IMPLEMENTING FAMILY SYSTEM NURSING INTO CLINICAL PRACTICE AND A THREE YEAR FOLLOW UP EVALUATION ON FNP AND JOB SATISFACTION AT A UNIVERSITY HOSPITAL

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GREATINGS FROM ICELAND

OVERVIEW OF THE PRESENTATION

- Introduction to the Research Field of Family System Nursing
  - Involving Families into Nursing Care
  - Purpose of the Family Strength Oriented Therapautic Conversaton Intervention program (Fam-SOTCI program) at LUH
- Intervention research
- Family nursing practice—Advanced Nursing Practice
- Nursing practice and the Job Demand, Control and Support Model
- Family Nursing Practice and the Educational and Training Intervention Program (ETI-Program) at LUH
  - Results on a follow up study regarding Nurses Practicing with Families and their Job Satisfaction at LUH
- Development of the Fam-SOTCI program (strength oriented therapautic conversaton interventio program) at LUH
  - Results from Interventon Studies amoung Families of Children and Adolescents with Chronic and Acute Illnesses at LUH
- Conclusions

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…PURPOSE

- …to present results from *a program of research (Fam-SOTCI program)* regarding the process of implementing Family System Nursing (FSN) into clinical practice at an institutional level, the *Landspitali University Hospital (LUH)* in Reykjavik Iceland (2007-2011), … *with a special focus on:*
  - (a) reporting on family nursing practice and job satisfaction three years following (2014) the implementation of an Educational and Family Skills Training Intervention research program (ETI-program), that was administered to general and advanced nurses practicing at LUH.
  - (b) to report on results regarding outcomes of strength oriented brief therapeutic conversation interventions for families of children and adolescents at LUH.

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FAMILIES IN THE NORDIC CONTEXT

- Icelandic families, have over the last 1200 years or since 874, needed to adapt to unexpected natural disasters (e.g volcanic activities, earthcyacks, geysers explosion, floodings and loosing family members at see or in the wilderness/highlands)

- Similarly to other families in the Nordic community, *modern Icelandic families* may need in addition to living their daily familiy life, to deal with relational difficulties do to addictions, violence, injuries or acute/chronic physically and psychologically illnesses, that requires professional counsiling and or support from health care professionals

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DEFINITION OF THE FAMILY CONCEPT

- Families need to be invited into health care services …BECAUSE…
- …a family consist of a group of two or more individuals that are *connected to each other through strong emotional ties*, they *have the feeling of belonging to each other*, have *a real interest* in each other and are *interested in being aloud* to participate in each other´s lifes.

(Bell & Wright, 2009)

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FAMILY CENTERED HEALTH CARE SERVICE

- FAMILIES SHOULD BE …
  - Welcomed …
  - Invited to participate …
  - Encouragated to take a respite when needed …
- Do we RESPECT,---ACKNOWLEDGE---OR MAKE FAMILY'S CONTRIBUTION TO HEALHT CARE visible?
- Are family members contribution DEFINED?
- Do we expect COLLABORATION between family members and health care professionals?
- Do we offer family members support and information?
- Do we work with family members constraining /facilitating BELIEFS when dealing with illnesses?

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MY FAMILY

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INVOLVING FAMILIES INTO NURSING CARE

- Involving families in health care services is a phenomenon that is getting increased attention both among administrators, and scientists in general, as well as among advanced health care practitioners.
- World Health Organization (2006) has put forward recommendations on the importance of involving families in health care.
- Research findings on improved health outcomes following interventions for families dealing with chronic or acute illnesses (Bell & Wright, 2011; Chesla, 2010; Leahey & Svavarsdottir, 2009; Svavarsdottir, Sigurdardottir & Tryggvadottir, 2014; Sveinbjarnardottir, Svavarsdottir, & Wright, 2012)
- Emphasize worldwide from health care leaders on ---circularity between knowledge transfer and clinical practice---
- Families who are supporting their loved one at hospitals are often dealing with very complex health situation. Therefore, it is vital to understand the importance of relational practices between health care professionals and families.
  - *Families who experience high quality relationships between health care professionals and their family members are less likely to experience feelings of isolation or being vulnerable or uncertain in their caregiving role.*

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INVOLVING FAMILIES INTO NURSING CARE

- The attitude towards involving families in nursing care has been studied by researchers in Western societies (Saveman et al., 2011, Sveinbjarnardottir, Svavarsdottir & Saveman, 2011; Simpson, 2006).
- The *attitudes of health care professionals* are believed to influence the quality of clinical practices among family practitioners.
- When establishing therapeutic relationships and offering families therapeutic conversations, where the goal is to offer support, facilitate change, and/or to maintain or enhance family functioning and well-being, positive attitude towards families are essential.
- Family scientists who have conceptualized these beliefs in their models, such as in the Beliefs and Illness Model (Bell & Wright, 2011; Wright & Bell, 2009) and in the Calgary Family Assessment and Intervention Models (CFAM/CFIM) (Wright & Leahey, 2013), have emphasized that positive attitudes or beliefs towards involving families into their care are fundamental to the possibility of *creating therapeutic change, leading to healing, and to decrease suffering among family members.*

