Geriatric Nursing xx (2016) 1–6

Contents lists available at ScienceDirect

Geriatric Nursing

journal homepage: www.gnjournal.com

Feature Article

Becoming visible – Experiences from families participating in Family Health Conversations at residential homes for older people

Åsa Dorell, RN, DN, MSc, PhD Student *, Karin Sundin, RNT, MSc, PhD [a]

Umeå University, Department of Nursing, S-891 18 Örnsköldsvik, Sweden

ARTICLE INFO

Article history:
Received 29 November 2015
Received in revised form
8 February 2016
Accepted 15 February 2016
Available online xxx

Keywords:
Family Health Conversations
Family nursing intervention
Family support
Family systems nursing
Residential home for older people

ABSTRACT

Having a sick family member living at a residential home for older people can be difficult for families, who as a result often suffer from feelings of forsakenness and powerlessness. In response, the purpose of this study was to illuminate family members' experiences with participating in Family Health Conversations at residential homes for older persons 6 months after concluding the conversation series. Twenty-two family members who participated in the conversations later took part in group interviews, the texts of which were analyzed according to qualitative content analysis. Findings showed that participating in Family Health Conversations mediated consolation, since within such a liberating communicative interaction, family members for the first time felt visible as persons with individual significance. Family members reported a positive experience involving both being open to each other and speaking and listening to each other in a new, structured way. As a result, families were able to discover their family members' problems and suffering, as well as to identify their family's resources and strengths.

Introduction

A considerable amount of research on illness and ill health shows a significant impact on the quality of life for the person living with illness and for their significant others.[1,2] When a family member is ill, it affects the whole family.[3] Most studies focus on the individual family member's experience of illness. When an old and sick family member's condition worsens, the family often reaches a point where they no longer can provide care at home and they must to consider a move to a residential home for older people.[4–6] This move often involves feelings of failure and guilt on the part of the family.[7,8] It might give the family a sense of relief, but also creates feelings of a guilt and remorse. Guilt is a powerful feeling caused by multiple factors. Although the families might have struggled for a long time with having the sick family member at home, they might still feel that they could have done more.[7,9] They often feel a sense of failure regarding their inability to care for their sick family member. During the time of transition, families might also be affected by their sick family member's emotional changes and feelings of becoming a burden to their family, and this might lead the family to question the placement decision, thus exacerbating the feelings of guilt.[4–6]

Furthermore, when the older person is living in a residential home, the family members often do not dare to interfere by questioning the nurses' activities, because they are afraid they will be perceived as demanding, and this will have a negative effect on their family member's care.[10] Some studies have also indicated feelings of powerlessness on the part of the family members because they feel a lack of control over the situation and an inability to influence the care that their loved one receives.[11,12] Evidence from several studies points to the importance of involving families in health care, and families have been found to be important in care of patient with acute and chronical illness.[13–16] In order for nurses to provide sufficient care, it is necessary for them to understand the needs of the families who have an older family member living in a residential home.[17] This can be done by sharing the families' experiences through dialogue.[18,19] Families with an ill family member will be helped by nursing care that takes a Family Systems Nursing (FSN) approach. The concept of FSN includes the important role of family interaction in the older person's life and also on all the other family members' lives. FSN is an approach that focuses simultaneously on the ill person as well as the other family members.[20] The aim of FSN is to preserve well-being, decrease suffering and support family health. According to the study by Östlund and Persson,[21] FSN

Ethics: The Regional Ethical Review Board at Umeå University approved the study (DNr: 2011-335-31M).
Funding: There was no funding.
* Corresponding author. Umeå University, Department of Nursing, Box 843, S-891 18 Örnsköldsvik, Sweden. Tel.: +46 660 29 25 28; fax: +46 660 29 34 69.
E-mail address: asa.dorell@umu.se (Å. Dorell).
[a] Tel.: +46 660 29 25 28; fax: +46 660 29 34 69.

http://dx.doi.org/10.1016/j.gerinurse.2016.02.015

is a means to facilitate families' communication, increase connectedness and well-being, and enhance confidence and capability in dealing with a sick family member. An examination of FSN interventions showed that family support is effective in improving well-being and health and in improving families' abilities to manage their situations in relation to the problems described by the families.[22–29]

One example of an FSN intervention program is Family Health Conversations (FamHC). FamHC includes a person-centered approach,[30] i.e., all family members are regarded as important, valid persons with their own experienced life world[31] being made visible to the other family members. In FamHc all the people, in the family are regarded according to system theories. That is to say that all family members are considered as a system in which they are influenced by each other and influencing each other. System theories thus suggest that illness has an impact on the family as a system and a unit.[32]

