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JENNI KERPPOLA

**Parental  
empowerment in  
child and family  
services**



# **PARENTAL EMPOWERMENT IN CHILD AND FAMILY SERVICES**

**Jenni Kerppola**



Jenni Kerppola

# **PARENTAL EMPOWERMENT IN CHILD AND FAMILY SERVICES**

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## **ABSTRACT**

**Background and aim:** Parental empowerment in children's everyday life is crucial from the perspective of family functionality. According to previous research knowledge, there are shortcomings in supporting parental empowerment. The aim of this study was to examine how parental empowerment is supported in Finnish child and family services, as well as how collaborative working practices and empowerment in management are related to the support of parental empowerment from the viewpoint of professionals. A further aim was to describe parental empowerment and related supportive factors from the viewpoint of lesbian, gay, bi, transgender, and queer (LGBTQ) parents.

**Methods:** The study included three data sets. The inquiries were gathered from 1) professionals working in substance abuse services (n=132, 36%) and from 2) employees working in health care, social welfare, and education settings (n=457, 37%). The interview data were collected from 3) LGBTQ parents with experience of using maternity and child clinic services (n=22). Quantitative data were analyzed using statistical methods and qualitative data by inductive content analysis.

**Results:** The support of parental empowerment was associated with co-operative working practices and empowerment in management. Parental

empowerment was supported most within the families' everyday life and least within the service system. LGBTQ parents defined empowerment as being visible. Respectful, gender-neutral communication and being treated as a parent irrespective of legal ties to their child was a key element supporting parental empowerment.

**Conclusions:** New knowledge was revealed about parental empowerment in the context of substance abuse and child and family services. In the future, attention should be paid to the management and organizational boundaries. Supporting LGBTQ parents' empowerment requires more research and education about the particular needs of parents.

**Keywords:** Empowerment; Parents; Child Health Services; Family Nursing; Maternal Health Services; Professional-Patient Relations

Kerppola, Jenni

Vanhempien osallisuus lasten ja perheiden palveluissa.

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## TIIVISTELMÄ

**Tutkimuksen tausta ja tarkoitus:** Vanhempien osallisuus lasten arjessa on keskeistä perheen toimivuuden näkökulmasta. Aikaisemman tutkimustiedon mukaan vanhempien osallisuuden tukemisessa on puutteita. Tämän tutkimuksen tarkoituksena oli selvittää vanhempien osallisuuden tukemisen toteutumista suomalaisissa lasten ja perheiden palveluissa sekä sitä kuinka yhteensovittavat menetelmät ja esimieheltä saatu tuki ovat yhteydessä vanhempien osallisuuden tukemiseen työntekijöiden arvioimana. Lisäksi kuvattiin vanhemman osallisuutta sekä sitä edistäviä tekijöitä homo-, lesbo-, biseksuaali-, trans- ja queer-vanhempien (HLBTQ) näkökulmasta.

**Aineisto ja menetelmät:** Tutkimus sisälsi kolme eri aineistoa: 1) Päihdepalveluissa toimivien työntekijöiden postikysely (n=132, 36%), 2) Sosiaali-, terveys- ja opetustoimen henkilökunnalle osoitettu työntekijöiden postikysely (n=457, 37%) ja 3) HLBTQ-vanhemmiksi identifioituvien vanhempien haastattelu (n=22). Kvantitatiiviset aineistot analysoitiin tilastollisin menetelmin ja kvalitatiivinen aineisto laadullisella sisällönanalyysillä.

**Tutkimustulokset:** Osallisuuden tukemisella oli yhteys yhteensovittaviin työmenetelmiin sekä työntekijän esimieheltään saamaan tukeen. Osallisuuden tuki toteutui parhaiten perheiden arjessa selviytymisessä ja heikoimmin palvelujärjestelmään vaikuttamisessa. HLBTQ-vanhemmat määrittelivät

osallisuuttaan näkyvyydeksi palveluissa. Osallisuuden tukemisessa tärkeintä oli kunnioittava vuorovaikutus, sukupuolineutraali puhe ja vanhempana kohtelu ilman juridisia siteitä lapseen.

**Johtopäätökset:** Tutkimuksessa tuotettiin uutta tietoa vanhempien osallisuuden tukemisesta perheiden erilaisissa palveluissa. Palveluiden kehittämiseksi huomiota tulee kiinnittää johtamiseen sekä organisaatioiden ja palveluiden rajapintoihin. HLBTQ-vanhempien osallisuuden tukeminen edellyttää lisää tutkimusta ja henkilöstön kouluttautumista

**Avainsanat:** osallisuus; vanhemmat; äitiysneuvolat; lastenneuvolat; äitiyshuolto; perheet; palvelut; terveydenhuoltohenkilöstö

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II Kerppola J, Halme N, Pietilä AM and Perälä ML. Do co-operative working practices and empowerment in management support employees in family services to reinforce parental empowerment? *International Journal of Caring Sciences*, 9 (1): 9- 21, 2016.

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## ABBREVIATIONS

CINAHL Cumulative Index  
to Nursing and Allied Health  
Literature

EMPO Empowerment  
Questionnaire

ETENE The National Advisory  
Board on Social Welfare and Health  
Care Ethics

HILMO Register of Primary Health  
Care Visits

HIV Human immunodeficiency  
virus

HLBTQ Homo, Lesbo, Biseksuaali,  
Trans, Queer

LGBTQ Lesbian, Gay, Bisexual,  
Transgender, Queer

MSAH Ministry of Social Affairs and  
Health

NGO Nongovernmental  
Organization

PES Psychological Empowerment  
Scale

PUBMED United States National  
Library of Medicine

SETA Lesbian, Gay, Bisexual,  
Transgender, Queer, Asexual rights  
in Finland, a national human rights  
nongovernmental organization

SPSS Statistical package for social  
sciences

TENK Finnish Advisory Board on  
Research Integrity

THL Finnish Institute for Health  
and Welfare

TOPI Register of Social and Health  
Care Location

WHO World Health Organization



# 1 INTRODUCTION

In Finland, supporting empowerment is considered a core value of high-quality family care. Many health policy programmers highlighting parent empowerment (World Health Organization, WHO, 2020) as an important quality indicator for positive treatment outcomes. Moreover, as an important concept in strengthening parents' well-being and position in health care (Barlow & Ellard, 2004; Hook, 2006). In the context of family services, parents and caregivers are often targeted in efforts to promote empowerment, given their integral role in the care of children.

Empowerment is a multifaceted and diverse concept. It is peoples' recourses, such as skills, knowledge, or motivation (Fumagalli et al., 2015) to meet their own needs (Gibson, 1991), solve their problems (Ellis-Stoll & Popkess-Vawters, 1998; Gibson, 1991), and the opportunity to control their destinies and influence the decisions that affect their lives (Zimmerman, 1995) or life circumstances (Israel et al., 1994). It is suggested that empowerment is not a static state, but one that varies according to different life situations and the levels of the individual and community empowerment (Damen et al., 2020; Koren et al., 1992; Raivio & Karjalainen, 2013; Vuorenmaa, 2016.)

Parental empowerment manifests as feelings, knowledge, attitudes, and behavior (Koren et al., 1992). Previous research indicates that it is associated with many aspects of everyday parenting (Fumagalli et al., 2015; Koren et al., 1992; Vuorenmaa et al., 2014). More parental empowerment is connected to the well-being of parents and families (HuscroftD'Angelo et al., 2018; Koelen & Lindström, 2005) and children's improved growth and development (Boot et al., 2006; Ruffolo et al., 2006). Moreover, it seems that parental empowerment is connected to better use of social support and less use of professional care (Wakimizu et al., 2011).

In contrast, a lack of parental empowerment is connected with adversities, serious conflicts within the family, and mental health problems in parents (Vuorenmaa et al., 2016) concerns. Moreover, stresses about parenting (Nachshen & Minnes, 2005; Vuorenmaa et al., 2015; Wakimizu et al., 2011),

financial burdens or unemployment, and the inability to reconcile family and work in their daily lives (Vuorenmaa et al., 2016; Weiss & Lunsky, 2011).

In Finland, all family services are about supporting parental empowerment. Families with children have access to a wide range of public services, as well as the private sector, parishes, and nongovernmental organizations (NGOs). Multidisciplinary professionals who encounter families in various everyday situations are in an optimal position to improve parents' well-being and support their empowerment (Vuorenmaa et al., 2015).

However, there are barriers to achieving this support (Halme et al., 2012; Perälä et al., 2011; Vuorenmaa et al., 2016). Services that provide support for children and families, such as education, social welfare, or child welfare have developed over decades, resulting in a system in which is fragmented from a family perspective. Specific shortcomings and limited support have been identified in parents and families with complex or unknown special needs (Raitasalo & Holmila, 2017). Especially, parents who receive care from different health and social professionals and in multiple settings, such as parents, who are substance users (Korhonen et al., 2009; Tracy et al., 2010; Raitasalo & Holmila, 2017). Or parents who may lack support because of heteronormative ideologies, such as lesbian, gay, bisexual, transgender, or queer (LGBTQ) (Brennan et al., 2012; Hadland et al., 2016; Wells & Lang, 2016). Their intense use of multiple services or underutilize certain services (Brennan et al., 2012; Olin et al., 2010; Scheel & Rieckmann, 1998; Shields et al., 2012; Singh, 1995) may put them at greater risk of receiving fragmented or poor-quality care. Moreover, health care professionals lack of knowledge and training on parents who are substance users (Raitasalo & Holmila, 2017) and LGBTQ families (Kuosmanen & Jämsä, 2007; Chapman et al., 2012) has been demonstrated.