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INVOLVING FAMILIES INTO NURSING CARE

- The World Health Organization (WHO, 2005) and the Canadian Institute of Health Research (CIHR, 2005), have emphasized the importance of Knowledge Translation (KT) into clinical practice; where evidence-based information is incorporated into health care services (e.g., interactions among researchers and users) in such a way that *it effects optimal health care outcomes* and strengthens health care systems.
- The process of translating *new knowledge* into clinical practice has been conceptualized in the Knowledge –to-Action-framework by Graham and colleagues (2006) and by Strauss et al (2011).
- In this model, KT is seen as occurring in two interactive phases: (a) *the knowledge creation phase,* and *(b) the action phase;* with fluid boundaries between the creation and the action components of the model. In the *knowledge creation phase,* knowledge is created. In the *action phase*, knowledge can be implemented simultaneously and the knowledge phase can influence the action phase at several points in the model.

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IMPLEMENTING FSN INTO CLINICAL PRACTICES AT LUH

- At LUH a group of nursing scientists, researchers, administrators and clinicians have collaborated together over the last 7-8 years on *applying FSN on all units and divisions at LUH* and to *translate new knowledge on family nursing into clinical practice* as well as to *evaluate the benefits of involving families into nursing care*.
- A program of research was established around the implementation project in 2007-2011 and a follow up project is ongoing where the sustainability of FSN at LUH is evaluated.
- *… THERAPAUTIC CONVERSATIONS INTERVENTIONS…*
- *…NOT THERAPY…*

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INTERVENTION RESEARCH

- Globally, current economic constrains in health care have the potential to threaten psychosocial services such as offering therapeutic conversation interventions to families of individuals diagnosed with chronic illnesses.
- The *family intervention literature* points to several factors that can help patients and family members better manage an illness situation such as by using active coping strategies, by practicing optimistic thinking, and by finding meaning in the illness situation (Moules, Laing, Morck & Toner, 2011; Northouse, 2005; Kendall & Tabacco, 2011)
- *Family-level interventions* have been found to significantly reduce patient outcomes such as patient depression and patient mortality and also to significantly decrease family members' outcomes such as caregiver depression and caregiver burden (Armour, Norris, Jack, Zhang, & Fisher, 2004; Ducharme, 2011; Hartmann et al., 2010).
- Effective nursing interventions need to balance theoretically and clinically grounded approaches with empirical evidence… these interventions will need to be *deliverable in a brief format* and designed so *creatively* that they will be able to be woven into *psychiatric practices* and *health care economics*.

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INTERVENTION RESEARCH

- Over the last decade, researchers have focused more on *what effects, if any,* interventions conducted with families managing a chronic illness, had on *patient/caregivers* outcomes …
- These researchers have concluded that *there is consistent evidence* in the literature that *family-oriented interventions* are *more beneficial* than *patient-oriented interventions* (*obesity, diabetes, heart diseases, COPD*, etc.) (Berry et al., 2004; Carr, 2009; Chesla, 2010; Martire, 2005; McBroom & Enriques, 2009; Rosland & Piette, 2010).

  - McBroom and Enriques (2009) conducted *a systematic literature review* to examine family-centered interventions that enhance the health outcome of children with type 1 diabetes. Findings from *nine RCT studies indicated that family-centered interventions significantly improved A1Ca*, enhanced family dynamics, and decreased family conflict.
  - In a structured review on meta-analyzes, Chesla (2010) concluded that in *eight RCT that tested family intervention with childhood and adult diabetes*, a moderate significant positive effect was found on *glucose control* when patients and their families who received the family-level intervention were compared with the control condition, indicating the *benefits of the family-level interventions on health*.

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THEORY BASED INTERVENTION RESEARCH

- *Developing interventions:* The *strength* of an intervention, the *competence of the interventionist*, and the *models used* when delivering the intervention, always need to be *considered carefully* when developing and *testing* the effectiveness of a theory-based intervention within clinical settings.
- Researchers *who design an intervention* are interested in whether the *content of the intervention* is delivered as planned and whether all of the participants received the same *dosage*.
- It is *crucial* to systematically analyze *the strength and integrity of a pilot intervention* so that the designers become more fully informed of what works and what does not work and to be able to decide whether to continue the intervention as originally designed or to make changes as needed (Brandt and colleagues (2004); Northouse (2005).
- In an era of cost constrains such as the one we are living in today, it is necessary to consider *what dose of an intervention is essential and under what condition* (Lauver et al., 2002) *the desired intervention effects* are to be obtained.

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INTERVENTION RESEARCH

- Circularity between knowledge creation and knowledge uptake--*an important link to improve health outcomes.*
- Speeding up the *"knowledge uptake process."*
- New knowledge which has been *"created"* through high quality research is of great value to health care professionals.

