listens carefully to the family for their strengths, respects their stories and takes the family members seriously. (Feeley & Gottlieb 2000, Gottlieb & Gottlieb 2007.)

Collaborative relationships between a family nurse and parents have often been conducted at families’ homes (Kirkpatrick et al. 2007, Moss et al. 2011, McCabe et al. 2012). Home visits have a long history in family health care (Olds et al. 2007), because the home is as a natural environment for the family and enables the family nurse to observe the way the family lives and to support potential resources that they have in their everyday life (Korfmacher et al. 2008, Kardamanidis et al. 2009, LeCroy & Krysik 2011). Collaboration has also been realized in family health care centers in the form of family nurse appointments, individual health appointments (Rots-de Vries et al. 2011, Tammentie et al. 2013) and group activities (Häggman-Laitila & Pietilä 2009, McDonald et al. 2009, Thome & Arnardottir 2013). In addition, information and guidance have also been offered and utilized by using interactive technology assisted methods, such as the Internet (Salonen et al. 2011) and telephone (Milgrom et al. 2011).

The contents of a collaboration relationship include encouraging families (Gallant et al. 2002, Rossiter et al. 2012) and urging them to act by giving positive feedback to parents (Kirkpatrick et al. 2007, Cleek et al. 2012). In addition, noting and listening to family members’ individual needs (Gottlieb 2014) and intellectual maturity, friendliness, and honesty (Kirkpatrick et al. 2007) is essential. The features of a balanced collaborative relationship also include mutual respect and trust, (Briggs 2006, Heaman et al. 2007, Shepherd 2011, Vaittinen 2011, Rautio 2013), honesty (Kirkpatrick et al. 2007), equality, positive approach (Aston et al. 2006, Epley et al. 2010, Rossiter et al. 2012), empathy (Rossiter et al. 2012) as well as genuineness and caring-orientation promote the success of collaboration (Aston et al. 2006, Briggs 2006, Rossiter et al. 2012). Trust is an essential foundation for the development of respect. In collaboration, respect is shown by listening
to (Kirkpatrick et al. 2007), acknowledging, validating and being aware of others (Paton et al. 2013). Respect is indicated by body language and the way with which messages are communicated (Paton et al. 2013). Parents have valued family nurses’ good interactive and collaborative skills (Aston et al. 2006, Kardamanidis et al. 2009) and the practical support they have received during family nursing (Paton et al. 2013).

Development of a collaboration relationship and supporting the entire family is challenging for nurses. Parents may not be motivated to overcome the challenges of staying in family nursing if they do not perceive the intervention as matching their needs (Rots-de Vries et al. 2011, Hogg et al. 2013). It is also important that nurses understand both the psychological and the contextual factors that influence parents’ ability to engage (Williams Domian et al. 2010). Dissatisfaction with collaboration relationships has often focused on difficulties in establishing meaningful communication (Kirkpatric et al. 2007). Collaboration has in the past been weakened by, for example, a family nurse’s overtly intense and inquisitive method of work (Rots-de Vries et al. 2011), which has diminished parents’ commitment and participation (Paton et al. 2013).

Parents have also found it stressful if the family nurse assigned to them has been replaced (Heaman et al. 2007). Parents have experienced that the role of the professional is not always understood and the advice given is not always considered appropriate (Hogg et al. 2013, Holland et al. 2013). Broaching issues requires that parents are encouraged (Hogg et al. 2013) and their engagement in the intervention is supported (Paton et al. 2013), and nurses must have skills in listening and communication, working in a partnership and by using strength-based approaches, as well as up-to date and evidence-based knowledge of resource-enhancing family nursing (Rossiter et al. 2012). If parents have had a previous positive experience of support provided by a family nurse, it might help the development of collaboration (Kirkpatrick et al. 2007, Kardamanidis et al. 2009). A family is more likely to want to collaborate when they feel valued, understood, respected and secure (Gottlieb 2014). According to Kirkpatrick et al. (2007) and Kanste et al. (2013) successful collaboration in providing services for families requires an awareness of services and also efforts to overcome barriers for collaboration.

**Working methods toward resources**

Versatile working methods have been used in resource-enhancing family nursing. Resource-enhancing discussion (Häggman-Laitila 2003) is the most frequently used method and is based on the support needs identified by families themselves (Feeley & Gottlieb 2000, Häggman-Laitila 2005, Gottlieb & Gottlieb 2007). Other methods supporting discussion that have been used in resource-enhancing family nursing interventions are as follows: video-assisted family counselling (Häggman-Laitila et al. 2003, Eirola 2003, Häggman-Laitila et al. 2010), network collaboration (Häggman-Laitila et al. 2000, 2001), group activity (Häggman-Laitila & Pietilä 2007, 2009, Haaranen 2012), observation of family situations and experiential methods (Häggman-Laitila et al. 2000, 2001).

A resource-enhancing discussion is goal-oriented and future-oriented by nature and aims to create an encouraging atmosphere between a family nurse and their client. In discussions, everyone’s own experiences and views on reality are respected, and room is
given to all participants. The family nurse listens to families, respects their stories and takes family members seriously. (Feeley & Gottlieb 2000, Häggman-Laitila 2005, Gottlieb & Gottlieb 2007, Gottlieb 2014.) Discussions can be used on a promotional, preventive and healing level when working with a family-focused nursing method. They are based on a multiverse, salutogenic, relational and reflective approach, and acknowledge each person’s experience as equally valid, and focus on families’ resources and the relationship between the family and its environment. (Benzein et al. 2008.)

**Video-assisted family counselling, i.e., video home training** is a method based on observing a family’s life conditions and supporting the family’s control over their life. This process consists of goal-orientated reflection by parents on videotaped segments of their everyday family life under the guidance of a family counsellor. The method emphasizes parental strengths and responsibility at families’ own home environments (Eirola 2003, Häggman-Laitila 2003, Häggman-Laitila et al. 2007, Häggman-Laitila & Pietilä 2007, Häggman-Laitila et al. 2010) and aims to increase instances of successful interaction.

**Network collaboration** has also been used as a beneficial method in resource-enhancing family nursing. It focuses on social support given by persons and authorities named and considered important by the family. The aim of network collaboration is to identify and activate families’ own existing networks consisting of those close to them and their relatives, and authorities that can help the family in solving their problems. (Häggman-Laitila et al. 2000, Määttä 2007.) **Group activities** organized for families with small children have been found to respond to families’ psychosocial support needs and provide parents with knowledge about family life and encourage them to seek information. Aims of groups have included supporting parenthood, identifying and strengthening parents’ internal and external resources and helping them to solve their problems (Häggman-Laitila & Pietilä 2007, Haaranen 2012). Groups can provide social support, increased parental knowledge and improved interaction between children and parents (Häggman-Laitila & Pietilä 2007, 2009.)

In resource-enhancing family nursing, the method of observation of family situations has also been used. The method aims to assess everyday life events and situations of families or their individual members in a natural environment. Observations can be recorded on video or in writing, and the material can be reflected upon during later discussions (Häggman-Laitila et al. 2000). **Experiential methods** such as creation of a family tree and creation of a parents’ role map are generally used supporting methods in resource-enhancing family nursing. Creation of a family tree is a pictorial presentation of family events. The aim of the method is to help families to make visible, and increase awareness of, their resources and values supporting them as a family. (Rönkkö & Rytkönen 2010.) The creation of a parents’ role map is a practical tool for assisting families that allows parents to observe and understand their own actions as parents. The aim of the parents’ role map is to help parents in self-assessment, in parenting discussions and parenting groups. (Helminen & Iso-Heiniemi 1999, Rautiainen 2002.)

A nursing intervention is the actual treatment and set of actions that are performed to help a client or patient to reach the goals that are set for them. The nurse uses clients’ or
patients’ knowledge, experience and critical thinking skills to decide which interventions will help them the most. (Burns & Grove 2009.)

2.3.3 Effects of resource-enhancing family nursing

Resource-enhancing family nursing and strength-based interventions for families with small children have had several positive effects on families’ health and well-being in everyday life. Parents’ needs for support have been facilitated and considerably decreased with early support interventions. Especially interventions conducted at families’ own homes (Eirola 2003, Häggman-Laitila 2003, Benzies et al. 2008, Häggman-Laitila et al. 2010, Rossiter et al. 2012, Aston et al. 2015) and in the form of group activities (Häggman-Laitila & Pietilä 2007, 2009, Haaranen 2012) have been effective.

Parents who are aware of their resources are content with their parenthood and can improve their marital relationship and are able to support their children’s healthy development and strengthen their resources (Häggman-Laitila et al. 2010). The surrounding community and its culture may be a significant mental resource for the family. The family’s increasing awareness of its own resources (Feeley & Gottlieb 2000, Häggman-Laitila et al. 2003) may manifest itself as better decision-making, increased understanding of the course of life, altered ways of perceiving problems within the family and a revival of hope. Family life becomes more organized than before.

During resource-enhancing family nursing interventions, parents have strengthened their sense of coping with parenthood (Häggman-Laitila 2003, Kirkpatrick et al. 2007, Kardamanidis et al. 2009, Häggman-Laitila et al. 2010, Rossiter et al. 2012, Thome & Arnardottir 2013) and increased their know-how on bringing up and taking care of children (Benzies et al. 2008, Häggman-Laitila et al. 2010, LeCroy & Krysik 2011, Kemp et al. 2013). Interventions have also introduced positive improvements to parents’ health. For example, parents’ mental health has been improved (Kirkpatrick et al. 2007, Häggman-Laitila et al. 2010, LeCroy & Krysik 2011, Leahy-Warren et al. 2011) and mothers’ dissatisfaction with their parenthood and stress has been decreased (Leahy-Warren et al. 2011, Kemp et al. 2013, Thome & Arnardottir 2013) through interventions. Parents’ health and well-being has also been improved because of a decrease in their use of intoxicants (Häggman-Laitila 2003, Häggman-Laitila et al. 2010).

Resource-enhancing family nursing has also produced positive effects on parents’ relationship with each other (Häggman-Laitila 2003, de la Rosa et al. 2009, Häggman-Laitila et al. 2010) and interaction within family (Häggman-Laitila et al. 2010) has increased. In addition, families’ social support networks have increased (Häggman-Laitila 2003, Häggman-Laitila et al. 2010, Leahy-Warren et al. 2011).

2.4 FAMILY NURSING INTERVENTIONS

A nursing intervention is the actual treatment and set of actions that are performed to help a client or patient to reach the goals that are set for them. The nurse uses clients’ or
patients’ knowledge, experience and critical thinking skills to decide which interventions will help them the most. (Burns & Grove 2009.)

2.4.1 Support needs in families’ health and well-being

Families with small children have needs for support that are often high in number and multidimensional. Support needs vary depending on the family nursing client. Needs vary between families, within family life situations and even between individual family members (Feeley & Gottlieb 2000). It is particularly challenging to get information on support needs from the perspective of children; indeed, there is little research available on the topic.