Parents with substance use disorder often have negative life events (Raynor, 2013). They may lack support both formal and informal networks that could offer emotional support and empowerment (Cameron, 2002; Tracy et al., 2010; Kuo et al., 2013), which has been linked to parenting self-efficacy (Gao et al., 2014; Mathew, et al., 2017; Raynor, 2013) and feelings of loneliness and social isolation (Cameron, 2002). Children may have a higher risk of suffering poor emotional and behavioral development (Stanger et al.,

2004) as well as developing insecure attachments as infants (Das Eiden et al., 2002) and experiencing physical abuse (Locke & Newcomb, 2003; Walsh et al., 2003).

According to Moring (2013), homosexual parenting has traditionally been opposed since growing up in a homosexual family is seen as against the best interests of the child. Despite recent improvements in attitudes toward LGBTQ people (European Commission, 2019; Fetner, 2016; Juvonen, 2015), Finns have a slightly more negative attitude toward homosexuality than other Nordic people (Smith et al., 2014; van den Akker et al., 2013). In particular, attitudes toward homosexual parenting are more negative than general attitudes (Kontula, 2009; Nikander et al., 2016). It has been shown that LGBTQ youth continue to experience abuse and victimization in schools (Friedman et al., 2011; Kaltiala-Heino et al., 2019; Khan et al., 2017). Research indicated that LGBTQ youth face the challenge of developing positive sexual and gender identities in cultural, social, and familial contexts that are largely stigmatizing (Toomey et al., 2010; Wright & Perry, 2006). Compared with their heterosexual and cisgender peers, the LGBTQ youth are at an increased risk of bullying, hopelessness, suicide and suicide attempts, and sexual and physical violence (Khan et al., 2017), all of which may continue to affect their health and well-being into adulthood and parenthood (Vuorenmaa et al., 2016). Research concerning child and family services and LGBTQ families in Finland is scant. However, it has been suggested that these families may not be fully supported by maternity or child health care services because of heteronormative ideologies and the attitudes and practices of certain professionals (Kuosmanen & Jämsä, 2007; Shields et al., 2012). Moreover, it seems that these parents are at risk at reluctant to fully participate in the treatment of their child and underutilize certain services (Brennan et al., 2012; Olin et al., 2010; Scheel & Rieckmann, 1998; Shields et al., 2012; Singh, 1995).

Given this complicated landscape, effective cooperation across services is paramount for families to maintain their wellbeing and avoid fragmented or duplicated healthcare services. Although new public policies and legislation (The Constitution of Finland 731/ 1999; Social Welfare Act 1301/2014; Child Welfare Act 417/2007; Health Care Act 1326/2010 Act on Qualification Requirements for Social Welfare Professionals 272/2005; Act on Health Care

Professionals 559/1994) are challenging municipalities to break these patterns, there is little research on how professionals support parental empowerment in different child and family services or how cooperation works between different service providers. Previous research has mainly focused on specific groups, services, or service situations (Vuorenmaa, 2016).

This study takes an interdisciplinary approach to study support of parental empowerment in the context of all family services, such as services aimed at clients with substance abuse issues, as well as health care, social welfare, and educational services. There is a need to obtain knowledge on collaborative working practices not only to improve employees' ability to provide families with safe, comprehensive, and high-quality services but also to help them create connections between factors that are important for a family's empowerment and welfare. Therefore, ongoing work is necessary to improve the understanding of how families can be helped to navigate significant transitions throughout their lives. Moreover, it is necessary to obtain knowledge on the experiences of different types of families and parents, as empowerment is an individualized concept that requires tailored services for clients.

This study aimed to examine how parental empowerment is supported in Finnish child and family services, as well as how collaborative working practices and empowerment in management are related to the support of parental empowerment from the viewpoint of professionals. This was a part of a project on Integrated Management in Children, Youth, and Family Services, by the Finnish Institute for Health and Welfare (Halme et al., 2014). A further aim was to describe parental empowerment and related supportive factors from the viewpoint of LGBTQ parents.

In this study, parental empowerment is defined as the sense of confidence that parents demonstrate when managing everyday life with their children (Ice & Hoover-Dempsey, 2011; Koren et al., 1992; Martinez et al., 2009; Vuorenmaa, 2016; Wakimizu et al., 2011). It includes the measures they take to meet the needs of their children (Koren et al., 1992; Vuorenmaa et al., 2015; Vuorenmaa, 2016; Wakimizu, 2011; Zhang & Bennett, 2003; Zimmerman, 2000), as well as the skills and knowledge required to navigate complex systems and access services (Koren et al., 1992; Palisano et al., 2010).

Supporting parental empowerment is seen as a process in which parents obtain the knowledge and help to be able to manage with their children's by supporting their critical awareness and knowledge concerning rights related to their child's essential services and the family service system (Koren et al., 1992; Zimmerman, 1995; 2000). The concept of family "refers to two or more individuals who depend on one another for emotional, physical and economical support" (Rowe Kaakinen et al., 2014). This definition emphasizes an important fact that a family is not necessarily be based on legal or biological bonds, but the judgment and love of its members.

The results of this study may be used to inform the development of policies and practices that will ensure families receive equal, nonprejudiced, and comprehensive health care. An insight into the factors supporting parental empowerment provides a good opportunity to understand whether or not care interventions effectively contribute to supporting parents' empowerment.

## **2 REVIEW OF THE LITERATURE**

### **2.1 EMPOWERMENT AND RELATED CONCEPTS**

This chapter builds on previous scientific knowledge on empowerment and other related concepts. Data and information were obtained through ongoing searches carried out during the research process. The searches were conducted using the CINAHL, PubMed, Web of Science, and Scopus databases. In this study, the focus was the phenomenon of empowerment. The search limitations specified that all articles should have been published in English in a peer-reviewed scientific journal between 1980 and 2020, and they should have investigated empowerment, parental empowerment, child and family services, the empowerment of professionals, empowering work environments, and management or supervisory support.

#### **Definition of empowerment**

The concept of empowerment is multifaceted and diverse. It is a concept that is difficult to define and understand (Gibson, 1991; Rappaport, 1984; Wallerstein & Bernstein, 1988), and it cannot be translated into many languages (Abel & Hand, 2018). Various definitions have been used in different contexts. Generally, empowerment is defined and measured on a personal level and a community level. Personal or individual empowerment refers to an individual's perceived ability and capacity to make their voice heard. Moreover, their capacity to influence others (Zimmerman, 2000). It comprises consciousness, as well as a sense of competence, self-determination, and meaning, (Spreitzer, 1995; Zimmerman, 2000). Community empowerment refers to one's sense of belonging (Itzhaky & Schwartz, 2001). It includes individual's involvement, engagement, or participation in social or political action or event that could improve their abilities to affect and improve their communities. (Boehm & Staples, 2004; Carr, 2003; Rappaport, 1987; Zimmerman, 2000).

In the literature, there are several concept analyses of empowerment (Appendix 1). Previously published works have explored nursing (Ryles, 1999), midwifery (Gibson, 1991; Hermansson & Mårtensson, 2011), community health nursing (Akpotor & Johnson, 2018), chronic illness (Dowling et al., 2011), and as well as critical care (Wåhlin, 2017), recovery from violence (Page et al., 2018), pediatric health care (Ashcraft et al., 2018), and pregnancy and childbirth (Nieuwenhuijze & Leahy-Warren, 2019). Furthermore, empowerment has been defined and described by clients, family caregivers, and nurses (Table 1).

Fumagalli et al. (2015) identified three main ways in which client empowerment has been understood in the existing literature. First, client empowerment could be seen as an “emergent state” when clients have the resources for them to feel they are in control of their lives (Castro et al., 2016, Gibson, 1991; Wåhlin et al., 2017) Client empowerment is peoples capacity to realize their own needs (Gibson, 1991), solve their problems (Ellis-Stoll & Popkess-Vawters, 1998; Gibson, 1991), and the necessary skills, knowledge, or motivation to become engaged in their health care. (Fumagalli et al.2015).

Second, it could be seen as a “process” that leads to clients experiencing an “emergent state.” It gives people hope, confidence, encouragement (Munn, 2010), and the opportunity to control their destinies and influence the decisions that affect their lives (Zimmerman, 1995) or life circumstances (Israel et al., 1994). Third, it could be seen as “behaviors” that involve clients participating in self-management and shared decision-making (McCarthy & Freeman, 2008).

Throughout the relevant literature, respectful, trusting relationships (Akpotor & Johnson, 2018; McCarthy & Freeman, 2008; Sakanashi & Fujita, 2017; Wåhlin, 2017; Weisbeck et al., 2019), active participation (Dowling et al., 2011), and client motivation are seen to as an important precondition for the empowerment process (Akpotor & Johnson, 2018; Castro et al., 2016; Dowling et al., 2011; Wåhlin, 2017). It has been suggested, however, that an empowered client does not necessarily take responsibility for their self-care, rather, they hand the responsibility over to health professionals (O’Cathain et al., 2005). Moreover, taking responsibility for one’s self-care or shared decision-making is not proof of being empowered (Fumagalli et al., 2015). The consequences of empowerment include clients taking personal responsibility for a healthier

lifestyle (Cawley & McNamara, 2011), an increased sense of coherence, and control over their situation and future (Castro et al. 2016; Wåhlin, 2017), and access to resources and ongoing social support (McCarthy & Freeman, 2008; Sakanashi & Fujita, 2017). A consensus on empowerment is still nonexistent, however (Bravo et al., 2015; Leino-Kilpi et al., 1998; McAllister et al., 2012). Due to the lack of context-specific instruments to measure this concept, there are numerous theoretical insights but little empirical knowledge (Damen et al., 2017; Vuorenmaa et al., 2014).