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KNOWLEDGE TRANSLATION

… is a *collaborative* process between health care researchers and clinicians and refers to the process by which new knowledge is put into action

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INTERVENTION RESEARCH AND FACILITATE SUCESSFUL KT

...apply FSN both at the

(a) general practice level

(b) advanced practice level

...through training

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FAMILY NURSE PRACTICE
CONFIDENCE IN APPLYING FSN INTO CLINICAL PRACTICES

- Fostering confidence in applying family system nursing into clinical practices among nurses practicing within hospitals settings, might increase *professionalism*, enhance nurses' *job maintenance* and *satisfaction.*

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ADVANCED NURSE PRACTICE

- *Advanced nurses* are *expected* in today's health care settings to offer families support, education and or *facilitating change* when needed in health behavior.
- Nurses and midwifes practicing in health care settings, needs therefore to be up to date in family centered care.
- It is *important for nurses* to receive continuing education in family system nursing, in order to be able to offer evidence based practice to families in clinical settings.
- Educational programs for nurse practitioners' focusing on empowering nurses to use *brief therapeutic conversation interventions with families,* where the main focus of the intervention is on supporting and educating family members about the health situations, has been found to be of benefit to families (Nancy Moles; Duhamel, 2009; Svavarsdottir, 2014).
- Therefore a decision was made in 2007 by nurse leaders at LUH and the UI, to offer all nurses practicing at the University Hospital in Reykjavik an educational and training interventional program (ETI-program).

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NURSING PRACTICE AND THE JOB DEMAND, CONTROL AND SUPPORT MODEL

- Within the nursing profession, several factors have been reported in the literature, that contribute to *job satisfaction* (Zangaro,& Steken, 2007; Finn, 2001; Mrayyan 2004; Aiken, 2012, 2013; Ultrainen & Kyngas, 2009).
- In the Job Demand and Control Model (JDC; Karasek1979), job strains/demands are defined as *a work load and time pressure*, and job control is distanced as *the workers' authority to make decisions where the employees' skills are applied over their tasks.*
- The combinations of job demands and job control, defines *four types of jobs*, that is, the *active job type* (high demands/high control), the *high strain type* (high demand/low control), the *passive job type* (low demands/low control) and the *low strain type* (low demand/high control).
- Having autonomy over work processes, will reduce a worker's stress and increase learning and growth.

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FAMILY NURSE PRACTICE AND THE ETI PROGRAM

- The program was developed by a family nursing steering committee at LUH.
- The content of the ETI-program was on training the nurses in *assessing* families and offering families within their clinical settings, appropriate educational and emotional support and interventions' based on the Calgary models.
- The participants were *offered family skills labs training* and *workshops* where the focus was on offering BRIEF family nursing interventions *e.g., conducting family trees and mapping relationships among family members and connection with society as well as training the nurses in asking interventive questions, drawing forward family strengths and offering commendations.*
- An emphasize was put on offering in the ETI-program, a *regular supervision every week* regarding the implementation, for a time period of *one up to four months.*

Healing Families...a particular kind of practice offered by a particular kind of nurse

- (Wright & Bell, 2009)

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RESULTS: NURSES PRACTICING WITH FAMILIES AT LUH

DEMOGRAPHICS OF THE SAMPLE OF NURSES IN 2014 AT LUH (N=440) ,WHO PARTICIPATED IN THE STUDY EKS, AOS, EK, 2014

Background variables	n	(%)
Age		
<30 years	44	(10.0)
31-50 years	225	(51.0)
>51 years	163	(37.0)
Working experience		
Less than 5 years	78	(18.0)
6-15 years	133	(30.0)
>16years	225	(52.0)
Completed formal education past		
BSc in nursing (MSc or PhD)		
Yes	71	(16.0)
No	369	(84.0)

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DEMOGRAPHICS (CONT.) EKS, AOS, EK, 2014

	n	(%)
Have taken the ETI-program in FSN at LUH		
Yes	240	(55.0)
No	200	(45.0)
Have taken a FSN graduate course at the UI		
Yes	86	(19.5)
No	354	(80.5)
Divisions		
Emergency	45	(11.0)
Mental Health	31	(7.0)
Womens and Children	110	(25.0)
Medical	143	(33.0)
Surgical	98	(24.0)

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DIFFERENCES IN PERCEPTION ON FAMILY NURSING PRACTICE IN 2014, BASED ON WHEATHER OR NOT THE NURSES AT LUH (N=440) HAD TAKEN THE ETI-PROGRAM, EKS, AOS, EK, 2014

	Taken the ETI-program at LUH	n	Mean	SD	t-test	p-value
Practice appraisal (PA)						
	YES	262	3.943	0.753	2.585	
	NO	165	3.752	0.730	2.603	**0.010**
Nurse Family Relationship						
	YES	253	3.954	0.669	1.353	
	NO	161	3.860	0.744	1.321	0.177