Family nursing research has been particularly concerned with the lives of mothers, as mothers are usually children’s primary caregivers (Nyström & Öhrling 2004, Deave et al. 2008). Mothers have wanted support in self-efficacy, for example, in the context of breastfeeding (Salonen et al. 2009), during the postpartum period (Leahy-Warren et al. 2011) and related to satisfaction with parenting (Salonen et al. 2010). Mothers have also needed support related to general issues of maternal health, physical activity and nutrition (Kemp et al. 2013). In particular, mental health issues has been an area where help has been wanted the most. Mothers have needed support when experiencing depressive symptoms during pregnancy (Thome & Arnardottir 2013) and during the months immediately after childbirth (Beeber et al. 2010, Leahy-Warren et al. 2011, Rossiter et al. 2012, Salonen et al. 2014). There has also been a need for support related to postnatal fatigue connected to children’s sleep problems (Giallo et al. 2012, Dunning et al. 2013). In addition, mothers have needed support for their emotional life and well-being (Ngai & Chan 2010, Shepperd 2011, Cleek et al. 2012).

During the last ten years, family nursing studies have been increasingly focused on fathers’ health and well-being only in the context of their experiences of different family life situations (Fägerskiöld 2006, Benzies et al. 2008, Deave & Johnson 2008, Halle et al. 2008, Hawkins et al. 2008, Aho et al. 2010, 2011). Fathers have wanted support in the context of their transition into parenthood (Fägerskiöld 2006, Deave & Johnson 2008, Halle et al. 2008, Hawkins et al. 2008), their relationship skills in interactions with their infants (Benzies et al. 2008) and positive involvement with their children (Julion et al. 2012). Fathers have also needed support related to their practical skills and confidence in caring for their babies (Fägerskiöld 2006, Deave & Johnson 2008, Hawkins et al. 2008, Ferguson & Gates 2013) as well as regarding information on breastfeeding to encourage mother to continue breastfeeding (Mitchell-Box & Braun 2012). Fathers have also needed support for postpartum depression (Letourneau et al. 2012) and paternal stress after the birth of a preterm infant (Lee et al. 2012).

Studies simultaneously focused on both parents’ needs for support deal with the transition to parenthood during the course of pregnancy (Thome & Arnardottir 2013) and the period of early parenthood (Feinberg & Kan 2008, Solmeyer & Feinberg 2011, Wilson et al. 2011, Brown et al. 2012, Ohashi & Asano 2012, Widarsson et al. 2013). In addition, both parents have been in need of support in the context of children’s health and well-being issues, such as upbringing and taking care of children (Häggman-Laitila et al. 2010,
Feinberg et al. 2010, Solmeyer & Feinberg 2011) and breast feeding an infant (Hannula et al. 2014), children’s atopic dermatitis (Cheung & Lee 2012, Son & Lim 2014), coping with childhood asthma (Sigurdardottir et al. 2013) and childhood obesity (Stark et al. 2011, Lorentzen et al. 2012, Junnila et al. 2012, Reed 2013). Parents’ have also needed support related to their relationship as a couple, particularly during pregnancy and the postnatal period (Ahlborg et al. 2009, Feinberg et al. 2010, Adamsons 2013, Ngai & Ngu 2014). Studies have indicated that families have been in need of support related to strengthening their social networks (Häggman-Laitila et al. 2010, Byrnes & Miller 2012), their socioeconomic situation (Phuphaibul et al. 2014) and decreasing parents’ alcohol consumption (Bjerregaard et al. 2011).

Parents’ needs for support are affected by age, gender, marital status and the number of deliveries. For instance, younger mothers require more support at the initial stage of motherhood than older mothers (McDonald et al. 2009, Stiles 2010, SmithBattle 2013, DeSocio et al. 2013). Single mothers have a higher need for psychosocial and practical support compared to mothers living in relationships. However, parenthood-related stress occurs in both groups (Copeland & Harbaugh 2010, Liu et al. 2012). Furthermore, when comparing primiparous and multiparous mothers, there have been higher cumulative risk scores and individual risk factors for multiparous mothers related to maternal and child health, behavioral health, and violence exposure. Multiparous mothers were more likely to independently seek out services and to use initiative services later on during the postnatal period (Lanier & Jonson-Reid 2014). In addition, pregnant women have experienced a higher degree of distress than their partners (Thome & Arnardottir 2013). Parents have also differed regarding their substance use. Alcohol use is related to gender issues and it has been indicated that men drink more alcohol in general and consider their alcohol consumption pattern less problematic than women (Bjerregaard et al. 2011).

### 2.4.2 Interventions supporting families’ health and well-being

In the context of family nursing interventions, different terms, meanings and conceptualizations have been used for supporting families with small children in everyday life settings. Interventions have been named through describing their content and form. (See Table 1., Appendix I) In recent years, studies have used, for example, an interactive technologically assisted approach, in which families have been supported through video home training (Häggman-Laitila et al. 2010), by telephone (Darbyshire et al. 2012), videotaping (Julion et al. 2012) and via the Internet, involving, for instance, an online platform (Merkel & Wright 2012) and other Internet-based solutions (Salonen et al. 2014, Son & Lim 2014). Interventions including discussions between nurses and families were named as therapeutic conversation (Kamban & Svavarsdottir 2013, Sigurdardottir et al. 2013, Svavarsdottir & Sigurdardottir 2013, Svavarsdottir et al. 2014) and motivational interviewing (Bjerregaard et al. 2011, Tucker et al. 2013) interventions. In addition, home (Kelley et al. 2010, 2012) and community-based (Breitenstein et al. 2010, 2012) interventions were other typical family nursing interventions.
Most family nursing interventions for families with children have targeted mothers or both parents (mothers and fathers) at the same time, often by referring to them with the general concept of ‘family’. Farther two studies targeted the health and well-being of grandmothers raising their grandchildren in parent-absent homes (Kelley et al. 2010, 2012).

Studies that were aimed at mothers were concerned with, for example, low-income mothers (Beeber et al. 2010), mothers during the prenatal and postnatal period (Kemp et al. 2013), and those experiencing distress and/or depression during the early months after childbirth (Rossiter et al. 2012). In addition, studies have been targeted to mothers with intellectually disabled children at risk of depression (Yildirim et al. 2012), primiparous and multiparous mothers (Salonen et al. 2014), and mothers who have children with diagnosed atopic dermatitis (Son & Lim 2014).

Interventions have also been targeted to mothers and fathers at the same time. Interventions have been conducted with distressed pregnant women and their partners (Thome & Arnardottir 2013), African American and Hispanic parents of young children (Breitenstein et al. 2010), and families in need of more support than can be offered by child welfare clinics (Häggman-Laitila et al. 2010). Interventions were also targeted to both parents who had concerns about their child’s health, for example, related to their child’s overweight (Stark et al. 2011, Junnila et al. 2012, Tucker et al. 2013) and parents whose children had been diagnosed with chronic diseases as well as type 1 diabetes mellitus (Merkel & Wright 2012) and asthma (Sigurdardottir et al. 2013). In addition, the interventions targeted families whose children had been in active cancer treatment.
(Svavarsdottir & Sigurdardottir 2013), to bereaved parents following the death of their child (Darbyshire et al. 2012) and to parents with risky alcohol consumption habits, realized in a pediatric unit (Bjerregaard et al. 2011).

Few studies targeted only fathers. These studies were focused on grieving fathers after the death of their child (Aho et al. 2011) and African American fathers who did not reside with their children (Julion et al. 2012). In addition, studies were focused on fathers of premature infants admitted to a neonatal intensive care unit (Lee et al. 2012) and transition into parenthood of male partners of low-income pregnant mothers (Mitchell-Box & Braun 2012).

Family nursing interventions are usually realized as face-to-face situations where there is a connection between a family nursing professional and the client (for example, Häggman-Laitila et al. 2010, Rossiter et al. 2012, Kemp et al. 2013, Thome & Arnardottir 2013). Family nursing interventions have been conducted in different contexts. Most interventions have been described to have taken place in hospital settings, usually a pediatric unit (Bjerregaard et al. 2011), a neonatal intensive care unit (Lee et al. 2012) or a medical center (Mu & Chang 2010, Tucker et al. 2013). Interventions have been also realized in community settings, such as child care centers (Breitenstein et al. 2010, 2012), conference meeting rooms (Julion et al. 2012) and education and rehabilitation centers (Yildirim et al. 2012). In contrast, resource and strength-based interventions realized at an early stage are usually conducted at family homes (Beeber et al. 2010, Häggman-Laitila et al. 2010, Kelley et al. 2010, 2012, Rossiter et al. 2012, Kemp et al. 2013, Thome & Arnardottir 2013).

Two types of intervention strategies can be identified; discussion and concrete family or nurse activity interventions (Anderson 2000). Discussion in particular is commonly used in different ways in family nursing interventions. Various concepts and meanings have been used in relation to different contexts of discussion. These include different elements, such as providing education (Yildirim et al. 2012), information (Aho et al. 2011, Kemp et al. 2013, Sigurdardottir et al. 2013, Son & Lim 2014) and counselling for families (Darbyshire et al. 2010, Häggman-Laitila et al. 2010, Rossiter et al. 2012). Through discussion, families have received, for instance, social (Beeber et al. 2010, Lee et al. 2012, Merkel & Wright 2012, Mitchell-Box & Braun 2012, Salonen et al. 2013), psychosocial (Häggman-Laitila et al. 2010, Kemp et al. 2013), cognitive (Thome & Arnardottir 2013) and emotional support (Kelley et al. 2010, 2012). In addition, problem solving (Breitenstein et al. 2010, Kelley et al. 2010, Breitenstein et al. 2012, Kelley et al. 2012, Rossiter et al. 2012), sharing thoughts and feelings (Häggman-Laitila et al. 2010, Yildirim et al. 2012), interviews (Kamban & Svavarsdottir 2013, Svavarsdottir et al. 2014) and questions (Sigurdardottir et al. 2013, Svavarsdottir et al. 2013, Thome & Arnardottir 2013, Tucker et al. 2013) have been used. Activities realized in interventions have included physical activity (Stark et al. 2011, Junnila et al. 2012, Tucker et al. 2013) and general health promoting activities (Kemp et al. 2013).
2.4.3 Evaluation and outcomes of interventions

The evaluation of the effectiveness, success and efficacy of intervention studies has used both the quantitative (Rossiter et al. 2012, Kamban & Svavarsdottir 2013) and qualitative (Häggman-Laitila et al. 2010, Mitchell-Box & Braun 2012, Kemp et al. 2013) approaches. A multitude of concepts have been used in evaluating interventions, such as benefits of intervention (Häggman-Laitila et al. 2010, Kemp et al. 2013, Sigurdardottir et al. 2013, Svavarsdottir & Sigurdardottir 2013), effectiveness of intervention (Lee et al. 2012), effect (Yildirim et al. 2012, Son & Lim 2014) and impact (Salonen et al. 2014) of intervention. In addition, service evaluation (Häggman-Laitila et al. 2010, Thome & Arnardottir 2013) and process evaluation (Kemp et al. 2013) have also been used.

Intervention study designs vary and many different designs can be identified. Studies have used the single-measured post-test (Häggman-Laitila et al. 2010, Aho et al. 2011), pre-test and post-test measurement without using a control group (Kelley et al. 2010, Bjerregaard et al. 2011, Kelley et al. 2012, Kemp et al. 2013, Thome & Arnardottir 2013) and pre-test and post-test measurement whether there were differences between in the intervention and a control group (Beeber et al. 2010, Aho et al. 2011, Breitenstein et al. 2012, Junnila et al. 2012, Yildirim et al. 2012).