**Table 1.** Descriptions of empowerment based on previous studies.

| Author and year          | Definition   |
|--------------------------|--|
| Rappaport (1987)         | Empowerment is a process through which people, organizations, and communities gain mastery over their affairs.   |
| Gibson (1991)            | Empowerment is the feeling of being in control of one's life.  |
| Connelly et al. (1993)   | <p>Empowerment is a process through which people assert control over the factors affecting their lives. It is assumed that professionals cannot empower a client as he/she can only empower him/herself; however, health care providers can support him/her and remove as many obstacles to empowerment as possible.</p> <p>Empowerment is an ongoing process involving levels through which individuals progress. There are four levels of empowerment: Participating, choosing, supporting, and negotiating. The personal significance of empowerment varies depending on the individual, and the level of empowerment on which he/she functions varies.</p> |
| Feste & Andersson (1995) | Empowerment philosophy assumes that to be healthy, people must be able to bring about change not only in their persona and behaviors, but also in their social situations and in organizations that influence their lives.   |
| Zimmerman (1995)         | Empowerment is a process by which people, organizations, and communities gain mastery over issues of concern to them and "PE [psychological empowerment] is a feeling of control, a critical awareness of one's environment, and an active engagement in it" (Zimmerman, 1995) The author distinguishes between two complementary uses of empowerment: Empowering processes and empowering outcomes. He states that psychological empowerment consists of intrapersonal, interactional, and behavioral aspects.  |
| Dempsey & Foreman (1997) | Empowerment is the ability to actively satisfy one's needs and gain control of one's life.   |

| Author and year            | Definition   |
|----------------------------|--|
| Fulton (1997)              | Presents British nurses' views on the concept of empowerment as both a process and an outcome, i.e., related to having personal power, relationships within a multidisciplinary team, and feeling right about oneself.   |
| Johnston Roberts (1999)    | People are empowered when they have the knowledge, skills, attitudes, and self-awareness necessary to influence their own behavior and improve the quality of their life.  |
| Lundqvist et al. (2002)    | A sense of nearness and encouragement, a warm and human approach with empathy, individualized care, encountering goodness with respect for individual desires, information with a careful approach, staff being attentive, being given time, nearness and sympathy, being respected as a person, intersubjective relationships, having one's lived experiences understood and accepted.  |
| Dempsey & Dunst (2004)     | An individual's ability to mobilize and apply strategies that lead to greater control over their life by influencing their interpersonal and social environments.  |
| Funnell (2004)             | The opportunity to participate when willing and able, assistance to assess how to handle a situation, information in simple terms, involvement, and participation in one's care as soon as it is desired, targeted information, being encouraged and listened to.  |
| Andersson & Funnell (2005) | The empowerment process is regarded as an individual's discovery and development of their inborn capacity to control and take responsibility for their life.   |
| Johansson et al. (2005)    | Empowerment involves trusting oneself and encountering charity and professionalism; to be accepted as I am with my way of thinking and to meet people who care; to be shown consideration; to encounter professionalism; to get help building a platform of control with trust in oneself; to have the abilities and cognitive resources that lead to feelings of calm and security; to feel welcome and to share information and thoughts; to experience feelings of participation. |

| Author and year                  | Definition  |
|----------------------------------|---|
| Adib Hajbaghery & Salsali (2005) | Nurses described empowerment as a dynamic process resulting from mutual interactions among staff. The culture and structure of the organization were also described as important.   |
| Christensen & Taylor (2007)      | Central to empowerment is the formation of a partnership between health care staff and patients; the facilitation and access to comprehensible, unbiased information; mutual respect between those involved; being viewed and treated as an individual; experiencing sensitive communication within a positive and comfortable environment.   |
| Hibbard et al. (2007)            | Empowerment is viewed as a process of "improving client's own actions for their health" (Hibbard et al., 2007) and as a process through which clients become aware of their role.   |
| Redman (2007)                    | Patient empowerment helps patients discover and use their own innate ability to gain mastery over their disease. Empowerment educates patients to make informed decisions and to set behavioral goals to make changes of their own choosing. When people are empowered, they are experts on their own needs and can solve their own problems. |
| Aujoulat et al. (2008)           | Empowerment is defined as a process of a behavior change with a focus on how to help people become more knowledgeable and take control over their bodies, disease, and treatment. Empowerment is a process of activating patients.  |
| Andersson & Funnel (2010)        | Patients are equipped to make informed choices for themselves with enough skills and support from the health services.  |
| Holmström & Röing (2010)         | Patient empowerment is an interdependent concept. It can be achieved by patient-centeredness, but patients can also empower themselves.   |
| Cawley & McNamara (2011)         | Empowerment is a relationship where power is shared between a health practitioner and a client.   |

| Author and year                | Definition  |
|--------------------------------|---|
| Hermansson & Mårtensson (2011) | Empowerment in the midwifery context is described as developing a trustful relationship, starting a process of awareness, making it possible to reflect on a changing situation, acting based on the parents' situation on their own terms, getting them involved in making informed choices, confirming the personal significance of becoming parents. |
| Wåhlin (2017)                  | Common attributes of empowerment in critical care are a mutual and supportive relationship, knowledge, skills, the power within oneself, and self-determination.  |
| Akpotor & Johnson (2018)       | Empowerment involves a supporting relationship.   |

## Related concepts

The definition of empowerment is closely related to and difficult to distinguish from other terms, such as personal control, engagement, enablement, and activation (Bravo et al., 2015; Fumagalli et al., 2015; McAllister et al., 2012; McCarthy & Freeman, 2008; Meninchetti et al., 2016), which highlight clients' important role in their care (Fumagalli et al., 2015; Meninchetti et al., 2016). Fumagalli et al. (2015) clarified the boundaries between these concepts. Engaged clients are motivated by self-management, but they cannot necessarily carry out self-care (Meninchetti et al., 2016). Enabled clients understand their state of health. They are capable of participating in decision-making concerning their care, but they may not have the motivation or power to do so. Client activation emphasizes clients' abilities, such as confidence, skills, and knowledge to manage their health and understand their role in the care process (Hibbard & Greene, 2013). Client empowerment and client activation relate to increased abilities, motivations, and power, although client empowerment has greater connotations than activation (Barr et al., 2015; Fumagalli et al., 2015).

Other concepts related to empowerment have been identified, including involvement, participation, and self-efficacy (Anderson et al., 2000), a sense of coherence (Koelen & Lindström, 2005), and choice (Rodwell, 1996), which have typically been used synonymously (Baart & Abma, 2010; Ygge, 2005), or as each other's consequences (Rentinck et al., 2009). It has been argued that the concepts of "involvement" and "participation" are essential since without clients' participation, it is impossible to promote their empowerment (Molenaar et al., 2018). These terms have often been used to describe clients' role in their care and their opportunity to be included in decisions concerning their care (Cygan et al., 2002). Some advocacy definitions also contain several dimensions of empowerment, such as empowering the client and protecting their autonomy, rights, and interests that apply in cases when clients are unable to confirm these on their own. This ensures that clients have impartial access to the available resources that represent the views of clients and not merely their needs (Schwartz, 2002). In previous studies, these concepts have been defined in several different ways.

## **2.2 PARENTAL EMPOWERMENT**

This study focuses on parental empowerment, as this has been considered crucial for family well-being. Parental empowerment is defined as a sense of confidence that parents demonstrate when managing everyday life with their children (Ice & Hoover-Dempsey, 2011; Martinez et al., 2009; Vuorenmaa, 2016; Wakimizu et al., 2011). It includes the measures they take to meet the needs of their children (Vuorenmaa, 2016; Vuorenmaa et al., 2015; Wakimizu, 2011; Zhang & Bennett, 2003; Zimmerman, 2000), as well as the skills and knowledge required to navigate complex systems and access required services (Palisano et al., 2010).

### **2.2.1 Concepts and definitions**

Parental empowerment has been studied since 1990. Published works have explored the empowerment of parents whose children have disabilities (Caldwell et al., 2018; Dempsey & Dunst, 2004; Itzhaky & Schwartz, 2001; Wakimizu et al., 2016; Willis et al., 2019) or emotional and behavioral challenges (Huscroft-D'Angelo et al., 2018), autism (Banach et al., 2010; Casagrande & Ingersoll, 2017). Furthermore, there are few studies on parents of critically ill children (Melnyk et al., 2004; Sufyanti & Diyan, 2019), parents of children with epilepsy and other chronic neurological conditions (Segers et al., 2019; Sheijani et al., 2020), asthma caregivers (Coutinho et al., 2016; Teymouri et al., 2017; Yeh et al., 2016), pediatric rehabilitation centers (Alsem et al., 2019), and mental health services for children's (Bode et al., 2016).

Moreover, there have been studies about parental empowerment and teacher professionalism (Addi-Raccah & Arviv-Elyashiv, 2008), advocacy, and empowerment in parent consultation (Holcomb-McCoy & Bryan, 2010). Also, parent commitment and empowerment in schools (Jasis & Ordoñez-Jasis, 2012), relationships between parent empowerment and academic performance (Kim & Bryan, 2017), family-school partnerships (Burke, 2017; Burke et al., 2019), and parent-teacher collaboration in schools (Myende & Nhlumayo, 2020) and preschools (Cameron, 2018), as well as in special education (Burke et al., 2020). To my knowledge, no studies have investigated the empowerment of LGBTQ parents. Furthermore, there are few studies on

parental empowerment in instances of substance use (Chou et al., 2018) and on different services for children and families (Casagrande & Ingersoll, 2017; Dempsey & Foreman, 1997; Vuorenmaa et al., 2016a).

In previous studies, researchers inconsistently defined parental empowerment, conceptualizing it using multiple frameworks and measuring it in a variety of ways (Koren et al., 1992). The concept only takes on meaning once the context and examined agent are considered (Holden et al., 2004; Vuorenmaa et al., 2014). Parental empowerment is not a static state, but one that varies according to different life situations and the levels of individual and community empowerment (Damen et al., 2020; Koren et al., 1992; Raivio & Karjalainen, 2013; Vuorenmaa, 2016). It has been shown that the age, gender, family type, and education level of parents and the child's age and place of care, as well as the parents' participation in services, are connected with parental empowerment (Damen et al., 2020; Vuorenmaa et al., 2016).