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ANOVA RESULTS ON THE NURSES PERCEPTION OF THEIR FNP IN 2014 (N=440), BASED ON THE CLASSIFICATION OF THE FOUR JOB TYPES (HIGH STRAIN, PASSIVE, LOW STRAIN OR ACTIVE) AS PRESENTED IN THE JDC MODEL, EKS, AOS, EK, 2014

Jobs types	n	Mean	Std deviation	SS	df	F- test	p- value
FNP-Practice Appraisal							
High strain (high demand, low control)	107	3.71c	0.788				
Passive (low demand, low control)	124	3.80b	0.689				
Low strain (low demand, high control)	113	4.05a	0.063				
Active (high demand high control)	78	3.92	0.094	235.007	421	4.524	0.004

FNP-Practice Appraisal: a>b and a>c

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ANOVA RESULTS ON THE NURSES PERCEPTION OF THEIR FNP IN 2014 (N=440), BASED ON THE CLASSIFICATION OF THE FOUR JOB TYPES (HIGH STRAIN, PASSIVE, LOW STRAIN OR ACTIVE) AS PRESENTED IN THE JDC MODEL, EKS, AOS, EK, 2014

Jobs types	n	Mean	Std deviation	SS	df	F- test	p- value
FNP-Nurse Family Relationship							
High strain (high demand, low control)	106	3.88	0.646				
Passive (low demand, low control)	119	3.75c	0.677				
Low strain (low demand, high control)	109	3.98b	0.767				
Active (high demand high conrol)	76	4.11a	0.646	199.852	409	4.831	0.003

FNP-Nurse Family Relationship: a>b and a>c

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ANOVA RESULTS BASED ON DIFFERENCES IN PERCEPTION ON JOB TYPES (2014) (HIGH STRAIN, PASSIVE, LOW STRAIN OR ACTIVE), BASED ON WHEATER OR NOT THE NURSES (N=440) AT LUH, HAD TAKEN THE ETI-PROGRAM OR NOT, EKS, AOS, EK, 2014

Jobs types	ETI-P	n	Mean	Std deviation	SS	df	F- test	p- value
High strain (high demand, low control)	Yes	67	3.75b	0.78				
	No	40	3.64	0.79				
Passive (low demand, low control)	Yes	67	3.94d	0.59				
	No	57	3.63	0.75				
Low strain (low demand, high control)	Yes	74	4.09ac	0.72				
	No	39	3.97	0.55				
Active (high demand high conrol)	Yes	51	3.95	0.89				
	No	27	3.86	0.70	10.97	7	4.16	0.042

Job satisfaction: a>b and c>d

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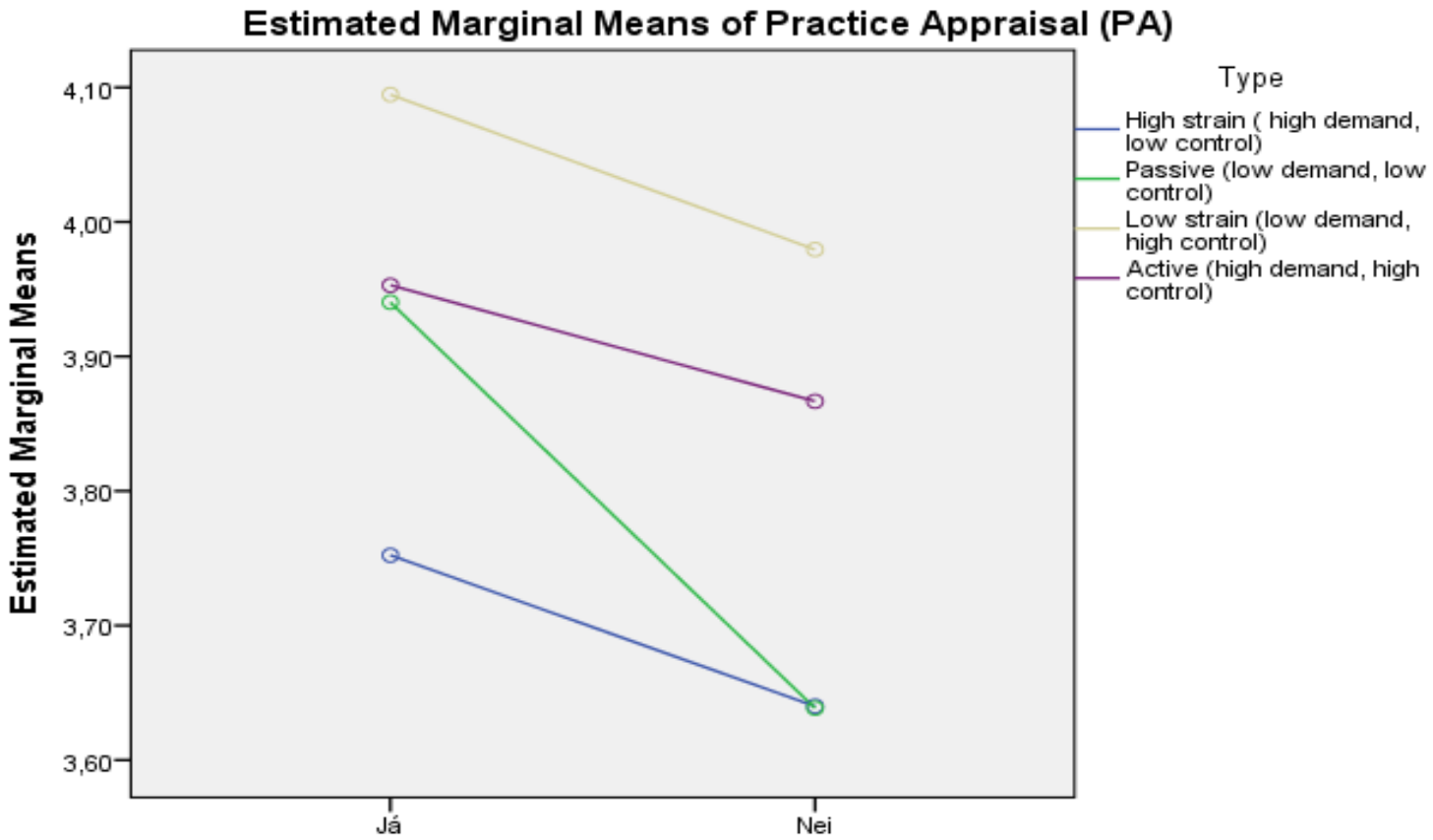
ANOVA RESULTS BASED ON DIFFERENCES IN PERCEPTION ON JOB TYPES (2014) (HIGH STRAIN, PASSIVE, LOW STRAIN OR ACTIVE), BASED ON WHEATER OR NOT THE NURSES (N=440) AT LUH, HAD TAKEN THE ETI-PROGRAM OR NOT, EKS, AOS, EK, 2014