Family nursing interventions have usually produced diverse positive effects and outcomes to families’ or some of its members’ health and well-being both in national (Häggman-Laitila et al. 2010, Aho et al. 2011, Junnila et al. 2012, Salonen et al. 2014) and international studies (Darbyshire et al. 2012, Rossiter et al. 2012, Kemp et al. 2013, Thome & Arnardottir 2013). Through the interventions, parents have received emotional (Aho et al. 2011, Sigurdardottir et al. 2013, Svavarsdottir & Sigurdardottir 2013, Svavarsdottir et al. 2014), cognitive (Kamban & Svavarsdottir 2013, Sigurdardottir et al. 2013, Svavarsdottir et al. 2013, 2014), social (Julion et al. 2012) and familial support (Sigurdardottir et al. 2013, Svavarsdottir & Sigurdardottir 2013, Svavardottir et al. 2014). Interventions have also supported parents’ coping with their parenthood. For example, fathers have experienced stronger personal growth (Aho et al. 2011) and satisfaction with their parenthood (Julion et al. 2012, Salonen et al. 2014). Parents have received support related to competences of bringing up and taking care of children (Beeber et al. 2010, Häggman-Laitila et al. 2010, Rossiter et al. 2012), and improved their confidence and strengthened their bond to their infants (Rossiter et al. 2012). Furthermore, parents have been supported in the context of their children’s behavior problems (Breitenstein et al. 2012). Interventions have also had positive effects on parents’ self-efficacy, which has improved (Breitenstein et al. 2010, Son & Lim 2014) and parents have experienced more positive parenting (Breitenstein et al. 2010). Positive parenting has been described as, for instance, strengthening of parents’ sense of coping with parenthood (Thome & Arnardottir 2013) and parents becoming more committed to their children (Julion et al. 2012).

Interventions have also brought about positive changes into families’ health habits (Kelley et al. 2010, Bjerregaard et al. 2011, Kelley et al. 2012, Junnila et al. 2012, Tucker et al. 2013). For example, parents alcohol intake (Häggman-Laitila et al. 2010, Bjerregaard et al. 2011), and consumption of vegetables has been found to increase (Junnila et al. 2012, Tucker et al. 2013). Physical activity (Kelley et al. 2010, 2012, Tucker et al. 2013) and
mothers’ sleeping time during weekends were also increased (Junnila et al. 2012). Interventions have improved mothers’ (Beeber et al. 2010, Breitenstein et al. 2010, 2012, Thome & Arnardottir 2013, Salonen et al. 2014), fathers’ (Aho et al. 2011, Lee et al. 2012) and grandmothers’ mental health (Kelley et al. 2010, 2012). Interventions have also reduced couple’s distress (Thome & Arnardottir 2013). In addition, interaction within the family (Häggman-Laitila et al. 2010) and relationship between partners have been improved (Häggman-Laitila et al. 2010, Julion et al. 2012, Mitchell-Box & Braun 2012).

2.5 SUMMARY OF THE THEORETICAL BACKGROUND

Family nursing has been described from different perspectives as a strength-based, developmental and social learning theory, and a system theory. Definitions of families and family nursing have varied according to these theoretical perspectives. The approaches also highlight the health, well-being and resources of families. However, many studies have focused on the implementation of the problem-based support provided to families in clinical contexts. It is known that families’ own homes will provide a favorable and safe environment for an uncomplicated collaborative relationship between family nurses and families. In the current situation, it is possible to recognize a tendency of moving away from a problem-based method towards a resource-based approach, which is future-oriented and aims to create an encouraging atmosphere.

In resource-enhancing family nursing, identifying families’ strengths is the first and one of the most important strategies. The other strategies include developing and calling for resources. It is essential that families are aware of their own resources and the issues which can weaken them and that strength are recognized by both family nurse and the family. This enables the families to use identified resources for managing stressful factors and to find the reasons for events is their lives. The nature of the nurse-family relationship is collaborative, which means that the family’s expertise is appreciated and trusted. The home, as a natural environment, enables the family nurse to support potential resources by families. A collaborative relationship between the family nurse and the family is considered pivotal for the success of the resource-enhancing method of work. Nevertheless, only few studies have been published on the topic. In addition, there are only some studies regarding the effects of the resource-enhancing method of work as evaluated by families or focused on the experiences of family nurses on the use of the method. It is known that resource-enhancing family nursing strengthens the family’s internal and external resources in order to improve families’ functioning as a unit and considering children’s development and health.
3 Aims of the study

The aim of this study was to describe and evaluate the resource-enhancing family intervention (REFI) in families with small children, and to assess the effects of the intervention carried out at families’ homes from the perspectives of parents. The aim was also to evaluate preventive family nursing intervention studies. The study consisted of empirical research and a systematic review.

The specific objectives were as follows:

1. To identify and describe needs for support of mothers, fathers, children and entire family in family life at the beginning of a resource-enhancing family nursing intervention (Original publications I-II).

2. To describe and evaluate the implementation of the resource-enhancing family nursing intervention (Original publications II-III).

3. To assess the effects of resource-enhancing family nursing intervention from perspectives of parents (Original publications II–III).

4. To identify and evaluate the critical methodological aspects and effects of preventive family nursing intervention studies (Original publication IV).
4 Methods

Study design
In this study, qualitative and quantitative methods were used to produce new and multidimensional information on preventive family nursing interventions (Burns & Grove 2009, Monrad 2013). The study consisted of an empirical study and a systematic review. (Figure 2.)

The empirical study method was used in order to identify Finnish families’ needs for support in family life situations, and evaluate the effects of resource-enhancing family nursing intervention, and describe and evaluate the collaborative relationship between parents and a family nurse during the intervention.

The systematic review (2003–2014) was selected as the method to be used in order to evaluate the methodological aspects and effects of preventive family nursing intervention studies. This review was thus concerned with international intervention studies focused on interventions at families’ homes. A quality appraisal tool was developed for the evaluation of these intervention studies (Windle 2010).
Resource-enhancing nursing in the homes of families’ with small children

Evaluation of early interventions

Empirical study of resource-enhancing family nursing intervention

Resource-enhancing family intervention at families’ home
Families (n= 30) including 129 family members with support needs in family situation
Years 2004–2005

Entry to the intervention referred to
- Friends and relatives
- Media
- Authorities of public social and health care services:
  - public health nurses
  - social workers
  - day care centres
  - psychiatric clinics
  - home help services

Aim: To identify and describe studies that cover preventive family nursing interventions in families’ homes and how the studies relate to the families’ health and well-being

Limitations: English language, years 2003–2014

Databases: CINAHL, PubMed, Web of Sciences, Scopus

Data: 2077 original studies, 11 selected based on inclusion and exclusion criteria

Figure 2. Study design
4.1 EMPIRICAL STUDY OF RESOURCE-ENHANCING FAMILY NURSING INTERVENTION

4.1.1 Research context
The intervention was conducted in municipalities with a few thousand inhabitants in southern Finland between 2004 and 2005 during a 19–month-period. The two municipalities were willing to implement the recommendations of the Ministry of Social Affairs and Health. At that time, the Ministry’s national recommendations for family services emphasized preventive and early support for the families with small children. According to the recommendations, trained family workers with competency in social services should be employed by child health clinics or family service networks. In addition, each family worker was recommended to be paired with a public health nurse and maintain collaboration with day-care and school staff. The ultimate aims for the family services were to pay a sufficient attention to the families’ life situations and to offer family- and client-centred services. In addition, the aim was to empower parents and entire families as well as to hear family members’ own interpretations of their life situations. (Ministry of Social Affairs and Health 2004.)

The municipalities which participated in this study received government funding for the family service development and hired a family nurse, whose services complemented the existing preventive family nursing services. Family nurse worked in collaborative relationships with families and authorities in the municipalities. Family nursing was conducted mainly in families’ homes, but some families were met in social and health care service facilities. At that time, the total of 623 families with small children between 0 and 6 years of age lived in the two municipalities observed in this study (Statistics Finland 2013).

4.1.2 Participants and recruitment
The participants in this study included altogether 129 Finnish family members from 30 families with small children. The families either had at least one child 0–6 years of age or the families who were expecting a child. The families comprised of children (n=71), mothers (n=30) and fathers (n=28). Twenty-seven parents shared joint custody of their children. Three were single parents, out of whom one was male and two were female. (Table 3.)

The families were the clients of public child health clinics in the municipalities. Public health nurses or others professionals offered a family nursing services for families in need of health care services as a form of additional support. The participants in this study were families who felt that their needs were not been sufficiently met with the services of a family nurse, but who did not fall under the sphere of corrective child welfare services. The families themselves decided to seek out the services provided by the family nurse. (Figure 2.)
Table 3. Background information of families’ (n=30) and family members’ (n=129)

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<tr>
<th>(n= 30 families)</th>
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<tr>
<td><strong>Background information</strong></td>
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<td>Mothers (n=30)</td>
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<td>mothers’ age</td>
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<td>36–43 years</td>
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<td>Mean 32.1</td>
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<tr>
<td>fathers’ age</td>
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<td>21–25 years</td>
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<td>Mean 33.9</td>
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<td>Standard Deviation 8.1</td>
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<td>Total</td>
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<td>Children (n=71)</td>
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<td>8–18</td>
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<td>Mean 4.8</td>
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<td>Standard Deviation 4.2</td>
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<tr>
<td>Total</td>
<td>71</td>
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<tr>
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<tr>
<td>2–3 children</td>
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<td>47</td>
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<tr>
<td>4–5 children</td>
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<td>23</td>
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<td>Mean 2.5</td>
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<td>Standard Deviation 1.3</td>
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<td>Total</td>
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<td>Type of family (n=30)</td>
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<tr>
<td>Shared joint custody</td>
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<tr>
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<td>10</td>
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<tr>
<td>Total</td>
<td>30</td>
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</table>
The families who participated in this study received information about the family nurse service by the municipalities’ public health nurses, social workers, day care centre personnel, health centre psychologists, psychiatrics clinics and home help services. In some cases, the families had heard about the service from their friends, relatives, or in the media. However, the families personally made themselves the decision about their participation. (Figure 2.)

The parents voluntarily enrolled themselves to the services. The family interventions were aimed at all families with small children and were intended for i) for families with a need for early psychosocial support, ii) families who had either an expectant mother or at least one child under the age of seven and iii) families who did not fall under the sphere of corrective child welfare services.

**4.1.3 Intervention**

In this study, resource-enhancing family nursing interventions were conducted at families’ homes in 2004–2005 during a 19 month-period. A client- and family intervention approach was used based on McGill Model of Nursing (MMN) (Feeley & Gottlieb 2000). The aim of this intervention was to give early support to families and to help them use resources of their individual members and of the family as a unit. In addition, the aim was to support families’ to use resources external to the family system, to solve problems, to cope with different issues, to achieve goals and to develop as a family. The duration of conducting family nursing varied according to the strengths and abilities in the families. The service was new and was offered free of charge to the families. (Figure 3.)

The family nurse and the family established a collaborative relationship wherein the family’s expertise was appreciated and trusted. Families themselves defined the matters and habits that were significant to them. They also decided on suitable intervention methods for themselves and determined the number of meetings with the family nurse. Other methods supporting the discussion included video assisted counselling, creation of a family tree and parents’ role map, network collaboration with close relatives of the family and authorities, observation of the family situation and parent-child group activity.