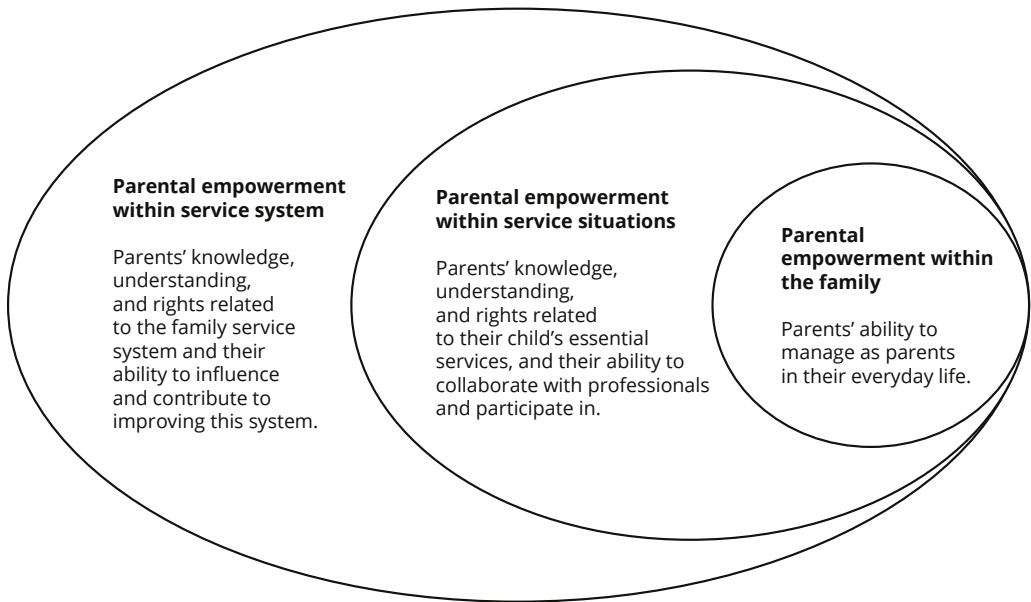
Individual empowerment refers to parents' abilities, and skills to improve their or their children's life situation (Gutierrez, 1995; Koren et al., 1992). Community empowerment refers to parents' sense of belonging and participation (Carr, 2003; Zimmerman, 2000) in a school community (Itzhaky & Schwartz, 2001) and a neighborhood. Individual empowerment comprises a sense of competence, self-determination, consciousness, and meaning, (Kim & Bryan, 2017; Koren et al., 1992; McWhirter, 1991; 1998; Spreitzer, 1995; Zimmerman, 2000). Sense of competence refers to parents' ability to manage in everyday life (Koren et al., 1992; Uliano et al., 2013; Vuorenmaa et al., 2016; Zimmerman, 2000), and parents' skills to support their children's schooling (Holcomb-McCoy & Bryan, 2010). Moreover, the ability to access services they need (Caldwell et al., 2018; Vuorenmaa et al., 2016). Self-determination is managing things that affect one's life (Prilleltensky, 2008) such as, making decisions about their children's care (Fumagalli et al., 2015; Hallström & Elander, 2007; Koren et al., 1992), advocating for their children in different social and welfare or educational settings (Boehm & Staples, 2004; Koren et al., 1992) and taking control of their children's education (Boehm & Staples, 2004). Consciousness is parents' critical awareness of their religious, ethnic, or sociocultural background and how these affect their and their children's lives (Holcomb-McCoy & Bryan, 2010). A sense of meaning refers to parents'

beliefs that they are good parents who are “worthy of care” (Anderssen et al., 2017). Community empowerment includes parents’ right and abilities to influence the service system (Koren et al., 1992) and their trust in the professionals they work with (Boehm & Staples, 2004; McWhirter, 1998).

### **2.2.2 Parental empowerment within the family, service situation, and service system**

This study aimed to examine how parental empowerment is supported in Finnish child and family services from the viewpoint of professionals. The support of parental empowerment was evaluated using the version of the FES aimed at professionals (Vuorenmaa et al., 2014). This questionnaire is based on Koren’s (1992) research group’s original research on parental empowerment. According to Koren et al. (1992), parental empowerment occurs at three levels: (a) within the family (an individual, i.e., parents’ management of daily situations); (b) within the service situation (an organization, i.e., services that the child and family services or school provide); and (c) within the service system (a community, i.e., service system structures and policies that impact families; Vuorenmaa et al., 2014). Within the family, empowerment includes parents’ sense of their abilities to manage as parents in daily life, capability to solve problems, and ask for help if needed. Moreover, it is acquiring the required skills and knowledge needed to contribute to their child’s development. By supporting the daily life and community of the family, the resources of the child, young person, and family can be strengthened. Support and capacity building may be needed, for example, in parenting, raising a child and young person, in a relationship, in situations of parental separation, or unexpected everyday challenges. Everyday support and community activities are either open to everyone or aimed at people in a certain life situation.

Empowerment within the service situation and the service system reflects the broader definition of empowerment used by Koren et al. (1992). These levels include parents’ capacity to promote positive outcomes and greater control over their lives. Moreover, parents’ capacity to influence their social environments, especially their own or their children’s care (Singh et al., 1995). (Figure 1.)



**Figure 1.** Parental empowerment within the family, service situation, and service system (modified by Koren et al., 1992).

### **2.2.3 Outcomes of parental empowerment**

Parental empowerment is considered to be an important concept in terms of enhancing the well-being of parents and families (Huscroft-D'Angelo et al., 2018; Koelen & Lindström, 2005), as well as strengthening parents' position in health care (Green et al., 2007; Hook, 2006) and educational settings (Burke et al., 2019; Taylor et al., 2017). Positive associations have been found in relation to involvement and participation in family services (Burke et al., 2019; Koren et al., 1992; Øien et al., 2009; Taylor et al., 2017; Wakimizu, 2011), care planning (McCann et al., 2008; Rangachari et al., 2011), decision-making (McKenna et al., 2010; Wiggins, 2008), the ability to make choices regarding their children's treatment (Gallant et al., 2002; Koren et al., 1992; Øien et al., 2009; Vuorenmaa et al., 2014) or education (Burke et al., 2019).

It has been shown that parental empowerment relates to internal resources, parenting self-efficacy (Green et al., 2007; Ice & Hoover-Dempsey, 2011; Zhang & Bennett, 2003) and a more positive perception of parenting (Chao et al., 2006; Uludag, 2008; Weiss et al., 2015). Higher levels of parental

empowerment are associated with family cohesion, relationships, and functionality (Scheel & Rieckmann, 1998). In addition, it has been shown that the lower levels of parenting stress (Chacko et al., 2009; Damen et al., 2017; Gallant et al., 2002; Kazdin & Wassell, 2000; Nachshen & Minnes, 2005; Øien et al., 2009; Ruffolo et al., 2006; Vuorenmaa et al., 2016; Weiss et al., 2015) and parents ability to solve family problems (Farber & Maharaj, 2005) are associated with higher levels of parental empowerment. Furthermore, it has been shown that parental empowerment is related to and children's improved growth (Weiss et al., 2012; 2015) and development (Ruffolo et al., 2006).

In contrast, a lack of parental empowerment is associated with adversities, serious conflicts within the family and mental health problems in parents (Vuorenmaa et al., 2016). Lower levels of parental empowerment are associated with stress about parenting (Nachshen & Minnes, 2005; Vuorenmaa et al., 2015; Wakimizu et al., 2011), financial burdens or unemployment, and the inability to reconcile family and work in their everyday lives (Vuorenmaa et al., 2016; Weiss & Lunsky, 2011). Parents who feel disempowered may be reluctant to fully participate in the treatment of their child, so they may underutilize certain services (Olin et al., 2010; Scheel & Rieckmann, 1998; Singh, 1995).

## **2.3 SUPPORTING PARENTAL EMPOWERMENT IN CHILD AND FAMILY SERVICES**

The WHO defines client empowerment as a process through which people gain greater control over decisions and actions affecting their life (WHO, 1998). In the context of family and child health care, parents are often targeted in efforts to promote empowerment, given their essential role in the care of children. Building on the WHO definition of client empowerment, supporting parent empowerment can be seen as a process in which parents obtain the knowledge and help to be able to manage as parents in their daily life by supporting their critical awareness and knowledge concerning rights related

to their child's essential services and the family service system (Koren et al., 1992; Zimmerman, 1995; 2000).

Strategies used by professionals to support parental empowerment have been studied (Anderson & Funnell, 2010; van der Pal et al., 2014). An appropriate theoretical framework or way to support parents has not been found, however. There are different types of orientations behind effective parental support working methods; many emphasize social learning theory, whereas others have a stronger attachment emphasis and often combine different theoretical frameworks. Furthermore, the duration and forms of support vary from home visits to parent groups and individual meetings with parents. Generally, working methods include resource orientation, parental respect, and empowerment, as well as an activating, concrete approach and the practice of parenting skills, positive interaction, and positive parenting practices (Bauer et al., 2016; Prinz, 2016). The personal capacity of professionals, including their skills and knowledge (Matthews et al., 2006), empowering work environments, and employees' empowerment (Cawley & McNamara, 2011) are the focus of this study, as it has been found that they are relevant and interconnected.

### **2.3.1 Professional capacity to support parental empowerment**

Throughout the relevant literature, collaboration between parents and professionals (Alderson et al., 2006; Burke, 2013; Burke et al., 2019; Ewertzon et al., 2008; Fiks et al., 2011; Hook, 2006; McKenna et al., 2010; Mikkelsen & Frederiksen, 2011), mutual trust and respect, and addressing the family's needs and vulnerabilities (Alderson et al., 2006; Burke et al., 2019; Fiks et al., 2011; McKenna et al., 2010) are referred to as essential prerequisites for empowering parents in different social and welfare services. Moreover, active participation, focusing on strengths and decision-making, as well as developing skills were found to be relevant and interconnected (Aston et al., 2006; Cawley & McNamara, 2011; Falk-Rafael, 2001; Hermansson & Mårtensson, 2011; Rodwell, 1996).