Hefur þú sótt námskeið í fjölskylduhjúkrun á Landspítala ? Vinsamlegast athugið, eftir að hafa svarað Já eða nei, veljið "NÆSTA" til að halda áfram þátttöku.

KNOWLEDE CREATION AND DEVELOPMENT OF THE FAM-SOTCI PROGRAM AT LUH

Series of research were developed: Theory driven interventions

(a) *a one session strength oriented "brief therapeutic conversation"* intervention research programs

(b) *a 2-3 session strength oriented "therapautic conversation"* intervention programs

(c) a 3-5 session strength oriented *"therapautic conversation"* intervention programs

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BACKGROUND OF THE FAM-SOTCI PROGRAM AND RESILIENCY AND HARDINESS IN FAMILIES

- *Supporting hardiness* in families is an *important goal* within the health care system –*hardiness* can help families to cope with and adapt to chronic illnesses or traumatic life events over time.
- Research has indicated that hardiness among family members can be *increased* by *empowering SOC* (sence of coherence), by *decreasing depressive symptoms* among family members and by *encurraging well-being*.
- In a *family centered* health care service, an *emphasize should be* on --- increasing the feeling of being in control of illness symptoms, and to be in control of the challanges that arises following an illness diagnosis.

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THE FAM-SOTCI PROGRAM

- These programs of research are based on the MODELS: Knowledge to Action (Graham, 2006); CFAM/CFIM (WB, 2009; WL, 2013) og Beliefs & Illness (WB, 2009)
- In the therapautic conversation interventions an emphaise is put on *assisting family members* to *discover* new solutions and to help with decreasing or ease fealings of *powerlessness and bad feelings* which could then help with or contributing *to maintaining effective family functioning*.
  - Several PhD theses.
  - About 20 MSc research projects and research projects among CNS.
  - Professional Counsil of Family Nursing at LUH: Implementing FSN into clincal practice; over 10 projects.

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THE CONTENT OF THE FAM-SOTCI PROGRAM

- When designing *a brief therapeutic conversation intervention* for famlies, it is curcial to keep in mind the importance of the relationship between how the information is delivered an in what way families are offered the emotional and psychosocial support.

- Efffective interventions are those that patients and family members respond to because of the *„fit“* between the intervention offered by the health care professional and the biosyschosicial structure of family members.

- CFAM/CFIM and the Beliefs and Illness model were used as the theoretical foundation of the interventions.

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THE FAM-SOTCI PROGRAM: BELIEFS AND ILLNESS MODEL—ADVANCED PRACTICE MODEL

- In the *Beliefs and Illness model*; Interventions are offered with the intention to bring out change and to soften or heal emotional and physical illness suffering. The IBM is a *compasion, strength resiliency and goodness* based clinical approach model.
- *Beliefs* can hinder an adjustment, healing or recovery, when diffucult life events occure (e.g., illness diagnosis).
- The central foundation of the IBM is *to create a context for beliefs to change* where individuals can easily share their *suffering, get empowered and become optimistic on how they can more easily handle their circumstances* regarding an illness or a disorder.
- *In therapautic conversations,* the emphasis is on collaborative relationship with family members, to remove obstacles and to establish trust and hope for healing.