The families received resource-enhancing support from one family nurse who worked in connection with child health clinics and other authorities in the municipalities. The family nurse was a woman trained as public health nurse and as a family therapist. She was employed by the municipalities. She had long work experience and was specialised in resource-enhancing family nursing as well as video-assisted family counselling. The family nurse’s work was based on values such as individuality, self-determination of family, openness, honesty, confidentiality, equality, flexibility and comprehensiveness (Häggman-Laitila et al. 2000).

The collaboration was aimed at the whole family, although there were also families in which only some family members needed support, depending on their needs for support. During the intervention, the family nurse worked in collaborative relationships with families in their homes (Kardamanidis et al. 2009). The home was a natural and safe environment for the families, but at the same time, it was a challenging working
environment for the family nurse. Each single home was a unique and a private place for the families, and the family nurse’s working environment and methods varied.

**Resource-enhancing discussion**

Resource-enhancing discussions were based on the support needs identified by the families themselves. (Figure 3.) A resource-enhancing discussion is goal- and future-oriented by nature and it aims to create an encouraging atmosphere between a family nurse and their client. The following principles of resource-enhancing family nursing were included: separation, dialogue, reflection and community (Holm 2000, Gottlieb 2014). The principle of separation means that each family is unique, and a family nurse works with the whole family although there were also families in which only some family members needed support. Dialogue refers to the emotional relationship between parents and a family nurse, which includes care, trust and respect for one another. It is a way for finding solutions together, adding to and increasing what a family already has, and it can be the key to collaboration. In discussions, everyone’s own experiences and views on reality are respected, and room is given to all participants. The family nurse listened to the families, respected their stories and took the family members seriously. (Häggman-Laitila 2005.) In reflection, the family nurse supported each family to evaluate their own lives and everyday life actions. In other words, a family can learn through their own actions and become aware of their own abilities and needs. The principle of community means that a family nurse and parents agree together on the limits for the family nursing realised in the family. Family members also define themselves and their respective positions within the family and their community though the means of life stories and identity stories.

In this study, resource-enhancing discussions were carried out in all family meetings with the members of the family either together or separately. The family nurse used discussions formulated in three strategies. At the first, resources were identified and feedback was provided. The nurse asked questions from the parents on issues including their functional solutions to everyday life situations, favourable changes, exceptions and differences in everyday life, current and past resources, and prospects for the future. At the second, resources were developed by transferring the use of resources, turning weaknesses into resources and developing competencies. At the third, the resources were called by using different family nursing methods such as family trees, network maps and network meetings. Resources were also mobilised and used effectively, and the family nurse assisted the family in regulating the use of the resource. (Feeley & Gottlieb 2000, Gottlieb & Gottlieb 2007.)

**Video-assisted family counselling**

Video-assisted family counselling (=VHT, Video Home Training or VIG =Video Interaction Guidance) is a method that supports parents’ and the children’s activities at their home by using video recording (Jansen & Wels 1998, Eirola 2003, Kennedy et al. 2011) and it is an authentic tool that provides a starting point for counselling sessions and enables the participants to recall family processes by watching them. The aim of the method is to improve the management of family life, and it promotes a focus on family life, emphasises
parental responsibility and enhances life management skills of families with small children. In addition, the aim is to increase instances of positive and successful interaction, which are necessary for the improvement of families’ health and the development and progress of both children and parents. (Eirola 2003, Häggman-Laitila et al. 2010.)

The video recording allows a detailed analysis of interaction from the both perspectives provides a suitable preventive method to client-oriented family work. Using of the method requires voluntary participation of the family. It is important that families are willing to change their life situations and also that they are committed to the change. The method also emphasises parental strengths and responsibility at families’ own home environments (Häggman-Laitila & Pietilä 2007).

The video home training method requires both long-term education and regular mentoring (Eirola 2003, Häggman-Laitila et al. 2007). Family nurses need to master the video training equipment and video recording technology. It is also essential also that the family nurse has good interaction skills, capabilities to counsel families and takes into consideration the ethical viewpoints connected with the method (Häggman-Laitila et al. 2010). Moreover, it is important that family nurses have enough time to work with families and strengthen their resources.

In this resource-enhancing family nursing intervention, the video home training was implemented through five phases (Häggman-Laitila et al. 2010). First, the family nurse started by drawing up a video home training plan together with the family to address the needs for change identified by the family. Second, recording sessions were realized at the family’s home. Third, after each recording session, the family nurse chose the parts of the recording about which she wanted to give the family feedback. The family nurse commented on instances where the parents had used positive interactions. The fourth phase consisted of the nurse’s feedback visits, which lasted approximately 1.5 hours per family. During each visit, the recording was watched and reflected upon according to families’ needs, such as either frame by frame or one section at a time or, alternatively, by covering longer film sequences. The fifth phase was conducted as follow-up visits in which parents described and evaluated the realization of possible changes and the permanence of these changes in their family life. (Figure 3.)

Experiential methods

Creation of a family tree is a pictorial presentation of family events. The aim of the method is to help families to make visible, and increase awareness of, their resources and values supporting them as a family. A family tree is a picture drawn by family members and visualises family relationships, including tensions and distances between of family members’. The basic idea for using a family tree is to illustrate the family’s history. In the creation of a family tree, a family concentrates to illustrate past and current events in their family life and make visible feelings they have experienced and their meanings to the current situation. Increased awareness of the family history helps to understand families’ everyday lives and their habits. Different lifestyles, values, and family secrets may be passed on from parents to children (Rönkkö & Rytkönen 2010).
Creation of a parents’ role map is a practical tool in family work that allows parents to observe and understand their own actions as parents. The aim of the parents’ role map is to help parents in self-assessment, in parenting discussions and parenting groups. (Helminen & Iso-Heiniemi 1999.) Through a parents’ role map, parents and a family worker can systematically assessed parenthood. It also helps to identify needs for changes concerning to the children and their development. The method has been developed to improve outlining of comprehensive parenting and difficult issues as a natural part of parenting. In a role map parents have five main roles: a guardian, a giver of love, a limit setter, an interpersonal expert and a teacher of a life. Each main role is divided into 6–9 sub-roles. (Helminen & Iso-Heiniemi 1999, Rautiainen 2002.)

In this study, the family nurse and some of the participant parents created together family trees and parent’s role maps in their own homes during the intervention. These methods were used for calling resources or if parents considered that they would personally benefit from using them. (Figure 3.)

Network collaboration
Network collaboration focuses on social support given by of important persons and authorities as named by the family. The aim of the network collaboration is to identify and activate families’ own existing networks consisting of families’ close and relatives and authorities that can help the family in solving their problems. Network collaboration is founded on flexibility, continuity and mutual trust (Määttä 2007). A family nurse helps assessing families’ satisfaction with their relationships and their quantity and contents. Network collaboration has been recognized to be useful especially at the initial phase, but also at the end, of the family’s clientship. (Häggman-Laitila et al. 2000.)

In this study, some of the parents selected the network collaboration method with the family nurse, other authorities and friends and relatives. Network collaboration meetings were prepared together the families. Families were asked about the topics for discussion and people to participate in the meetings. Network collaboration meetings were held when a family had a number of active supporters and when it was important to discuss each support issue and function in collaboration. (Figure 3.)

Parent-child group activity
Group activity for families with small children responds to families’ psychosocial support needs. The aims of groups have included supporting parenthood, identifying and strengthening parents’ resources and helping them to solve the problems (Häggman-Laitila & Pietilä 2007, Haaranen 2012). Groups can provide social support, increased parental knowledge and an improved interaction between children and parents. During the group activities, parents’ have an opportunity to share their questions and problems with others with a similar life situation. They also have a possibility to get new perspectives to their own lives. Mutual discussions create a feeling that individual parents are not alone with their difficulties. Thus, group activities are reciprocal: at the same time, participants receive social support from, and provide it to, others. Group activities have usually been provided as a part of public services or third sector and they have been free
of charge. Families have had free access to the groups. Groups are operations are either permanent or temporary. (Häggman-Laitila & Pietilä 2007, 2009.)

In this study, some mothers participated in group-activities with their child. Groups were publicly facilitated though social and health care services. Groups gave an opportunity to mothers to create a new social support networks and receive more information about motherhood. Groups also supported mothers’ own growth as parents. (Figure 3.)

Observation of family situations
Observation of family situations is a method which aims to assess families’ or their members’ everyday life events and situations in a natural environment. Observation can be conducted by professionals in agreement with families and by focusing on the families’ priorities. Observation can focus, for example, on a child’s development and function in everyday life contexts. Observations can be recorded by video or in writing, and the material can be reflected upon during later discussions (Häggman-Laitila et al. 2000).

In this study, a family nurse observed some children at day care centers and recorded these observations in writing. This observation method was also used with families at their homes in order to gain knowledge of families’ everyday life functions and habits. (Figure 3.)

4.1.4 Data collection methods
In this study, data were collected by using qualitative and quantitative methods, including data such as client reports, family care plans and Family Situation Barometers (FSB). Multiple data collection methods were used in order to acquire knowledge from different perspectives. The duration of data collection depended on the length of the families’ participation period and was based on discussions between the family and the family nurse during the intervention. In addition, empirical data consisted of the responses to a semi-structured questionnaire realized among parents at the end of intervention. The selected methods were used in the nursing intervention for three main purposes: 1) they helped in planning family nursing 2) they were used as a data collection instruments and 3) they enabled following up the progress of family nursing and evaluating it (Häggman-Laitila et al. 2000).

Family care plan and client report
Family care plans were used as a working tool as well as a data collection method in order to identify, follow and report the targets and achieve goals of family nursing (Häggman-Laitila et al. 2000). The plans have been developed to support the family nursing. A family care plan is a multi-page form which includes open-ended questions concerning family situations, such as the number and age of family members, parents’ current employment status, the most important support needs identified by the parents, social support networks, parents’ goals for family nursing and the methods chosen to meet them, and appointments with the family nurse. The parents and the family nurse assessed the changes in the family’s situation during the intervention in shared discussions. The
information was written down by the family nurse using the family’s own words and their experiences. The family care plan was then condensed into a client report form, including a summary of the family’s background information, support needs, social support network, set and achieved goals, used methods, family nursing assessments, number of appointments and their duration, and the reason for ending the client relationship.

Family Situation Barometer
The Family Situation Barometer (FSB) instrument is a structured questionnaire for mothers, fathers, children and entire families (Häggman-Laitila et al. 2000) whose purpose is to evaluate families’ needs for support and life situation and changes in issues concerning families’ everyday life. A form of the instrument adapted for mothers, fathers and family situations contains 14 propositions, while an instrument for children’s support needs contains 12 propositions. The instrument includes Likert-type scales of 1, no need for support; 2, slight need for support; 3, some need for support; 4, much need for support; and 5, very great need for support. In this study, the families filled out the FSB together with a family nurse at the beginning and at the end of the intervention. The respondents were requested to circle a number to indicate the need for support in each assessment area.