Studies have shown that ongoing interactions between professionals and parents seem to be supportive when professionals are characterized as being able to listen, share, and empower (Gavois et al., 2006). This allows families

and professionals to work together towards a common goal (Bedwell et al., 2012). It enables professionals to identify and address the family's needs and vulnerabilities and allows parents to be involved in the planning and decision-making concerning their family's care (Hallström & Elander, 2007) and their child's education (Burke et al., 2019). Cross-cultural studies on school-family collaborations show that partnerships are important, not only for schools (the improvement of school programs and environment) and the family (a sense of parental efficacy and positive parenting behaviors), but also for the child in terms of their adjustment to school (Lau & Power, 2018; Phillipson & Phillipson, 2007).

According to parents, professionals' communicative competence and interpersonal competence are valued as important factors in a good relationship between parent and professional (Alderson et al., 2006). Furthermore, parents appreciate individualized information, emotional support (King et al., 2002; King et al., 2006), and advice about how to navigate the health care system (Palisano et al., 2010). Such information provides parents with the opportunity to regain control over their family life, to plan for the future (Pain, 1999), and to feel better able to become involved in decision-making (Fumagalli et al., 2015).

To be able to support or better communicate with parents from diverse backgrounds, professionals require reflective skills (Bryan et al., 2016), specific education (Engström et al., 2018; Lau & Ng, 2019), and awareness of the services available for families (Burke et al., 2019). Due to the great variation in family needs and the changes in such needs over time, there is a requirement for culturally sensitive care, including concepts of tailored care, respect, understanding, knowledge, consideration (Foronda, 2008). Furthermore, there is a need for technical knowledge and experience (Fiks et al., 2011). The reflective skills of professionals, such as self-knowledge, are necessary to improve their awareness of their limitations, as well as the emotions and attitudes that may affect care delivery and the quality of care (Bryan et al., 2016). The attitudes of professionals are perceived as important, especially when working with substance abusers (van Boekel et al., 2012) or LGBTQ parents (Bennet et al., 2016; Shields et al., 2012). Nurses' attitudes of courage, healthy curiosity, and honest, open, and nonjudgmental

communication are positively associated with successful engagement when relating to parents (Bryan et al., 2016). According to Huscroft-D'Angelo et al. (2018), this requires professionals to break through barriers such as the unresponsiveness of professional support, uneasiness about interactions and relationships with professionals and a lack of trust in service providers (Children's Bureau, 2016).

### **2.3.2 Empowering work environment, collaboration, and supervisory support**

Organizational factors, such as an empowering work environment, culture and management (Adib Hajbaghery & Salsali, 2005; Cawley & McNamara, 2011; Corbally et al., 2007; Ho, 2009), as well as the levels of empowerment of the professionals are related to how they support their client's empowerment. An empowering work environment seems to improve job satisfaction and commitment (Heponiemi et al., 2014; Laschinger & Finegan, 2005; Laschinger et al., 1999), and organizational structures; for example, the successful cooperation between services and professionals may reduce the negative effects of stressful working conditions (Bakker et al., 2014; Onyett, 2011).

The terms collaboration, cooperation, coordination, and integration are often used synonymously. These concepts describe as the process by which service providers from different settings work together (Cooper et al., 2016). The importance of this kind of collaboration between different family services is emphasized widely (WHO, 2016) as this improves the quality of care (Cheng et al., 2013; Hamric & Blackhall, 2007; van Bogaert et al., 2013) and earlier identification of families' multiple needs (Oliver et al., 2010). According to earlier studies, integrated services enables families to experience continuity of care as they transition through services (Schmied et al., 2010). Moreover, better collaboration between services enables employees to receive support from each other as well as exchange experiences and knowledge (Glisson & Green, 2011; Onyett, 2011). There are also some indications that collaboration between services can lead to greater cost-effectiveness (Nolte & Pitchforth, 2014). However, the research also suggests that collaboration between child and family services, from the broader field of health and social care (Cooper et al., 2016) may lead to professional identity confusion as well as increases

in workload (Oliver et al., 2010). Conversely, a lack of cooperation between services and professions have negative consequences for clients (Fewster-Thuente & Velsor-Friedrich, 2008) and for professionals (Bedwell et al., 2012; Jha, 2008; Karasek & Theorell, 1990).

Effective collaboration often depends good management and managerial support (Jha, 2008) and the capacity of employees to be empowered and to empower others. Previous studies has argued that management is essential in determining team and organizational effectiveness (Burke, et al., 2006; Judge & Piccolo, 2004; Zaccaro et al., 2001). Management is coaching and providing support to the team. Moreover, it is removing barriers to cooperation (Hackman, 2002; Salas et al., 2005). According to Karasek and Theorell (1990), it appears that giving employees the opportunity to influence their work processes is important. When employees feel they have a lot of control and the freedom to use all their available skills, they are motivated, and their growth is supported.

Empowerment in management can be defined as the extent to which leaders value their employees' contributions and care about their well-being. Empowered management refers to a situation in which employees are treated fairly and provided with accurate information, resources, and opportunities to accomplish organizational goals and empower others (Kanter, 1993). This supervisory support includes empowering support, such as the opportunity to be respected in their job, and skills-oriented support, such as opportunities to receive clinical supervision and education to support their professional development (Räikkönen et al., 2007). Moreover, treating employees fairly through honest, equal, and open relationships is positively associated with a wide range of beneficial employee outcomes (Moorman, 1991).

Effective supervisory support improves the quality of services, which leads to improved outcomes in terms of safety, permanence, and the well-being of families (Dill & Bogo, 2009; Faller et al., 2004; Salus, 2004). It reduces the job stress of child welfare workers (Chen & Scannapieco, 2010; Smith, 2005; Zeitlin et al., 2014) and improves their performance (Cearley, 2004), competencies (Clark et al., 2008), satisfaction, commitment, and retention (Chen & Scannapieco, 2010; Smith, 2005; Zeitlin et al., 2014). Furthermore, when employees are fairly treated, they exhibit positive work attitudes,

including work motivation, increased involvement and job satisfaction, trust in the management as well as the intention to remain job (Cho & Sai, 2012; Choi, 2011; Hassan, 2013a; Kim & Rubianty, 2011; Ko & Hur, 2014). In contrast, employees who perceive inequality or lack access to supervisory support are more likely to develop dissatisfaction and poor work motivation (Adebayo, 2005; Elovainio et al., 2001; Moorman, 1991). Relatively little is known about how organizational justice relates to employees' capacity to meet their clients' needs; indeed, no research has been conducted on the association between the fairness of treatment of employees and parental outcomes in family services.

## **2.4 MEASURING EMPOWERMENT**

In previous studies empowerment has been measured in a variety of ways. According to a recent systematic review conducted by Pekonen et al. (2020), there are 13 instruments to measure a client's empowerment; six were developed to measure client empowerment and seven measured concepts related to empowerment (client enablement, client activation, client engagement, and perceived control).

The available evaluation tools for measuring empowerment have been focused on particular conditions, such as, cancer (Bulsara et al., 2006; Seçkin, 2011), diabetes (Anderson et al., 2000), Human immunodeficiency virus (HIV) -infected clients (Johnson et al., 2012), or specific contexts, such as rehabilitation (Rogers et al., 1997), primary care (Howie et al., 1998), or long-term conditions (Small et al., 2013). There are differences between these measurements depending on the framework and constructs used (McAllister et al., 2012). Moreover, the measured outcomes are usually limited to one aspect of client empowerment, such as activation levels (Hibbard et al., 2004), self-management (Lorig et al., 2009), or self-efficacy (Rogers et al., 2008).

## Parental empowerment

Evaluation tools for measuring parental empowerment have concentrated on various caregiver groups, such as the caregivers of clients with acquired immunodeficiency syndrome (Webb et al., 2001), terminal renal disease (Tsay & Hung 2004), cancer (Bulsara et al., 2006; Degeneffe et al., 2011; Lopez et al., 2010), diabetes (Anderson et al., 1995) and mental illness (Hansson & Bookman, 2005). Moreover, individuals with brain damage (Empowerment Questionnaire, EMPO; Man, 2001) parents of children with a disability (the Psychological Empowerment Scale (PES); Akey et al., 2000), family members and caregivers of a brain-damaged family member (The Family Empowerment Questionnaire; Man, 1998) as well as the Family Empowerment Scale, (FES) (Koren et al., 1992; Vuorenmaa et al., 2014), which measures the extent to which parents act to acquire services for their child from the care system and the Empowerment Questionnaire (EMPO), which examined changes in parental empowerment and children's behavioral problems over a period of youth care (Damen et al., 2019). Five of these questionnaires have been estimated to provide good or reasonable evidence of reliability and validity; The Family Empowerment Questionnaire (Man, 1998), The Parent Empowerment Survey (Trivette et al., 1996), the EMPO (Man, 2001), the FES (Koren et al., 1992) and the PES (Akey et al., 2000).

There are few instruments that measure the support of parental empowerment. Existing instruments measure certain elements, such as attitudes toward parental participation (Seidl & Pillitteri, 1967), family-professional partnerships (Summers et al., 2005), involvement (Epstein, 1995), and the perception of the amount of family-centered services (Woodside et al., 2001), connected to supporting factors of parental empowerment (Vuorenmaa et al., 2014).