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THE FAM-SOTCI PROGRAM: BELIEFS AND ILLNESS MODEL—ADVANCED PRACTICE MODEL

- *…The macromoves of the IBM include:*
  - Creating a context for changing beliefs
  - Distinguishing illness beliefs
  - *Challenging Constraining Beliefs*
    - Family members are often overwhelmed with difficult feelings and constraining beliefs like *hopelessness and worthlessness*. The *clinician distinguishes which beliefs forster healing, maintain suffering or limit problems solving*. To *challenge constraining beliefs*, the clinician invites conversation about difficult matters, introduces alternative beliefs, externalizes problems, offer commendation and reflection.
  - *Strengthening Facilitating Beliefs*
    - The clinicianan explores and uncovers facilitating beliefs that *open the possibility for change* and growth and soften suffering.
- *The micromove (intervention)* singles out a specific aspect of the therapautic conversations; *such as by, using therapautic questions, using commendation or suggestions*, and or by distinguishing illness beliefs, challenging constraining beliefs and strengthening facilitating beliefs.
  - However *„move“* included all of the conversational processes that involve *change* and occur between clinician and family members.

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THERAPAUTIC CONVERSATION INTERVENTIONS FOR FAMILIES AT LUH

Special Section: The Landspitali University Hospital Family Nursing Implementation Project (2007-2011)

Knowledge Translation in Family Nursing: Does a Short-Term Therapeutic Conversation Intervention Benefit Families of Children and Adolescents in a Hospital Setting? Findings From the Landspitali University Hospital Family Nursing Implementation Project

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Article

Strengths-Oriented Therapeutic Conversations for Families of Children With Chronic Illnesses: Findings From the Landspitali University Hospital Family Nursing Implementation Project

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Abstract

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FAMILY NURSING IN ACTION

Listening to the Family's Voice
Nordic Nurses' Movement Toward Family Centered Care

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University of Iceland

Clinical nurses, teachers, and researchers in the Nordic co

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Implementing Family Nursing: How Do We Translate Knowledge Into Clinical Practice?

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JCN Journal of Clinical Nursing

HOSPITALISED PATIENTS

Does a therapeutic conversation intervention in an acute paediatric setting make a difference for families of children with bronchiolitis caused by respiratory syncytial virus (RSV)?

Journal of Clinical Nursing

ólrún W Kamban and Erla Kolbrun Svavarsdottir

ns and objectives. To measure the benefit of a short-family therapeutic conversation (STC) intervention in an acute diatric unit

Online Exclusive Article

Benefits of a Brief Therapeutic Conversation Intervention for Families of Children and Adolescents in Active Cancer Treatment

Erla Kolbrun Svavarsdottir, RN, PhD, and Anna Olafia Sigurdardottir, RN, MSN

Cancer in children and adolescents differs from adults in that it has unique epidemiology (e.g., lymphoma, leukemia, endocrine tumors) and in that the ment itself can

Purpose/Objecti

RESULTS: FAMILIES OF CHILDREN AND ADOLESCENTS WITH ACUTE AND CHRONIC ILLNESSES

BENEFIT OF BRIEF THERAPAUTIC CONVERSATION INTERVENTION FOR FAMILIES OF INFANTS WITH RSV AT THE ACUTE CARE UNIT AT LUH: SK & EKS, JCN 2013

- Purpose: To measure the benefit of *a brief-family therapeutic conversation* (BTC) intervention in an acute peadiatric unit.
- Method: Quasi-experiment from a convenience sample of 41 parents of infants with bronchiolitis caused by RSV (21 in the experimental group; 20 in the control group).
- Intervention: Parents in the experimental group received one brief therapautic conversation intervention (20-50 min; family relations, information, strengths identified and interventive questions used) from an advanced nurse practitioner. The parents in the control group received traditional care as usual.
- Results: Mothers in the intervention group perceived significantly higher support after the intervention compared with the mothers in the control group. The findings also showed a significant difference between the genders (mothers and fathers) in the intervention group. The mothers perceived higher cognitive support than the fathers.
- Conclusion: Despite often chaotic environment in an acute care setting, a brief-therapautic conversation intervention offered by a nurse within an acute peadiatric unit can support families in handling the illness experience.