A semi-structured questionnaire
A semi-structured questionnaire was used to gain information on the contents and form of family nursing and to be able to evaluate the realisation of the family intervention from parents’ perspectives (Baumbusch 2010). The questionnaire contained 12 structured questions, 7 open-ended questions, and two Likert-type scales. The open-ended questions focused on support needs (questions 13–15), benefits of family nursing (questions 16–17) and discussions with the family nurse (questions 18–19). Two Likert scales were used to ask about collaboration with the family nurse. The scale was as follows: 0, does not concern me; 1, negative relevance; 2, fairly negative relevance; 3, no relevance; 4, fairly positive relevance; 5, positive relevance. The second Likert scale was concerned with the realisation of collaboration and used an assessment scale ranging from 4 to 10 (4 = very poor; 10 = excellent).
Figure 3. Details of the description and evaluation of REFI
4.1.5 Data analysis
Data collected through family care plans and client reports were analysed first by a qualitative content analysis (Graneheim & Lundman 2004, Elo & Kyngäs 2008, Vaismoradi et al. 2013) and then by descriptive statistical methods. In the first phase of qualitative content analysis, the original expressions and quotes were extracted from data according to the research question. Subsequently, selected original expressions were listed and compared in relation to their similarities and differences. Expressions with the same meaning were then classified into the same subcategory and named. Again, these subcategories were compared, and then combined into main categories. In total, four main categories were found and named according to the research question: i) families’ previous support, ii) support needs, iii) social networks, and iv) set and achieved goals. In the second phase, the data were analysed by using descriptive statistical methods. The frequencies of background information (e.g., parents’ and children’s ages, amount of children in families, duration and amount of family nursing, elapsed time in family nursing) and the contents and forms (e.g., amount of support needs, social support networks and used methods, previous supporting authorities) of the methods were calculated and expressed as percentages (Table 3).

Data from the Family Situation Barometers (FSB) were analysed with descriptive statistics and non-parametric Wilcoxon tests using SPSS for Windows 19. The data were categorised in order to present the data in condensed form. The data analysis was started by combining statements indicating the amount of support needed support into the following three categories: 1, no need for support; 2, some need for support (categories 2 + 3 combined); and 3, much need for support (categories 4 + 5 combined). Subsequently, categories 2 and 3 were combined, resulting in the following categories: 1, no need for support and 2, need for support. Frequencies and percentages were calculated for the need for support. The Wilcoxon test was used to compare the two paired groups.

The data from the semi-structured questionnaire were analysed with descriptive statistical methods using SPSS for Windows 19. The frequencies were calculated and expressed as percentages. The contents of open questions were calculated manually according to the semi-structured questionnaire.

4.1.6 Validity and reliability of methods
The data collection methods of the empirical part of this study were developed and used during the Families with Children Project (1996–2000). Moreover, some of the methods have been utilised in an earlier study on family nursing (Häggman-Laitila 2003) and found useful. The data were collected by one family nurse, but she was not part of the research group, and did not contribute to the data analysis. Instead, during the analysis, the family nurse collaborated with the researcher, deepening the understanding on the contents of family nursing. The researcher (H-MT) independently analysed and reported on empirical data, and was responsible for taking care of the preservation of data after the intervention.

Family care plans and client reports described family nursing realised at families’ homes. The families evaluated their situations immediately after the family nursing had taken
place, and evaluations were recorded together with the family nurse. The credibility of the study was improved because of the family nurse’s good relationship with the families, her familiarity with them as her clients, and the possibility she had for encouraging the families to describe their experiences in the open-ended questions. The researcher (H-MT) verified the information directly from the family nurse before classifying and saving the data in the case of unclear questions. The family nurse confirmed the results of the analysis.

Family Situation Barometers were completed for all family members, who needed the support according to the parents. This was the first study concerning the systematic use of the FSB in assessing a family nursing intervention. The content validity of the FSB is based on a study conducted using qualitative and quantitative content analysis (Häggman-Laitila 2003). The content validity and the concepts of the FSB can thus be considered good. The level of abstraction was sufficiently high and the concepts can be used to recognise the support needs of family members at different stages of life (Häggman-Laitila 2003). This increased the applicability of the FSB and added to the credibility of the study. The Cronbach’s alpha for the sum variable was 0.61 based on the support dimensions. The values indicated moderate internal consistency of the formed sum variables. (Bonett & Wright 2015)

Parents filled out the evaluation a semi-structured questionnaire used to evaluate the family nursing immediately at the end of the intervention, when their experiences could still easily be relived. The questionnaire form was a measurement tool developed in a group of experts and had been previously used and tested. Its contents had their premises on qualitative analysis on the efficacy of family nursing and cooperative relationship with family nurses (Häggman-Laitila 2003, Häggman-Laitila 2005). The trustworthiness of data collection was enforced by a close cooperative relationship between the research group and the family nurse during the data collection.
4.2 SYSTEMATIC REVIEW OF FAMILY NURSING INTERVENTIONS

Systematic review was selected as the research method in order to gain latest international knowledge. The review was concerned with preventive family nursing intervention studies conducted at home and determining how interventions affect to the families’ health and well-being.

4.2.1 Electronic searches of original articles

As a tool for data collection, electronic searches were conducted in the four databases of CINAHL, PubMed, Scopus and Web of Science. Search phrases were structured by combining words intervention* and home visit* with words concerning family members (child*, baby*, infant*, mother*, father*, parent*). The search words were selected in collaboration with an informatician (Windle 2010). Electronic searches were limited to articles published between the years 2003 and 2014 in the English language.

The inclusion criteria were identified in order to limit the risk of selection bias and ensure similarity of the selected articles (Evans 2004, Windle 2010). Inclusion criteria were as follows: i) scientific publication, ii) studies including family nursing interventions provided to families in their homes, iii) focus on families with child or children under seven years old, and iv) interventions conducted by at least one trained nurse. The identification of interventions was based on the manifest description in selected articles. Articles were excluded if they: i) focused on a specific situation or changes of the families’ life (such as delivery, teen pregnancies, preterm infant care, child abuse or neglect, or family violence), ii) were concerned with a specific family health care issues (such as oral care, overweight in children or nutrition), and iii) dealt with the illnesses in the family (such as diagnosed diseases, fatal health issues, disorders or hospitalisations). In addition, articles were excluded if they iv) did not included any interventions or v) intervention was realised only by paraprofessionals or volunteers and there were no any nursing education professionals.

The selection process was conducted in stages (Windle 2010). At the beginning, two authors (H-MT and MK) identified (N=2077) publications from the databases. Subsequently, the authors selected original articles based on title (n=257), abstracts (n=95), and full texts (n=11). All stages were conducted independently by both authors, and selections made in agreement (Figure 4).
4.2.2 Quality appraisal of original studies
The quality of all eleven (n=11) selected original studies were evaluated (Windle 2010, Voss & Rehfuess 2013). Because no suitable appraisal tool was available for preventive family nursing intervention studies, one was developed in this study based on previously published criteria. The Support Unit for Research Evidence, SURE (2013), which was published earlier, was used to identify interventions, and criteria by Gifford et al. (2007) were utilized to specify different methods. The created tool consisted of four themes, including 31 quality domains, with four possible responses: yes, no, not reported or not relevant for this study (see Table 1, original publication IV). Evaluation of the selected studies was carried out independently by the two authors (H-MT, MK), and confirmed in an agreement in a research group. All of the eleven selected studies were included in the process.

4.2.3 Data extraction, analysis and abstraction
The data analysis of systematic review was conducted in three stages. First, each selected articles was read through several times in order to get an overview of its contents. Second, the data were tabulated and extracted by publication information (author(s), year and country), methodological characteristics (aims, methods, participants) and description of interventions (intervention programme or approach, person who carried out the intervention, the type and duration of intervention) and main results. Third, the results of the selected studies were analysed by using inductive content analysis (Graneheim & Lundman 2004, Elo & Kyngäs 2008, Vaismoradi et al. 2013). In the analysis, the contents of results were identified according to the research questions and categorized into 17 sub-categories based on their similarities and differences, and abstracted and connected again to the four main categories. In addition, frequencies in all main categories were calculated. All of the data analysis was conducted by one author (H-MT) and then confirmed and agreed upon by the research group.
4.2.4 Limitations and trustworthiness

The limitations and trustworthiness of the review are related to the selection and evaluation of the original studies. Formulating the search phrase was a crucial step in the process. The use of MeSH terms is suggested in order to improve trustworthiness, but due to unestablished terms in the field of family nursing, using the terms provided no desired search results. Two preliminary searches were conducted, and, as a result, an informatician and the research group were consulted to use free words and phrases in the search.

In order to improve trustworthiness, exactly defined inclusion and exclusion criteria were used for the selection of studies. During the extraction phase of the analysis, the author ensured the trustworthiness by using background information of the intervention programmes of the selected studies, such as references lists and internet searches for selected categories were formed, and subsequently confirmed and agreed upon by the research group.

In the quality appraisal phase, suitable tools were not available for preventive interventions carried out in families’ homes. Therefore, the researcher group developed a new tool based on previous criteria, because quality has been recognised to be important (Whittemore & Knafl 2005), a fact encouraging the development of detailed quality domains for the selected studies.

4.3 ETHICAL CONSIDERATIONS

Ethical issues were taken into account throughout the whole research process. This study was conducted according to the research ethical guidelines of the Finnish Advisory Board on Research Integrity (2012), following the main principles of research ethics: respecting study participants’ self-determination, autonomy and privacy, protecting data, and avoiding any harm for participants (Finnish Advisory Board on Research Integrity 2012). In this study, the main ethical issues were concerned with the following questions: official ethical approval, families’ participation and informed consent, observing families in their own homes, and data protection.

**Official ethical approval:** According to the Finnish law (1999/488, 2004/295, 2010/794), this type of study does not need statement from an official research ethics committee. The empirical study received administrative approval from the participating municipalities. Permission for the study was granted by officials in charge of the social and health care services in the municipalities which this study concerned. Based on the decision of a social administrator in the municipalities, the family nurse was responsible for collecting the data. The family nurse informed families at baseline about the use of the family nursing documents for research purposes. In addition, the study participants were informed about the evaluative goals for new services in the municipality and research-related aspects.

**Families’ participation and informed consent:** The families made autonomously decisions on their participation in the study. Resource-enhancing family nursing was conducted in
the families’ homes, was voluntary and service free of cost. During the research process, it was ensured that no harm would be caused to the families and the parents were told that they could not be identified from the study reporting. Families were informed that they could withdraw from participating in the study at any given occasion. This was an important detail to take into account, as some families may have felt that refusing to participate in the research would exclude them from receiving help from the family nurse. All families gave their written informed consent to the research. However, children who participated were not requested a written proxy consent in the research because the parents were the legal guardians of their children and thus had the main responsibility to find out if their children were willing to participate. Parents had the right to decide on their children’s participation.

Data collection and analysis: Data were collected at families’ homes. As a result, ethical principles related to respecting privacy and autonomy had to be considered. This meant that data had to be collected by educated professionals and families’ point of views had to be prioritized. During the analysis, all data were handled with confidentiality and families could not be identified from the reports written on the data.

Data protection: The research data were protected accurately. The researcher (H-MT) analysed the empirical data and took care of the preservation of data after the intervention. The data were kept in a safe place in the researcher’s home.
5 Results

5.1 FAMILY’S SUPPORT NEEDS AT THE BEGINNING OF THE RESOURCE-ENHANCING FAMILY NURSING INTERVENTION (ORIGINAL PUBLICATIONS I-II)

Mothers’ and fathers’ needs for support

More than half of the mothers (65%) needed support with their mental health, such as with mood, coping with daily life and reducing the use of intoxicants. The need for support was also focused on physical health and emotional life. Mothers especially wanted support for boosting their self-esteem and expressing their emotions. More than half of the mothers (58%) wanted to be supported in social relationships. Approximately half of the mothers (51%) needed support with raising and taking care of children, such as coping with child care and increasing the amount of time spent together. (Figure 5)

Fathers had needs for support related to mental health (68%), such as in mood and in reducing the use of intoxicants. Half of fathers (50%) also needed support with their emotional lives, such as with expressing their feelings and boosting their self-esteem. Less than half of fathers (42%) needed support with their employment situation. Approximately one-third of them (37%) wanted support for physical health, parenting and child care (28%), social relationships (26%) and connected to having more hobbies (26%). (Figure 5)
The majority of children (87%) had a need for support connected to mental health. More than half of them (60%) needed support with behavior and with sleep-related issues (57%). Nearly half of children (47%) needed support with eating. In addition, approximately one-third (30%) needed support related to development and physical health and a little less than one-third of children (27%) needed support regarding day care and school attendance.