## **2.5 SUMMARY OF THEORETICAL BACKGROUND**

According to earlier research, parental empowerment has a positive impact on the well-being of families (Koren et al., 1992; Vuorenmaa et al., 2014). The support of parental empowerment through services is important for professionals (Cawley & McNamara, 2011; Falk-Rafael, 2001; Hermansson & Mårtensson, 2011), even though they are not always certain about what empowerment actually means or how it can be supported (Cawley & McNamara, 2011; Corbally et al., 2007). Little attention has been paid to professionals' capacity (Corbally et al., 2007; Kuokkanen & Leino-Kilpi, 2000; Rodwell, 1996) to support their clients' empowerment. Organizational factors such as management (Adib Hajbaghery & Salsali, 2005; Cawley & McNamara, 2011; Corbally et al., 2007) could be associated with better support of parents' empowerment. Furthermore, there is a lack of knowledge on LGBTQ parents' empowerment.

For the purpose of the current study, parental empowerment is defined as the sense of confidence that parents demonstrate when managing everyday life with their children (Ice & Hoover-Dempsey, 2011; Koren et al., 1992; Martinez et al., 2009; Vuorenmaa, 2016; Wakimizu et al., 2011). It includes the measures they take to meet the needs of their children (Koren et al., 1992; Vuorenmaa, 2016; Vuorenmaa et al., 2015; Wakimizu, 2011; Zhang & Bennett, 2003; Zimmerman, 2000), as well as the skills and knowledge required to navigate complex systems and access services (Koren et al., 1992; Palisano et al., 2010). Supporting parental empowerment is seen as a process in which parents obtain the knowledge and help to be able to manage as parents in their everyday life. Moreover, it is seen as supporting their critical awareness and knowledge concerning rights related to their child's essential services and to the family service system (Koren et al., 1992; Zimmerman, 1995; 2000). The concept of family "refers to two or more individuals who depend on one another for emotional, physical and economical support" (Rowe Kaakinen et al., 2014).

### **3 AIMS OF THE STUDY**

The aim of this study was to examine how parental empowerment is supported in Finnish child and family services, as well as how collaborative working practices and empowerment in management are related to the support of parental empowerment from the viewpoint of professionals. A further aim was to describe parental empowerment and related supportive factors from the viewpoint of LGBTQ parents. The specific research questions addressed are presented below.

Sub-study I: Supporting parental empowerment in substance abuse services.

1. How well is the empowerment of parents who are clients of substance abuse services supported from the perspective of those working in the substance abuse services? (Original article I)

Sub-study II: Supporting parental empowerment and factors related to it in child and family services.

2. How do employees in child and family services support parental empowerment within a) the family, b) the service situation, and c) the service system? (Original article II)
3. How are a) cooperative working practices (awareness of services, functionality of cooperation, shared cooperation practices) and b) empowerment in management (opportunities to make decisions at work, supervisory support, fairness of treatment) related to supporting parental empowerment? (Original article II)

Sub-study III: Supporting LGBTQ parents' parental empowerment in maternal and child health care.

4. How do self-identified LGBTQ parents in Finland describe parental empowerment in maternity and child health services? (Original article III)
5. What are the supporting factors of parental empowerment in maternity and child health care from the perspective of self-identified LGBTQ parents in Finland? (Original article IV)

## **4 SUBJECTS AND METHODS**

### **4.1 METHODS**

This study comprises three sub-studies of quantitative and qualitative studies, which include three different data sets (Table 2). In sub-studies I and II, a quantitative study with a cross-sectional study design was used. Data were gathered from: 1) professionals working in substance abuse services (Original article I); and 2) employees working in health care, social welfare, and education settings (Original article II). In sub-study III, a qualitative inductive approach was used. Data were gathered from LGBTQ parents with experience of maternal and child health care services (Original articles III and IV). Quantitative data were analyzed using statistical analysis, and inductive content analysis was carried out on the qualitative data. The results of the study are presented in detail in four original articles.

**Table 2.** Summary of study design by sub-studies and original articles I–IV.

| Sub-studies and study design  | Research questions   | Participants  | Data collection  | Main study variables/ themes  |
|---|--|---|--|---|
| <b>Quantitative studies</b><br><br>Sub-study I (Original article I)<br>Cross-sectional study design | How well is the empowerment of parents who are clients of substance abuse services supported from the perspective of those working in substance abuse services?                                | Employees working in substance abuse clinics (n = 132)                                  | Postal survey in 2009<br>A total of 372 surveys were sent. A total of 132 employees responded (response rate of 36%)   | Supporting parental empowerment<br>a) within the family<br>b) within the service situation<br>c) within the service system  |
| Sub-study II (Original article II)<br><br>Cross-sectional study design                              | How do employees in family services support parental empowerment?<br><br>How are a) cooperative working practices and b) empowerment in management related to supporting parental empowerment? | Employees in health care, social welfare, and educational settings in Finland (n = 457) | Postal survey in 2009<br>A total of 1,220 surveys were sent. A total of 457 employees responded (response rate of 37%) | Cooperative working practices, including:<br>- Awareness of services<br>- Functionality of cooperation<br>- Shared collaboration practices<br><br>Empowerment in management:<br>- Opportunity to make decisions at work<br>- Supervisory support<br>- Fairness of treatment |

| Sub-studies and study design  | Research questions   | Participants  | Data collection  | Main study variables/ themes  |
|---|--|---|--|---|
| <p><b>A qualitative inductive design</b></p> <p>Sub-study III<br/>(Original article III)</p> <p>(Original article IV)</p> | <p>How do self-identified LGBTQ parents in Finland describe parental empowerment in maternity and child health services?</p> <p>What are the supporting factors of parental empowerment in maternity and child health services from the perspective of self-identified LGBTQ parents in Finland?</p> | <p>Parents (n = 22)</p> <p>Inclusion criteria:</p> <ol style="list-style-type: none"> <li>1) Self-identifying as LGBTQ;</li> <li>2) At least 18 years of age;</li> <li>3) A biological or nonbiological parent;</li> <li>4) Have experience of using Finnish maternity or child health services during the 2000s</li> </ol> | <p>Internet recruitment</p> <p>22 interviews (8 face to face and 14 by telephone) were carried out between July and September 2016</p> | <p>Parental empowerment in maternal and child health services</p> <p>Supporting factors of parental empowerment</p> |

## **4.2 QUANTITATIVE STUDY**

### **4.2.1 Data collection**

#### **Supporting parental empowerment in substance abuse services (Sub-study I, Original article I)**

Data were gathered as part of a project carried out by the Finnish Institute for Health and Welfare on Integrated Management in Children, Youth, and Family Services. The sample was collected from Finnish substance abuse services (n = 372), which were A-Clinic outlets, health counseling centers for drug users, outpatient clinics providing substance abuse treatment, outpatient care units, rehabilitation facilities, substance abuse treatment centers, and substance abuse treatment daycare centers. Purposive sampling was used to identify organizations with a substantial role in providing services to this population. A list of available services was compiled based on data available from national health care and social welfare registers: (1) TOPI; (2) HILMO; and (3) network information about the A-Clinic Foundation and the foundation's daughter company, A-Clinic Ltd treatment and rehabilitation services.

A questionnaire aimed at professionals working in substance abuse services (n = 372) was sent to the heads of service units in the fall of 2009 and the spring of 2010. In the cover letter, the head of the unit was asked to choose one responder who could assess the unit's working methods. A reminder letter was sent in January 2011. In total, 132 professionals responded to the questionnaire. A response rate was 36%.

#### **Cooperative working practices, empowerment in management, and parental empowerment (Sub-study II, Original article II)**

Data were gathered in 2009 by the Finnish Institute for Health and Welfare as part of a project on Integrated Management in Children, Youth, and Family Services (Halme et. al., 2014). The sample was compiled from Finnish municipalities that provide child health clinics, school health care, daycare, and preschool and primary school services. For larger municipalities (>4,000 inhabitants; n = 209), a questionnaire was sent to the heads of service

units. For smaller municipalities (<4,000 inhabitants; n = 123), a further 35 service units were randomly selected from within each service sector, and questionnaires were sent to the unit heads. The questionnaire (n = 1,220) was sent in May 2009. In the cover letter, the head of the unit was asked to choose one responder to evaluate the unit's working methods. A reminder letter was sent in August 2009. In total, 457 professionals responded to the questionnaire. A response rate was 37%.

#### **4.2.2 Measures**

This study utilized several scales that were considered to be suitable for studying family services in Finnish municipalities (Kausto et al., 2003; Toljamo & Perälä, 2008; Vuorenmaa et al., 2014). The support of parental empowerment in substance abuse services (Original article I) and in health and education services (Original article II) was evaluated using the version of the FES aimed at professionals (Vuorenmaa et al., 2014), and the association between the support of parental empowerment and collaborative working practices and management empowerment was evaluated using previously used questionnaires (Karesek & Theorell, 1990; Moorman, 1991; Räikkönen et al., 2007; Table 3).