The FamHC is a Swedish version of the Calgary models; Calgary Family Assessment Model (CFAM), which is a clinical model used to help families solve problem or issues based on the foundations of systems, cybernetics, communication, and change theory. The Calgary Family Intervention Model (CFIM) is a strengths-resilience-based family intervention model[20]; and the Illness Beliefs model (IBM)[3] focuses on the family as a unit of care, and believes that our views determine the way we interpret the world and thus cope with problems. The FamHC has been shown to be a way to increase well-being for families in relation to their situation,[24,25] and it has also been found to be cost-effective.[33] FamHC comprises a number of core components.[34] It focuses on the interplay and the relationship within the family and the non-hierarchical interplay between the family and the nurses. A central function of the FamHC is to identify the family's internal and external resources, and seek to identify and strengthen what is healthy about the family's situation instead of focusing on what does not function well.[3,34–36] Narratives and reflections constitute the basis of the FamHC,[23,34] and these reflections thus become a tool for understanding one's own and others' experiences, beliefs, and perspectives; and when needed, these reflections can encourage a change in beliefs and foster new insights.[3,37] According to Wright and Bell,[3] beliefs can be both facilitating and constraining. They determine how we respond to feelings, view the world, and handle situations. Family members, as well as nurses, have beliefs that facilitate and beliefs that constrain, and these beliefs are brought up and discussed during FamHC.

Having a family member living in a residential home is a family affair, and it can be difficult for the entire family. Experiences of being abandoned and unappreciated by the sick family member can cause ill health for other members of the family.[9] In addition, being separated from one's loved ones and not being involved in care can challenging. Having adequate communication and support from the nurse is important in feeling involved, and good communication can lead to a trusting relationship with the nurse.[38] The result of the above reported studies point to a need to expand the focus for care in order to support families that have a sick family member living in a residential home for older people. In addition the studies indicate a need for interventions to support both individuals and the family as a unit to minimize ill health, experiences of distress and broaden the concept of health to include the family as a whole. There is limited knowledge about this kind of family conversations in the context of residential homes for older persons. Thus the purpose of the study was to illuminate family members' experiences of participating in Family Health Conversation at residential homes for older persons six months after concluding the conversation series.

Method

Design

This study has a qualitative design with semi-structured group interviews, analyzed using qualitative content analysis. Qualitative content analysis was chosen as a method that involves both manifest and latent interpretation of participating in Family Health Conversations.

Setting and participants

In this study, a total of 12 families consisting of 24 family members of residents staying in three residential homes for older persons in a municipality in the north of Sweden participated in Family Health Conversations. Recruitment of the family members was conducted by the heads of the residential homes for older persons, together with the nurse working at the residential home. Evaluative group interviews were conducted six month after completion of the Family Health Conversations. Two families declined to participate, and indicated that their reasons were health-related or due to lack of time. The participating family members were between 39 and 84 years old (Md = 55); 20 were women (5 wives and 15 daughters) and two were men (sons). The exclusion criteria were that they could not speak and read Swedish.

The procedure using Family Health Conversations

Each family participated in three Family Health Conversations (FamHC), lasting 45–60 min. Two nurses, trained in the FamHC concept were conversation leaders at each meeting. One had the overall responsibility for leading the conversation process, and the other observed, asked additional questions and reflected on the responses. The structure of the FamHC is three conversations held at two-week intervals, with each conversation having a different focus. The *first conversation* focused on the family's experienced life situation. All family members were invited to offer their experiences and listen to each other's viewpoints. The conversations focused on what was important for the family to talk about, and the dialogue was intended to identify strengths and resources that the families had, both within and outside the family, with the purpose of creating alternative ways to think about and best deal with their situations. The *second conversation* started with an opportunity to reflect on the first conversation, and focused on suffering, problems, and beliefs identified in the first session. The *third conversation* was similar to the first two, but focused on the future, family strengths, and resources inside and outside the family, to address the changes undergone to facilitate healing. At the end of each conversation, the nurses provide a summarized reflection on what had been highlighted during the conversations. Two weeks after the third conversation, a closing letter,[39] was sent to the home of all participating family members, and in it the nurses reflected on the content disclosed in the conversations.

Data collection

Six months after the FamHCs series was completed, semi-structured group interviews were performed with eight families,[40,41] and individual interviews were performed with the two families in which only one family member had participated in the FamHC intervention. A researcher who had not participated in the conversations performed the evaluating interviews. The families were encouraged to speak freely, although an interview guide was used to add structure to the interviews. The interviews started with an open question: "Can you tell me about your experiences