**Families’ needs for support**

Based on responses to open-ended questions in the family care plans filled out at the beginning of family nursing, most of the families (87%) needed support in terms of the health and well-being of the parents. Many families (77%) also needed assistance in strengthening their parenthood as well as with raising and taking care of their children (70%). Approximately half of the families (53%) requested support for relationships between the parents. Less than half of the families (43%) wanted support for strengthening social networks and issues related to the health and development of their children. More than one-third (37%) of families needed support related to parents’ employment and study issues, and a little less than one-third of families (30%) needed support regarding the family’s financial situation, residence and housing (27%). Only a small number of families (17%) needed support for the prevention of domestic violence, parents’ reduction of the use of intoxicants (10%) or children’s custody and visiting rights (10%). (Figure 6)

![Figure 6. Families’ needs for support at the beginning of REFI](image)
5.2 IMPLEMENTATION OF THE RESOURCE-ENHANCING FAMILY NURSING INTERVENTION (ORIGINAL PUBLICATIONS II–III)

On average, the family nurse met with the families 20.70 times (variation 3–58 times/family). In total working hours, this lasted on average 31.78 hours (variation 4–90 hours). On average, interventions had the total duration of 7.56 months (variation 0.5–19 months). (Table 4)

During the intervention, the family nurse worked in a collaborative relationship with families at their homes. The resource-enhancing discussion method of family nursing was used with all of the families (100%). Video assisted family counselling was used with half of the families (50%). The creation of family tree method was used with one-third of the families (33%), while the creation of parents’ role map and network collaboration was used with approximately one-quarter of the families (27%). The observation and parent-child group activity methods were used with three families. (Table 4)
Table 4. Implementation of a resource-enhancing family nursing intervention (n=30)

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<tr>
<th>Family</th>
<th>Duration in family nursing per family (month)</th>
<th>Meeting times per family</th>
<th>Total amount of hours per family</th>
<th>Resource-enhancing discussion</th>
<th>Video assisted family counselling</th>
<th>Creation of family tree</th>
<th>Creation of parents role map</th>
<th>Network collaboration</th>
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Summary: 227 621 953.5 30 15 10 8 7 3 3

Mean: 7.56 20.70 31.78

Std.Deviation: 5.12 13.10 20.04

The family nurse met with the families 3–58 times. The families used 1–5 different methods during the interventions. The nurse used a number of methods with families with whom she worked often.

The mean for the success of the family nurse’s work was evaluated as 9.6 (range 9–10). With the exception of one family, parents expressed that they had met with the family nurse as many times as they needed.
According to assessments of the majority of the parents (85%), the collaborative relationship had felt natural, the family nurse had enough time in the meetings (85%) and the families received support for the issues where they needed the most help (85%). These issues were realized very successfully during the intervention. The majority of parents (81%) were able to rely on the professional skills of the family nurse and she sufficiently immersed herself in the families’ causes. More than half of the parents (69%) evaluated that the family nurse correctly understood their situations and they got to have an influence on the issues they discussed with the family nurse. Parents also evaluated that their confidence in their own resources increased as well as that encouraging them to find their own solutions was realized in the collaboration very well. A little more than half of the parents (54%) clearly agreed with the family nurse on the aims of family nursing.

5.3 EFFECTS OF RESOURCE-ENHANCING FAMILY NURSING INTERVENTION ON FAMILY LIFE FROM PARENTS’ PERSPECTIVES (ORIGINAL PUBLICATIONS II–III)

The families evaluated that they had on average of 5.0 support needs at the beginning of the family nursing (range 1–6). The number of support needs was in average 1.8 at the end of the intervention (range 1–3). (Figure 7)

At the beginning of family nursing, the average score for families’ living situations was 5.8 (variation 4–8.5). Approximately half of the parents (53%) wished for help in the form of listening and discussing with the family nurse. In addition, five parents hoped to get practical advice for coping better with everyday life.

At the end of family nursing, the average score for families’ living situations was 8.6 (variation 7–10). More than half of the parents (65%) evaluated that they had indeed received support in the form of listening and discussing and all parents (100%) evaluated that they had received support for coping with everyday life.
Families’ social support networks (original publication II)
The families evaluated that they had on average 2.3 social support networks (range 1–5) at the beginning of family nursing. In most cases (73%), the support network consisted of grandparents and friends of the parents (50%). Other support networks included the parents’ siblings (30%), other relatives (17%), authorities (17%) and the children’s godparents (13%).

At the end of family nursing, the families evaluated that they had 2.8 support networks on average (range 2–5). The importance of the parents’ siblings and grandparents increased the most (80%). The importance of the parents’ friends (57%), godparents (17%) and other relatives (20%) also increased slightly. The importance of authorities as a support network decreased.

The social support networks of more than half of the families (60%) remained unchanged at the end of the intervention and the networks of less than half (40%) of the families increased or became more diverse. (Figure 8)

Goals in the beginning and of the end of the resource-enhancing family nursing intervention (original publication II)
The parents participating in the family nursing set on average 3.6 goals (range 1–6) concerning their family situation. On average, the families were able to reach 4.5 goals (range 1–7) during the intervention. (Figure 8)
The majority of the families (90%) set strengthening their parenthood as a goal, and almost all families were able to achieve this. Moreover, most of the families (73%) hoped to improve the parents’ health and well-being, which was also achieved in many families. Many parents (70%) set a goal of developing their skills in raising and caring for their children. Over half of the families (67%) achieved this goal. Many families (60%) hoped that family nursing would support the parents’ relationship. This goal was achieved by two-thirds of the families (73%). Less than one-third of the parents (27%) hoped that family nursing would support their children’s health and development. One-third of the families (33%) achieved this goal. Only a few parents (13%) set the initial goal of supporting their own or their spouse’s success at work or with studies. Positive changes in these areas were found in nearly half of the families (43%) at the end of the process. The parents did not set any initial goals regarding their financial situation, or their house or housing situation, although positive changes did occur in all of these areas in one-fifth of the families (20%).

The effects of resource-enhancing family nursing intervention (original publication III)

Based on the parents’ experiences, they felt that the intervention had positive effects on their coping with everyday life. Families estimated that family nursing increased interaction within families, gave parents peace of mind, supported raising children and handling the task of parenting, and provided tools for their own mental growth. Family
nursing also had positive effects on parents’ making plans for their lives, taking care of their relationship, coping with everyday life as a family, and returning to work.

Parents anticipated the issues that they were able to avoid with the support they got from family nursing. They also evaluated that they avoided difficult life situations, depression and prevented anxiety or increased pressure. In addition, parents evaluated which problems were avoided in the families with the help of the support that they received. According to the parents, their families were able to avoid mental health problems, break-ups or divorces, disputes related to children’s custody and visitation rights, and difficult life situations.

5.4 CRITICAL METHODOLOGICAL ASPECTS AND EFFECTS OF PREVENTIVE FAMILY NURSING INTERVENTION STUDIES (ORIGINAL PUBLICATION IV)

The selected eleven original studies included one mixed study, two qualitative studies and eight quantitative studies. Six of the eight quantitative study designs were reports of interventions and comparison groups, three were randomized controlled trials and two were non-random assignments. Five of the eleven studies focused on mothers, two on fathers, three on both parents and one on the entire family. The interventions were carried out by individual nurses or nurses working in collaboration with other family workers or paraprofessionals. The starting point for interventions with families varied from the beginning of the prenatal period to families with three-week to five-year-old children. The frequency of visits also varied from one to several visits a week or one visit every fortnight. They lasted from 45 to 90 minutes.

The intervention programs or projects lasted from two to five years and the point when families were enrolled varied. Six studies focused on interventions that started during pregnancy and three studies were conducted until the child was under pre-school age. The interventions ended when the parents had achieved their goals or the child exceeded the age laid down by the program’s inclusion criteria. Two types of intervention methods were used: discussions and practical parenting skills. Discussions were featured in all studies and included nurses talking to parents, providing social support, sharing their thoughts and feelings, encouraging and motivating them, reflecting on parenting issues and providing positive feedback, counselling, engagement and anticipatory guidance. Practical parenting skills included participating in the families’ everyday lives and exercises such as scrapbooking and using booklets and handouts.

Critical methodological aspects of selected intervention studies
The eleven selected original intervention studies were evaluated by using appraisal tool developed in the research process for preventive family nursing intervention studies (see tool in original publication IV, Table 1). In these studies, the critical methodological aspects focused on four main methodological questions of the appraisal tool which were as follows: i) common questions, ii) design/planning of intervention, iii) intervention, iv)
methods for intervention data collection and data analysis concerning reporting reliability and validity of using instruments of quantitative studies. The studies were evaluated to be critical if they got five or more mentions “no” or “not reported” in the evaluation process.

The critical methodological aspects in common questions focused on ethical approval sought and received. Only five of the eleven studies reported on this matter sufficiently and five studies did not report about this at all.

The interventions were weakly described. Seven of the eleven studies were not described sufficiently regarding the contents and the forms of the interventions. In addition, the duration of the intervention periods for individual participants was not described in seven studies.

The critical methodological aspects were also concerned with the used methods for intervention data collection and data analysis of quantitative studies. The reliability and validity of most of the used instruments was not sufficiently reported.

Evaluation of the effects of intervention studies

The effects of preventive family nursing intervention studies (n=11) was evaluated according to four main categories, which were as follows: i) parents’ coping with their parenthood, ii) families’ relationships and interaction, iii) families’ health, well-being and social relations and iv) families’ socioeconomic situations. (See original publication IV, Table 4.)

Interventions helped parents to cope with their parenthood. Ten of the eleven studies reported that interventions improved practical parenting and child caring skills. Five of the eleven studies reported on these statistically significant improvements (Benzies et al. 2008, de la Rosa et al. 2009, Guthrie et al. 2009, Sawyer et al. 2013, Sadler et al. 2013). In five interventions, parents were supported regarding their sense of satisfaction with parenting. Statistically significant improvements were reported in three studies (Benzies et al. 2008, de la Rosa et al. 2009, Sawyer et al. 2013). Three studies reported that interventions strengthened the parents’ self-confidence and improved their coping skills. In Ferguson & Vanderpool’s study (2013), statistically significant improvements were reported in parental coping skills. One study reached the conclusion that the intervention had helped parents to identify and recognize the value of their families.

Interventions support families’ relationships and interaction in four ways. Nine of the eleven intervention studies resulted in better relationships between the parents and children. Statistically significant improvements were reported in five studies (Benzies et al. 2008, de la Rosa et al. 2009, Guthrie et al. 2009, Sadler et al. 2013, Sawyer et al. 2013). Three studies reported on improving parents as a couple and enhancing their interaction. Statistically significant improvement was reported in de la Rosa’s et al. (2009) study. In two interventions, the parents’ interaction skills were enhanced, and statistically significant improvement was reported to have occurred in this area in de la Rosa’s (2009) study. In addition, one study reported improving interaction between all family members.