**Table 3.** Measuring support of parental empowerment and related factors in this study.

| Main variables   | Study variable   | Measure-ment  | Subscales   | Reliability                                       | Analysis  |
|--|--|---|---|---|---|
| <b>Original article I</b>  |  |   |   |   |   |
| Supporting parental empowerment of employees of substance abuse services | Supporting parental empowerment<br>a) within the family<br>b) within the service situation<br>c) within the service system | The personnel version of the FES (Vuorenmaa et al., 2014) | Three subscales and 32 items.<br><br>10 items in the family subscale refer to how employees support parents' ability to manage everyday life with their children<br><br>12 items in the service situation subscale refer to how employees support parents' ability to obtain and influence the services required for their own child's needs from the service system<br><br>10 items in the service system subscale refer to how employees support parents' advocacy for improving services for children in general | Cronbach's alpha<br>a) 0.95<br>b) 0.92<br>c) 0.90 | Descriptive<br><br>One-way analysis of variance<br><br>Independent t-test |

| Main variables  | Study variable   | Measurement   | Subscales   | Reliability                   | Analysis  |
|---|--|---|---|-------------------------------|---|
| <b>Original article II</b>  |  |   |   |                               |   |
| Supporting parental empowerment of employees of child and family services | Supporting parental empowerment<br>a) within the family<br>b) within the service situation<br>c) within the service system | The personnel version of the FES (Vuorenmaa et al., 2014) | Three subscales and 32 items<br>- within the family 10 items<br>- within the service situation 12 items<br>- within the service system 10 items | a) 0.94<br>b) 0.92<br>c) 0.93 | Descriptive<br><br>One-way analysis of variance<br>Independent samples t-test<br><br>Multiple linear regression (MLR) |

| Main variables                | Study variable   | Measurement  | Subscales   | Reliability  | Analysis |
|-------------------------------|--|--|---|--|----------|
| Cooperative working practices | Employee awareness of services<br>Functionality of cooperation<br>Shared cooperation practices<br>Agreement on shared goals<br>Agreement on joint practices<br>Commitment to common goals<br>Flow of information<br>Agreement on monitoring and evaluation | Cooperative working practices – questionnaire<br><br>Job Content Questionnaires (Karasek & Theorell, 1990) | Employee awareness of services 18 items<br>Functionality of cooperation -15 social welfare and education services<br>-16 health care services<br><br>Agreement on shared goals 5 items<br>Agreement on joint practices 5 items<br>Commitment to common goals 5 items<br>Flow of information 5 items<br>Agreement on monitoring and evaluation 5 items | 0.89<br><br>0.91<br>0.94<br><br>0.81<br>0.82<br>0.81<br>0.80<br><br>0.88 |          |

| Main variables            | Study variable   | Measurement  | Subscales   | Reliability                         | Analysis |
|---------------------------|--|--|---|-------------------------------------|----------|
| Empowerment in management | <p>Opportunities to make decisions at work</p> <p>Supervisory support</p> <p>Fairness of treatment</p> | <p>Supervisory support scale (Räikkönen et al., 2007)</p> <p>Fairness of treatment (Moorman, 1991)</p> | <p>Opportunities to make decisions at work 6 items</p> <p>Supervisory support 12 items</p> <p>Fairness of treatment 7 items</p> | <p>0.79</p> <p>0.82</p> <p>0.93</p> |          |

## **Personnel version of the FES (Sub-study I, Original articles I and II)**

The support of parental empowerment in substance abuse services (Original article I) and health and education services (Original article II) was evaluated using the version of the FES aimed at professionals (Vuorenmaa et al., 2014). This measurement includes three subscales and 32 items: 10 items of the family subscale, 12 items of the service situation subscale and 10 items on the service system subscale. Family subscale refer to how employees support parents' abilities to manage everyday life with their children, for example: "I help parents gain control over their family life." The service situation subscale refers to how employees support parents' knowledge, understanding, and rights related to their child's services, and their ability to collaborate with professionals and participate in decision-making, for example: "I make sure that parents approve all services provided to their child". The service system subscale refers to how employees support parents' ability to influence and contribute to improving this system, for example: "I make sure that parents have information on the services for children available in their municipality". The personnel version of the FES uses a 5-point Likert-type rating scale (1 = fully disagree, 5 = fully agree).

The measurement is based on Koren et al.'s original FES (1992), which was developed for the parents of children with emotional disabilities. The personnel version of the FES was modified to reflect the perspective of the personnel's evaluation of their support of parental empowerment. The modification, as well as the back translation was carried out by a group of multidisciplinary experts. The personnel version of the FES was piloted with personnel (n = 17) in school health care and daycare. No changes were made following the pilot study. (Halme et al., 2014; Vuorenmaa, 2016.)

## **Cooperative working practices (Sub-study II, Original article II)**

Awareness of child and family services was measured with 18 items using a five-point Likert-type scale (1=very poor,5= very good) (Joensuu et al., 2013; Perälä et al., 2011). Such services included special education services, psychological support, parish, private sector services, and various forms of

financial support. The functionality of collaboration, within the previous 12 months with social welfare and education services and health care services social welfare was measured with 31 items on a five-point Likert- type scale (1=very poor, 5= very good) (Halme et al., 2014; Perälä et al., 2011)

Shared cooperation practices, agreement on shared goals, agreement on joint practices, commitment to common goals, the flow of information, agreement on monitoring and evaluation, between sectors and municipalities and with third- and private-sector actors providing services for children and families was elicited using a 30-item measure consisting of six items (Veil & Herbert, 2008). A five-point Likert-type scale (1 = strongly disagree, 5=strongly agree) was used (Halme et al., 2014; Perälä et al., 2011).

### **Empowerment in management (Sub-study II, Original article II)**

Job Content Questionnaires (Karasek & Theorell, 1990) was used to evaluate the opportunities for employees to make decisions about their work. Six items using a five-point response scale (1=very poor, 5=very good), were used to assess the employees' opportunities to make decisions about their work, work tasks and procedures, pace, established working methods, and division of labor, as well as the procurement of any tools and learning materials needed in their workplace. (Halme et al., 2014.)

### **Supervisory support (Sub-study II, Original article II)**

Supervisory support such as empowering support and skills-oriented support activities were measured with the 12-item Supervisory Support Measure (Räikkönen et al., 2007) using a five-point Likert-type scale (1=poor, 5=excellent). The measurement included 12 items. The empowering support behavior subscale contained five items: unit employees' opportunities to feel respected in their work, receiving feedback about the care they had provided, developing unit practices, influencing decisions made concerning unit practices, and acting according to the principles of good care.

The skills-oriented support activities subscale contained seven items: receiving training to support professional development, opportunities to

receive clinical supervision, discussing individual performance reviews and development, receiving support for studying on one's initiative, receiving support for development activities, being provided with information on best practices, and receive opportunities to participate in job rotation.

### **Fairness of treatment (Sub-study II, Original article II)**

The fairness of treatment (Moorman, 1991) was evaluated with a five-point Likert- type scale (1=strongly disagree, 5=strongly agree). The employees' perceptions of treatment by and relationship with their managers, including their opinions of whether the relationship was equal, honest, and open, were assessed according to seven items. A new item, "My line manager includes subordinates in the decision-making processes," was added to Moorman's (1991) original set of six items. The added statement worked well in the scale, and its correlation with other variables in the original measurement ranged from  $r = 0.58$  to  $r = 0.69$ . The internal consistency of the new, supplemented measurement, assessed by Cronbach's alpha coefficient, was excellent ( $\alpha = 0.93$ ), and thus followed the internal consistency of the original measurement (Kausto et al., 2003).

### **Demographic variables and aspects of the workplace (Sub-studies I and II, Original articles I and II)**

The surveys included demographic variables (e.g., age and gender) and questions about education and managerial position, as well as the industrial sector, workplace location, and the population size in the municipality (Table 1 in Original article I, Table 2 in Original article II).

### **4.2.3 Data analysis**

#### **Supporting parental empowerment in substance abuse services (Sub-study I, Original article I)**

The quantitative data were analyzed statistically using the SPSS Statistics 21.0 program for Windows. Descriptive statistics, including frequencies, percentages, means, and standard deviations were used to characterize the participants. Comparisons of groups were made using a one-way analysis of variance or the independent samples t-test. Statistical significance was set with a p-value of  $<0.05$ . The internal consistency assessed by Cronbach's alpha, ranged between 0,90–0,95 (Nunnally & Bernstein, 1994).

#### **Parental empowerment, cooperative working practices, and empowerment in management (Sub-study II, Original article II)**

The data were analyzed statistically using the SPSS Statistics 21.0 program for Windows and described using frequencies, percentages, means, and standard deviations. Comparisons of groups were made using a one-way analysis of variance or the independent samples t-test. Appropriate sample sizes were calculated with a power analysis (Halme et al., 2014). Statistical significance was set with a p-value of  $<0.05$ . The internal consistency assessed by Cronbach's alpha, ranged between 0.70 and 0.90 (Nunnally & Bernstein, 1994) (Table 1 in Original article II).

Multiple linear regression (MLR) was used to estimate the associations between the support of parental empowerment, cooperative working practices, and empowering management (Table 4 in Original article II). All the predictive variables used in the MLR were continuous. The assumption of no multicollinearity was verified before performing the MLR. Variables were entered into the MLR if the results from the previous phase (Table 3 in Original article II) indicated that there were statistically significant associations between the variable in question and parental empowerment support.

## **4.3 QUALITATIVE STUDY**

### **4.3.1 Data collection**

**Supporting the parental empowerment of LGBTQ parents in maternal and child health care (Sub-study III, Original articles III & IV)**

The data were collected between July 2016 and September 2016. Information about the study was obtained from the Internet and two nongovernmental organizations (NGOs), namely SETA and Rainbow Families. SETA is a national human rights NGO for Lesbian, Gay, Bisexual, Transgender, Queer, Lsexual (LGBTI) rights in Finland. It seeks a society of equality and individual welfare that includes everyone regardless of sexual orientation, gender identity, or gender expression. Rainbow Families, is an association for LGBTQ parents and their children in Finland and a member of SETA.

The inclusion criteria were as follows: 1) the parents self-identified as LGBTQ; 2) the parents were at least 18 years of age; 3) the respondents were biological or nonbiological parents; and 4) they had used Finnish maternity or child health care services during the 2000s. Participation was voluntary and confirmed by email. The parents expressed interest in participating in the study by responding to the promotional material, after which they received specific information about the study in a return email. In total, 22 self-identified LGBTQ parents participated in the study (Table 1 in Original article IV).