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BRIEF THERAPATUTIC CONVERSATION INTERVENTION FOR FAMILIES OF CHILDREN AND ADOLESCENTS IN ACTIVE CANCER TREATMENT: EKS & AÓS, ONF 2013

- Purpose: To test the *effectiveness of a two-to three session* family therapeutic conversation intervention (FAM-TCI; lasting for 60-90 min each session) for primary and partner caregivers of children and adolescents in active cancer treatment.
- Method: Quasi experimental one group pre-and post-test design, among 19 caregivers (10 primary caregivers and 9 partner caregivers).
- Intervention: Caregivers / parents were offered 2-3 sessions of therapautic conversation intervention (based on their needs) where *family relations* were discussed, *interventive questions* were used, *strengths identified* to handle their situation, *informations and recomendations* offered and worked with the *family members beliefs*.

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RESULTS: CAREGIVERS OF CHILDREN AND ADOLESCENTS IN ACTIVE CANCER TREATMENT

Variables	Pre-Intervention Mean (SD)	Post-Intervention Mean (SD)	t-tests	*p-value*
Primary Caregivers				
Family support	37.50 (5.60)	48.20 (11.05)	-2.79	0.021
Cognitive support	12.70 (2.91)	17.70 (4.52)	-3.06	0.014
Emotional support	24.80 (4.52)	30.50 (7.04)	-2.32	0.045
Expressive Family Funct	63.30 (10.50)	69.40 (7.53)	-2.57	0.030
Emotional communicat	15.30 (2.71)	16.80 (2.10)	-2.76	0.022
Collaboration/probl solv	18.10 (3.84)	20.10 (2.85)	-1.66	0.130
Verbal communication	15.60 (2.32)	16.10 (2.96)	-0.56	0.586
Behavior	14.30 (3.80)	16.40 (1.65)	-2.09	0.066

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RESULTS: CAREGIVERS OF CHILDREN AND ADOLESCENTS IN ACTIVE CANCER TREATMENT

	Pre-Intervention	Post-Intervention		
Variables	Mean (SD)	Mean (SD)	t-tests	*p-value*
Partner Caregivers				
Family support	37.88 (9.25)	38.56 (13.89)	-0.18	0.826
Cognitive support	15.00 (3.84)	14.00 (4.42)	0.51	0.623
Emotional support	22.89 (6.75)	24.56 (10.11)	-0.75	0.475
Expressive Family Funct	63.89 (4.93)	65.44 (9.34)	-0.00	0.623
Emotional communicat	15.67 (1.94)	15.67 (2.83)	-1.17	1.000
Collaboration/probl solv	17.11 (3.98)	19.00 (3.08)	-1.66	0.277
Verbal communication	16.00 (2.18)	14.33 (3.28)	2.88	0.020
Behavior	15.11 (1.76)	16.44 (1.65)	-1.54	0.162

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STRENGTH –ORIENTED THERAPEUTIC CONVERSATONS FOR FAMILIES OF CHILDREN WITH CHRONIC ILLNESSES: JFN EKS, AOS & GBT, 2014

- Purpose: To evaluate the benefits of a two-session family therapautic conversation intervention (FAM-SOTCI) for families of children diagnosed with *asthma, cancer or diabetes.*
- Method: Intervention data collected in 2010, from 37 familes (*60 parents; 35 mothers and 25 fathers*) of children with chronic illnesses.
- Intervention: The FAM-SOTCI consisted of two interview sections where the main focus of the interventin was based on the key elements of the brief family interview framework (e.g., drawing family genogram and an ecomap, in collaboration with the families, using therapeutic questions, and offering recommendations and commendations.
  - *The therapeutic conversations were introduced to the parents as an opportunity for them to engage in a therpeutic relationship. Each session lasted for 45-90 min.*

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STRENGTH –ORIENTED THERAPEUTIC CONVERSATONS FOR FAMILIES OF CHILDREN WITH CHRONIC ILLNESSES: JFN EKS, AOS & GBT, 2014

- *…cont…*
- *First session* the advanced nurse … offered information regarding the *child's health condition* and asked therapeutic questions such as: *(a) Could you tell me about the day when your child was diagnosed with …, (b) What was your reaction/response to learnig about the diagnosis?, (c) What is your illness story/narrative? (d) Who in the family do you think the illness has the most impact on? (e) Who is suffering the most? (f) What is the greatest challenge facing your family now?*
- *Second session* the advance nurse …asked specific interventiove questions such as: *(a) What has been most and least helpful to you in similar situations? (b) If there were one question you could have answered now, what would it be? (c) How do other members of your family handle the situation? (d) What beliefs do you have toward the disease? (e) What beliefs do other members of the family have toward the disease? (f) Does anyone in your family have constraining beliefs toward the illness or the situation the family is now in? (g) What core beliefs have you and your family found helpful to rely on when dealing with the illness on a daily basis? (h) What do you believe the future holds for your family and your child with …?*

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THE ROLE OF THE ADVANCED NURSE IN THE INTERVENTION

- The *role of the advanced practice nurse* who delivered the FAM-SOTCI was to *reflect on the parents' experiences* by asking relevant circular therapeutic questions, and encouraging, empowereing and pointing out in what way the families were handling their situatioins well.
- *…listened to the parents´stories* of their expereinces, pointed out differences between the parents and answered specific questions that were asked.
- …had to create a context in the interview where *families could make small or significant changes* by recognizing their *problems-solving abilities* and by realizing that interventions are focused on *cognitive, emotional, and/or behavioral* domains of family functioning.
- …encouraged family members to *explore alternative solutions to problems, invited them to think differently, encouraged different affective expressions and asked families to perform new tasks.*
- …*used questions as interventions, empowered and supported* the families and expressed confidence in their problem-solving abilities when appropriate.