Interventions promoted the health, well-being and social relationships of families. Three studies reported on the effects of interventions in parents’ health issues. Studies reported that parents’ health had been improved. However, at the same time, the outcome
of four studies was that parents’ health had not improved during the intervention. Statistically significant improvements were reported in two studies (Ferguson & Vanderpool 2013, Sadler et al. 2013). Three interventions helped parents to assess and decrease their substance abuse. Statistically significant improvements were reported in de la Rosa’s et al. (2009) and Sawyer’s et al. (2013) studies. In addition, in three studies, it was reported that interventions had helped the family to expand their social support networks. Statistically significant improvements were reported in two studies (de la Rosa et al. 2009, Ferguson & Vanderpool 2013).

Two studies reported that interventions had improved the parents’ and families’ everyday health, and out of these, one study reported statistically significant improvements (Sadler et al. 2013). Interventions had promoted children’s health and development. Statistically significant improvements were reported in Guthrie’s et al. (2009) and Sadler’s et al. (2013) studies.

Two of the eleven studies showed results indicating the effects of interventions in supporting families’ socioeconomic situations. Families’ were supported in financial and housing issues. In addition, one study reported that parents were supported in relation to their employment and study issues.

5.5 SUMMARY OF THE RESULTS

1. At the beginning of the resource-enhancing family nursing intervention (REFI), most of the parents and children were in need of support for family life. The mothers needed most support in the areas of mental and physical health, their emotional lives and social relationships. The fathers also wanted support for their mental health and emotional lives and in relation to reducing their use of intoxicants. From the perspective of the whole family, there were most support needs regarding parents’ health and well-being, coping with parenthood, bringing up children, child care as well as relationship between parents.

2. The methods of resource-enhancing family nursing were used diversely. The resource-enhancing discussion was used with all of the families, either separately or together. Other methods supporting the discussions included video assisted family counselling, creation of a family tree and parents’ role map, network collaboration with close relatives and authorities, observation of family situations and parent-child group activity.

3. Parents were pleased with the collaborative relationship with and support of the family nurse during the intervention. They were satisfied with the openness and encouragement received from the family nurse, equal treatment, and advice and tips for everyday life. Parents and the family nurse worked together in a natural way at the families’ own homes, and parents were able to rely on the nurse’s
proficiency. The family nurse had enough time for the families and was able to correctly understand different family conditions.

4. The families’ needs for support were reduced or alleviated during the REFI. The families achieved more goals contributing to the family’s health than was set at the beginning of the family nursing work. The families’ support networks were enforced and became stronger, and their need for support from authorities was decreased. Parents evaluated that their quality of life was improved during the intervention and that the family nursing had had a positive impact on the interaction within the family and on parenthood, upbringing and taking care of the children. Family nursing also decreased parents’ use of intoxicants.

5. The effects of preventive family nursing intervention studies were reported based on discussions and practical exercises to help parents cope with parenthood and relationships and interactions in the family, together with health, well-being, social relationships and socioeconomic situations. Greater knowledge of interventions is needed in the future in order to develop the contents and forms of interventions. It is similarly important to explore the validity and reliability of used measurements. In addition, more effort is needed to report the process of seeking for and receiving ethical approval, and appropriate quality appraisal tools must be developed for preventive interventions in the future.

6. Three critical issues related to contents and methodology could be identified in the preventive family nursing interventions conducted in the homes of families’ with small children home. Issues dealt with the description of the interventions, ethical issues related to the interventions and the evaluation of the interventions.
6 Discussion

The aim of this study was to describe and evaluate the resource-enhancing family intervention (REFI) in families with small children, and to assess the effects of the intervention carried out at families’ homes from the perspectives of parents. In addition, the aim of this study was to identify and evaluate the critical methodological aspects of preventive family nursing intervention studies. This study indicated that REFI was effective and improved families’ well-being and health. In addition, this study indicated that preventive family nursing intervention studies are effective and respond to families’ multidimensional needs. Despite these positive outcomes, preventive family nursing is still a little-studied area.

6.1 Success of preventive family nursing interventions

Supporting mothers, children, and their families is considered to be an important global health issue (WHO 2013). Preventive family nursing interventions have been found to be effective and they have responded well to the support needs of families with small children (McIntosh & Shute 2007, de la Rosa et al. 2009, Häggman-Laitila et al. 2010, Ferguson & Vanderpool 2013, Sawyer et al. 2013). There remains an important question: Why are the results of preventive family nursing interventions so positive? The first issue to be considered is that the approaches of preventive family nursing interventions has been both holistic and strength-based, which has enabled realizing and enhancing families’ own resources in nursing (Häggman-Laitila et al. 2010, Gottlieb 2014, Aston et al. 2015). Families have experienced that family nursing is meaningful for them and they have been heard and understood. However, there is also a critical question to be asked: How have family members’ individual support needs been recognized in family nursing?

The second issue connected to the positive results of preventive family nursing is that the family has to be taken into account as a whole. Family system nursing approaches, which focus on interactions within the family unit, have been used in family nursing research (Anderson 2000, Denham 2003). In the empirical part of this study, family members and the family were identified as a whole. The psychosocial needs for support were also recognized at the beginning of REFI from parents’ perspectives. Although information was gathered from mothers and fathers, a joint family view was missing. According to the results of this study, the REFI included identifying various support needs of each family member. The findings showed that family members’ support needs vary and the amount of support needs is not identical even within a family. There were particularly different amounts of support needs between mothers and fathers. This result is in line with previous family nursing intervention studies (Salonen et al. 2010, Thome & Arnardottir 2013, Kerstis et al. 2013, Widarsson et al. 2013, Hildingsson & Thomas 2014). In the future,
more attention should be paid to entire families’ support needs and especially also taking into account the points of view of both fathers and children should be emphasized.

There has been an increase in literature on fathers’ health interventions in recent years. However, significant gaps remain in family nursing researchers’ understanding of the characteristics of those who use services, their backgrounds, strengths and vulnerabilities as fathers (Letourneau et al. 2012, Lee et al. 2012, Ferguson & Gates 2013). In the empirical part of this study, fathers identified fewer needs than mothers, although their support needs were similar. This result is supported by earlier research findings (Kerstis et al. 2013, Hildingsson & Thomas 2014). The question of why fathers participate in preventive family nursing less than mothers is crucial. One reason could be that fathers may express their needs for support in a different way than mothers (Letourneau et al. 2012) or their needs have been more challenging to recognize in family nursing (Cowan et al. 2007, Deave & Johnson 2008, McKellar et al. 2008). It is known that men are less likely to express their negative emotions than women (Kerstis et al. 2013) and mothers and fathers have experienced stress in different areas (Solmeyer & Feinberg 2011, Thome & Arnardottir 2013, Widarsson et al. 2013). However, supporting fathers and coping with their parenthood is a very important issue in family nursing, as fathers influence family members’ relationships, especially in parent-child relationships and child well-being (Hawkins et al. 2008, Letourneau et al. 2012, Mitchell-Box & Braun 2012, Ferguson & Gates 2013), and co-parenting relationships (Solmeyer & Feinberg 2011, Ferguson & Gates 2013).

Previous studies with small children have made important contributions to the understanding of families’ health and well-being (Giallo et al. 2012, Kemp et al. 2013). In the present study, it was shown that the families participating in the interventions received support quickly for their children’s support needs. Families experienced that they were in need of support connected to children’s sleep-related problems and the support received from the family nurse in this context benefited the whole family. Sleep-related problems can greatly complicate family life and increase the level of stress experienced by parents (Dunning et al. 2013). However, according to the results of this study, family nursing had little effect on the development of children participating in the study. Changes in children’s development occur in the long term, and there was insufficient time for significant changes during the family nursing. One could also ask whether children’s own needs are recognized and identified in preventive family nursing. It is crucial to ask what would be a suitable age for gathering information from their perspectives. It is self-evident that small children are not able to verbalize their needs in a relevant way. Children in particular tend to be loyal to their parents and it could be difficult for children to bring up problems related to their family situation. Although we know that gathering information directly from children could be methodologically challenging, it could be important to involve them in future studies and to also collect information on family health situations from their perspectives.

Parents’ mental health problems have been estimated to affect children. These problems may create great vulnerability in families and increase costs to society (Sadler et al. 2013, Ordway et al. 2014). Results of this study showed that parents have most support needs related to their mental health issues. This finding is also supported by previous preventive
family nursing studies (Beeber et al. 2010, Rossiter et al. 2012, Thome & Arnardottir 2013, Salonen et al. 2014). In the future, more attention should be paid to both parents’ mental health needs in family nursing. When designing a supportive intervention, it is important to identify and recognize that mothers and fathers may have different needs for support in order to benefit both parents through the intervention (Benzies et al. 2008, Ferguson & Gates 2013). Another significant finding of this related to the parents’ mental health situations was that parents needed support connected to reducing the use of intoxicants. de la Rosa (2009), Häggman-Laitila’s et al. (2010), Bjerregaard et al. (2011) and Sawyer et al. (2013) found the same results in their studies. The parents participating in this study decreased their alcohol consumption and the interventions had positive effects on their mental health issues. In addition, more attention should also be paid to parents’ relationships crises in family nursing. The results of this study indicated that the majority of families wanted support for strengthening their parental relationships and needed to increase the amount of time they spent together. According to Cowan et al. (2007), the quality of the parent’s relationship affects family processes, such as father involvement in family life. In family nursing, focusing on both parents may reduce marital distress and minimize risks for divorce and separation among couples with small children (Ahlborg et al. 2009, Adamsons 2013).

The third successful issue in preventive family nursing interventions has been identified as good collaborative relationship between parents and a family nurse (Fägerskiöld 2006, Kirkpatrick et al. 2007, Shepherd 2011, Paton et al. 2013, Aston et al. 2015). During the REFI, parents worked willingly together with the professionally trained family nurse. According to the results of this empirical study, the parents experienced that they were working together in a natural way and were able to rely on the nurse’s proficiency. These results are in line with previous studies (Kirkpatrick et al. 2007, Kardamanidis et al. 2009, Paton et al. 2013, Aston et al. 2015). Although the fathers participated in family nursing less than mothers, they were satisfied with the collaborative relationship with a family nurse. Based on the results of this study, fathers’ social relationships improved significantly during the intervention. According to Letourneau et al. (2012), fathers have desired support from both formal sources, such as professionals, and informal sources, such as friends and family. Sometimes families try to manage difficult situations on their own for a long time before talking about their worries to a family nurse. This may lead to the escalation of problems and an increase in families’ support needs. Even though parents in this study felt that they could cope without the support of a family nurse when their support period ended, the families still considered that they needed support. The result correspond with previous studies using empowering and strength-based approaches (Eirola 2003, Häggman-Laitila & Pietilä 2007, Häggman-Laitila et al. 2010).