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RESULTS FOR MOTHERS PRE AND POST INTERVENTION OF CHILDREN AND ADOLESCENTS WITH CHRONIC ILLNESSES

	Pre-Intervention	Post-Intervention		
Variables	Mean (SD)	Mean (SD)	t-tests	*p-value*
Mothers (n=35)				
Family support	37.49 (17.55)	45.94 (16.75)	-3.99	0.000
Cognitive support	15.66 (7.23)	18.48 (5.87)	-3.49	0.001
Emotional support	21.83 (11.43)	27.49 (11.49)	-3.65	0.001
Expressive Family Funct	69.11 (8.58)	70.94 (7.16)	-1.85	0.074
Emotional communicat	17.00 (1.99)	17.06 (1.73)	-0.16	0.874
Collaboration/probl solv	20.20 (3.25)	21.03 (2.43)	-2.05	0.048
Verbal communication	15.71 (2.79)	16.14 (2.61)	-1.09	0.285
Behavior	16.20 (2.82)	16.71 (2.27)	-1.41	0.168

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RESULTS FOR FATHERS PRE AND POST INTERVENTION OF CHILDREN AND ADOLESCENTS WITH CHRONIC ILLNESSES

	Pre-Intervention	Post-Intervention		
Variables	Mean (SD)	Mean (SD)	t-tests	*p-value*
Fathers (n=25)				
Family support	44.00 (13.15)	44.60 (17.87)	-0.22	0.827
Cognitive support	18.20 (5.55)	17.52 (5.88)	0.64	0.529
Emotional support	25.80 (8.89)	27.08 (12.58)	-0.64	0.527
Expressive Family Funct	64.88 (7.55)	66.36 (11.47)	-0.86	0.398
Emotional communicat	15.76 (2.48)	15.64 (3.20)	0.23	0.824
Collaboration/probl solv	18.72 (3.55)	19.68 (3.45)	-1.30	0.204
Verbal communication	15.12 (2.44)	14.80 (2.53)	0.72	0.480
Behavior	15.28 (2.13)	16.24 (3.13)	-1.88	0.073

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RESULTS FOR CHILDREN AND ADOLESCENTS WITH ASTHMA PRE AND POST INTERVENTION OF THEIR PARENTS

	Pre-Intervention		Post-Intervention			
Variables	Median	Range	Median	Range	Wilcoxon's test (z)	*p-value*
Children with asthma (n=15)						
Asthma quality of life	79.46	43.75	85.71	47.32	-1.48	0.140
Asthma symptoms	72.73	47.73	77.27	54.55	-2.01	0.044
Treatment problems	88.64	36.36	90.91	40.91	-0.78	0.438
Worry	91.67	58.33	100.00	66.67	-0.24	0.809
Communications	83.33	75.00	83.33	83.33	-0.58	0.560

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FIRST CONCLUSION

- Evidence based TCI *can support* families in caring for their family member with chronic or acute illnesses and may advance clinical practices and health care services for families.
- Developing a family strengths-oriented intervention *(Fam-SOTCI)* that focuses mainly on assisting family members to discover new solutions to help diminish and ease emotional, physical, and spiritual suffering, *can contribute to strengthening, promoting and/or sustaining effective family functioning.*

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SECOUND CONCLUSION

- *Mothers of children with chronic illness reported significantly higher family support after a 2-3 session TCI compared with that before these interventions.*
- *Knowing that the mothers experienced that the study nurses offered them needed informaiton and their professional opinion regarding their child's disease, helped family members recognize their emotinal response, encouraged family members to share their illness narratives/stories and looked for the family strength, …is of great value in clinical practice.*
- *The mothers expressed their family to be better at dealing with problems after the intervention.*
- *The findings from the LUH-project are in harmony with findings reported by Kazak et al.who have found that working on identifying and changing beliefs about the disease and focusing on family relations enhanced family functioning and was of benefit to the primary caregivers of children with cancer.*

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THIRD CONCLUSION

- Relational practices are on its rise, especially where advanced practice nurses careing for family members with chronic or acute illnesses need to establish a collaborative relationship with families, to be able to offer quality and evidence-based health care services.
- *Family members need to be given an opportunity to reflect on how they are handling their caregiving activities and benefit from support and professional opinions regarding managing and coping with the illness situation on a daily basis.*
- *We are optimistic about the added benefits of the two-three session theory-driven FAM-SOTCI for families dealing with chronic illnesses… further research is however needed…*

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