This study produced new information on difficult issues in a collaborative relationship between a family nurse and parents. Parents experienced that it was most difficult to deal with topics concerning their own unpleasant and painful issues. In addition, parents’ had difficulty in processing their own emotions, and considered self-assessment to be the most difficult aspect. In family nursing, it is essential to recognize these kinds of challenges in order to remove barriers and strengthen confidential relationships. According to Vaittinen
(2011), the most common reasons for parents’ loss of confidence included failure to meet the expectations of the family, unprofessional behavior on the part of the nurse and conflicts regarding the rights of the child. The parents in this study also emphasized the importance of sufficient amount of time for meetings. According to Briggs (2006), Kardamanidis et al. (2009) and Vaittinen (2011), issues that parents most valued included time and the feeling that they had been heard in the collaboration.

The fourth successful issue in preventive family nursing interventions is related to early support. Families received support in interventions at an early phase and problems did not escalate. It is of utmost importance that suitable and well-developed interventions are available in preventive family nursing practice.

In conclusion, support provided at families own homes enhance the resources family members and the entire family and improve families’ health and well-being. Catering to different family members’ needs for support while simultaneously considering the overall family situation requires practical and interactional skills (de la Rosa et al. 2005, Fägerskiöld 2006), work experience and evidence-based knowledge by nurses, as well as health care services specialized in preventive work (Aston et al. 2015). In this study, the family nurse was able to use altogether seven different working methods during the intervention. According to the results, families benefited of the use of versatile methods, which also enabled extensive data collection and evaluation of the intervention. In the future, it is important to ensure that research in this area will focus on the wider family perspective so that we can observe the effects of interventions on families’ needs, beliefs and interests.

6.2 EARLY SUPPORT ENHANCES FAMILIES’ RESOURCES

The special features of preventive family nursing interventions include providing support to families with small children during different life phases, often at home contexts (Benzies et al. 2008, Häggman-Laitila et al. 2010, Ferguson & Gates 2013) and in an early phase. Home as a working context enables nurses to achieve a realistic understanding of the situations of individual families and their needs for support. Although the home is a private environment for families, it is also a natural context for them. According to the results of this study, preventive family nursing conducted at families’ homes offers a suitable solution to families’ expectations. Nevertheless, the subject has been rarely studied.

In this study, the family nurse worked with participating families at their homes. Resource-enhancing family nursing (REFI) was conducted based on an early support model, which was nationally applied in several municipalities in Southern Finland between the years 1996–2000. The quality of family nursing of this study was high, similarly as in previous years (Häggman-Laitila et al. 2000, 2001). There are a number of challenging and debated issues: What is the best time to intervene? How early is ‘early’? When should it begin? According to the interventions in this study, early support was described to focus on the transition into parenthood (Guthrie et al. 2009, de la Rosa et al.
2009, Ferguson & Gates 2013), coping after the birth of a child (McIntosh & Shute 2007, Benzies et al. 2008, Sawyer et al. 2013, Ferguson & Vanderpool 2013) and preventing family problems by supporting the family in health and interaction issues (Häggman-Laitila et al. 2010). In the future, more attention should also be paid to the economic point of view of preventive interventions as a part of family health care services. It is essential to take into account how the family nurse can prevent the use of later, more expensive and complex health care services (Ordway et al. 2014, Sawyer et al. 2014).

The working approach of early support and resource-enhancing family nursing includes listening to families and supporting their participation and involvement (Gottlieb 2014). The Finnish legislation supports every individual’s right to be heard, which allows for taking into account his or her wishes and opinions regarding an issue pertaining to himself or herself (The Constitution of Finland 731/1999, section 21). The new Social Welfare Act also supports the client’s participation in early support services and demands the support of families’ health and well-being. According to the Social Welfare Act, necessary home care services must be provided to children with families as a general family service if it is not possible to secure the child’s welfare due to special circumstances related to family condition or life situation. The aim of the Act is to lower the threshold for seeking support through the provision of social services in connection to other basic services by strengthening the basic services, and to decrease the need for corrective actions. (1301/2014, section 19)

This study showed that REFI was effective and enables many opportunities for the implementation of interventions. One essential issue is that the method requires nursing staff to be educated in early phase family nursing. Nurses need systematic continuing education and professional guidance. The most crucial feature for family nursing is the fact that it must be well-managed and taken into account in the organization. One challenge for management could be that working at families’ homes takes time. One family nurse can meet approximately 2–4 families per work day, and this demands sufficient resources. In addition, the family nurses should be able to use several, client-oriented working methods. Nurse’s individual characteristics and a genuine desire to work with families’ at their own homes are also essential to successful collaboration. All of these challenges mean that in order to successfully implement interventions, they must be developed well.

6.3 DEMANDS FOR THE DEVELOPMENT OF PREVENTIVE FAMILY NURSING INTERVENTION STUDIES

Preventive family nursing interventions is a more and more topical issue for supporting families’ health and well-being. This study showed that interventions provide a beneficial and effective way of responding to families’ increased and multidimensional needs. The families participating in the empirical studies experienced that interventions decreased their needs for the authorities. Families’ own resources were strengthened and their health and well-being were improved. However, despite these positive outcomes,
the result of this study showed that preventive family nursing at families’ homes has been rarely studied. In the future, there is a significant need for further research on the topic.

Evaluating preventive family nursing interventions is significant, but, at the same time, our research showed that there certain challenges remain. There is a need for more research for developing and evaluating preventive family nursing interventions studies. The results of the literature review showed that reporting on and concepts of preventive family nursing interventions have not yet been established (Epley et al. 2010). This means that the description of the content, forms and procedures of interventions can be poor. The establishment of clear concepts is important so that interventions can be transferred into other contexts and in order to compare them to other studies. In addition, this study showed that evaluation of questions related to ethicality and validity have been insufficient. This produces challenges when it comes to recognizing, comparing and implementing interventions. Furthermore, we found that the meaning of the ‘duration of intervention’ varied. In some studies, it referred to the duration of the intervention period for an individual participant, while in others, it referred to the time of enrolment, the whole program, or a particular study period.

The quality appraisal of interventions is ensured by compiling high-quality studies and evidence-based nursing (Windle 2010, Voss 2013). In this study process, it was found that suitable and useful appraisal tools for preventive family nursing interventions do not exist. Therefore, during the study process, the research group developed an appropriate appraisal tool in order to focus on high-quality studies, which should lead to better and more realistic estimates of the effects of nursing interventions (Windle 2010, Voss 2013). The appraisal tools that are currently available focus on either qualitative or quantitative studies or interventions realized in controlled situations. However, preventive interventions in the home environment need to take into account different sampling methods as well as conducting different interventions.

In conclusion, in the future, it will be important for family nursing to take the entire family into account as a unit. More attention needs to be paid to an exact and logical use of concepts and study reporting in order to develop comparable and evident preventive family nursing interventions. In addition, more effort is needed to ensure the validity and ethics of future studies. All of these demands require multilevel analysis of the family nursing intervention process using a longitudinal study design.

### 6.4 STRENGTHS AND LIMITATIONS

The results of both the empirical part and literature review this study showed several strengths. This study indicated that resource-enhancing family nursing (REFI) was a unique, theory-based approach and responded effectively on families’ multidimensional needs. The strengths also included the fact that REFI was conducted in a natural context, at families’ own homes, and that it lasted the period of 19 months. During this time, the family nurse met with the families 621 times and she worked with the families for 953.5
hours in total. Seven different working methods which had been previously tested and found suitable were used in REFI. It can be concluded that all of these elements decreased the subjective bias of the nurse’s work.

The small sample size was the foremost limitation of the empirical part of this study. In addition, the participants volunteered to sign up for family nursing, and hence there was no attempt at randomization. The research focused on single family members and not on the family as an undivided entity, which can be considered a further limitation. Due to this limitation, no information was yielded on how the family as a whole interpreted the prevailing situation and the need for support. The fact that fewer fathers than mothers participated in this study complicated the assessments of the overall family situation. The results obtained on the benefits of family work are based on the parents’ own estimates. They can nevertheless be considered more competent than outsiders in cases where the evaluation concerns matters inside the family and changes in them.

The results are founded on the support given by one well-trained nurse. The nurse’s personal working style and orientation, individual characteristics, and ability to establish a confidential relationship affected the parents’ experiences (Kardamanidis et al. 2009, Rossiter et al. 2012, Aston et al. 2015). The results can be considered reliable in this context, but it is necessary to be critical of generalizing or extrapolating based on them. This study did not sufficiently test the meaning of collaboration relationships. More research is needed on the matter. Furthermore, the obtained result was a general estimate of the usefulness of the support. The effectiveness of different methods used by the family nurse was not evaluated. No information was obtained about how exactly were the methods used and which was the most effective one. It is difficult to draw up detailed, uniform descriptions of the methods because they are used differently as interaction-based methods depending on the family, family nurse and context.

Limitation of the systematic review of this study was related to the quality appraisal of intervention studies (Windle 2010). It was remarkable that no suitable quality appraisal criteria for preventive interventions were available. As a result, a new tool based on previous criteria was developed, which aimed to develop detailed quality domains for the selected studies.
7 Conclusions

This study yielded new information about the effects of resource-enhancing family nursing interventions (REFI) in perceiving the overall situation of a family from the parents’ perspectives. In addition, the study yielded new information about the contents and used working methods of REFI and also the service assessment methods connected to REFI. Furthermore, this study produced new evaluative information on the contents and forms of preventive family nursing intervention studies.

7.1 CONCLUSIONS OF THE MAIN RESULTS

The following conclusions were made:

1. Preventive family nursing interventions are successful and effective because they identify families’ resources in an early phase, take into account the whole situation of the family, enable using versatile, previously tested methods and are founded on a theoretical background.
2. Resource-enhancing family nursing interventions help parents to cope with parenthood and relationship and improve interactions in the family, together with health, well-being, social relations and socioeconomic situations. The family nursing interventions conducted at families’ homes are effective.
3. In this study process, an appraisal tool for preventive family nursing was developed. The appraisal tool was shown to be suitable for and useful in evaluating interventions.
4. When evaluating interventions, it is important to take into account the accurate description of interventions, their long-term effects, and considering all members of the family.
5. The concepts and methods of present study can be used in the field of nursing science in the area of preventive family nursing.

7.2 SUGGESTIONS FOR FUTURE RESEARCH

This study emphasized recommendations for promoting the health and well-being of families with small children and resource-enhancing family nursing carried out at families’ homes. Suggestions for further research are as follows:

1. More research is needed to provide stronger evidence on the effects of the resource-enhancing family nursing at families’ homes.
2. Resource-enhancing practices need to be further developed and examined by using different methods, such as video-assisted counselling and group activities.

3. It is important to examine what kinds of skills and knowledge family nurses will need for implementing resource-enhancing family nursing. Nurses’ professional competences as family nurses and the ethical challenges connected to the resource-enhancing method of work should also be investigated.

4. Research is needed to gain information on difficult relationships. It is important to understand what kind of difficulties are there and how to deal with difficult relationships. Families who withdraw themselves from resource-enhancing family nursing interventions or who are unsuccessful clients should also be studied.

5. Even though it is methodologically challenging, future research should focus on the wider family perspective which includes children and use multilevel analysis of the family nursing intervention process with a longitudinal study design.

6. The appraisal tool for preventive family nursing intervention studies developed as a part of this study should to be further tested and developed in the future.
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Identifying families’ strengths is the first and one of the most important strategies. During the intervention (REFI), families’ support needs decreased and were alleviated, and the families’ life conditions improved. Effectiveness was found in relation to health, parenthood, the raising of and caring for children, parents’ relationships, social relations and children’s health and growth. In the future, it is needed to focus on the methodological and the ethical issues related to the preventive family nursing interventions.