All the interviews were audio recorded. They lasted between 40 and 90 minutes, an average of 60 minutes. The interviews were arranged at a time convenient to the participants and were conducted either by telephone (n = 14) or during a meeting (n = 8). Open interviews were selected to obtain knowledge of the participants' personal thoughts about parental empowerment and related supportive factors in Finnish maternity and child health services. The goal of gaining a deeper understanding of parental empowerment was highlighted.

The interviews started with the questions "If I say 'parental empowerment', what comes to mind?", "How would you describe that?", and "I would like to hear how you would describe the supporting factors of parental

empowerment in maternal and child health services. What would those factors be?" The natural conversation flow was expanded by asking more specific questions and encouraging reflection on statements relevant to the study. Examples of situations such as positive and negative aspects of nursing care were explored, while clarification and further elaboration were obtained. During each interview, the author made hand-written notes that were later transcribed. To ensure the validity of the data, the researcher allowed the interviewees to freely express their ideas. Background questions relating to the parents' living and family constellation, and previous experiences with healthcare services, especially maternity and child health services, were also discussed.

#### **4.3.2 Data analysis**

The 181 pages of data were analyzed using inductive content analysis (Graneheim & Lundman, 2004; Elo & Kyngäs, 2008). This was chosen due to the paucity of previous studies and the lack of appropriate knowledge about LGBTQ parents' empowerment (Burns & Grove, 2009; Elo & Kyngäs, 2008). All audiotapes and hand-written notes were transcribed verbatim. All interviews were included in the analysis. By the 17th interview, no new themes emerged. At that point, five more interviewees were selected to ensure the saturation of the data.

First, units of meaning, for example, a word, sentence, or whole paragraph with the same meaning, were identified. Then, these units were condensed into a description of their content. Next, all the data were read in detail. Subsequently, the condensing units of meaning were analyzed and organized into categories using similarities and differences. The main theme, as an expression of the latent content of the text, was understood to be a common core running through all the categories (Table 1 in Original article III, Table 2 in Original article IV).

The author of this thesis was responsible for the analysis and the findings were discussed until a consensus was reached (Elo et al., 2014). Eventually, three categories (Figure 1 in Original article III) were formulated to describe LGBTQ parents' experiences of empowerment in maternal and child health care, and four categories (Figure 1 in Original article IV) were formulated

to describe the factors supporting empowerment (Elo & Kyngäs, 2008; Graneheim & Lundman, 2004; Vaismoradi et al., 2016).

## **5 RESULTS**

### **5.1 SUPPORTING PARENTAL EMPOWERMENT IN CHILD AND FAMILY SERVICES**

#### **5.1.1 Participants**

Supporting parental empowerment in substance abuse services (Sub-study I, Original article I)

A total of 132 participants completed the survey, with a response rate of 36%. Among these, 76% worked as an immediate superior, and 77% were female. The participants were aged 25–68 years, and their average age was 48.55 years ( $SD = 9.15$ ). The duration of experience in their current work positions was in the range of two months and 35 years ( $SD = 8.53$  years). A little more than a third of participants (38%) had completed a higher university degree. Furthermore, 40% worked in different types of outpatient substance abuse clinics, and 21% worked as immediate superiors at the A-Clinic Foundation. Moreover, 15% of the participants worked in family units, such as the institutions of the Federation of Mother and Child Homes and Shelters, child welfare and social services, and treatment units for adolescents. Both urban and rural areas were included. Little over half (56%) of the participants worked in municipalities with more than 15,000 inhabitants. Most services and units were open during office hours. Almost half (47%) of responding units were open 24 hours a day. The special units for children and young people provide psychosocial services during regular office hours (Table 1 in Original article I).

**Cooperative working practices, empowerment in management, and parental empowerment (Sub-study II, Original article II)**

A total of 457 employees responded; among these, 93% were female. The participants were aged 26–63 years, and their average age was 48 years ( $SD = 8.37$ ). The duration of experience in their current work positions was in the

range of 0.8–40 years (SD = 9.41 years). Little over half, 52% had completed a lower university level. A little more than a third of participants (37%) worked as an immediate superior. Managers were examined as part of the group of employees because they are responsible for the daily management of line employees who offer the services and most employees interact with them daily. Half of all participants were older than 50 years and had more than 14 years of work experience in their current position. Half of the participants (50%) worked in health care settings at prenatal and child health care clinics or school health care, and a half (50%) worked in social and educational settings in daycare, preschools, and primary schools, or as social workers. In addition, 71% of the participants worked in municipalities with fewer than 15,000 inhabitants (Table 2 in Original article II).

### **5.1.2 Supporting parental empowerment in substance abuse services (Sub- study I, Original article I)**

**Supporting parental empowerment within the family, service situation, and service system**

*Within the family*, 79% of the employees supported parental empowerment by encouraging them to seek help if and when they needed it and 77% thought they were able to help parents gain control over their family life. Among the employees, 57% felt they ensure that parents understand their child's challenges and special needs. Moreover, 9 % totally or partially disagree that employees assisted parents in trusting their abilities to help their child grow and develop (Table 2 in Original article I).

Parental empowerment was better supported in the special units for children and young people ( $F = 0.44$ ,  $df = 115$ ,  $p = 0.07$ ) and in the clinics that were open for adults 24 hours a day ( $n = 117$ ,  $F = 1.021$ ,  $df = 115$ ,  $p = 0.07$ ). Employees in those units could better help parents gain control over their family life ( $p = 0.047$ ). Statistically significant associations were not found between parental empowerment and the employees' age, gender, duration of work experience, workplace location, or population size in the municipality. Parental empowerment was supported rather well within the family and service situations (SD 0.83–0.98) and moderately within the service system.

*Within the service situation*, 68% of the employees supported parental empowerment by encouraging the parents to maintain regular contact with the professionals providing services to their family, and 68% did so by supporting parents to find services for their children and family. However, 10% of employees felt that the employees in their clinics did not consider the parents' opinions regarding the services they felt their child needed, and 18% thought the employees did not ensure that parents approved of all the services provided to their child. Furthermore, 17% of the employees thought that parents' and professionals' opinions were not equally important when deciding on matters that concerned children (Table 3 in Original article I).

Parental empowerment was better supported in the special units for children and young people ( $F = 0.15$ ,  $df = 109$ ,  $p = 0.005$ ). Employees in those units were better able to take into account the parents' opinions regarding the services they felt their child needed ( $p = 0.002$ ) and thought that their clinic perceived the parents' and professionals' opinions as equally important when deciding on matters that concern children ( $p = 0.009$ ) more than the other studied units.

Those working in managerial positions had a more positive view of parental support compared to others ( $p = 0.023$ ). These differences were statistically significant. The support of parental empowerment was estimated as better in the clinics that were open for adults 24 hours a day, but no statistical significance was found. Furthermore, there were no statistically significant associations between parental empowerment and employees' age, gender, duration of work experience, workplace location, or the population size in the municipality.

*Within the service system*, 55% of the employees said they encourage parents to interact and support each other, while 48% urged parents to maintain contact with the authorities and decision-makers and to voice their opinions on developing services for children. However, only 30% of the employees ensured that parents understood how the service system for children worked, and 24% thought that they did not make good use of parents' skills and abilities during the development of services in their municipality (Table 4 in Original article I).

Employees working at the institutions of the Federation of Mother and Child Homes and Shelters verified that parents knew their rights, as well as their children's rights, better than employees in other units ( $p = 0.004$ ). Furthermore, their ability to inform the parents about methods that can be used to influence decision-makers and authorities ( $p = 0.054$ ), as well as to encourage parents to interact and support each other, exceeded that of employees in other studied units ( $p = 0.085$ ). Differences between units were statistically significant. There were no statistically significant associations between parental empowerment and the provision of services, workplace location, or population size in the municipality. Furthermore, the employees' age, gender, education, or duration of experience in their current work did not affect the support of parental empowerment.

### **5.1.3 Cooperative working practices and support of parental empowerment (Sub-study II, Original article II)**

**Supporting parental empowerment within family, service situation and service system in health care, social welfare, and education services**

The average score of supporting parental empowerment was 3.4–4.2 ( $SD = 0.6$ – $0.7$ ). Parental empowerment was supported better within families than within the service system. Moreover, support was highest in health care and lowest in social welfare and education services. Employees who were older, less well educated, and not working in a managerial position thought that they supported parental empowerment slightly better than other respondents (Table 2 in Original article II).

*Within the family*, parental empowerment was supported rather well in all units. Parents were encouraged to trust in their abilities to help their child grow and develop and to request assistance when it was needed. Moreover, they were informed about how to proceed if problems related to their child emerged. Support for parental empowerment was significantly associated with the employees' educational level ( $p = 0.021$ ) and working in a managerial position ( $p = 0.003$ ). Those who had completed a lower level of education and did not work in a managerial position were better able to support parental empowerment. No statistically significant associations were found

between parental empowerment and the employees' age, duration of work experience, workplace location, or the population size in the municipality (Table 2 in Original article II).

*Within the service situation*, parental empowerment was supported by improving parents' knowledge and understanding related to their child's services. Moreover, improving parents' ability to collaborate with professionals and participate in decision-making. However, only 19% had asked parents about the kinds of services they required for their child. One-third (30%) of the employees reported that the opinions of parents and professionals were equally important when deciding on matters concerning children, and only 17% had told parents how to proceed if they felt they had received poor service. In the service situation subscale, support for parental empowerment was significantly associated with the participants not working in a managerial position ( $p = 0.003$ ). Supporting parental empowerment was best achieved in maternity and child health clinics, but rarely achieved in primary education. No statistically significant associations were found between parental empowerment and employees' age, education, duration of work experience, workplace location, or the population size in the municipality (Table 2 in Original article II).

*Within the service system*, the support of parental empowerment was estimated to be less effective than support within the family or within services. Shortcomings were found in particular in the employees' ability to ensure the parents' understanding of the functioning of the service system and to utilize the parents' skills and knowledge in the development of services. About a third (26 %) of employees did not tell parents what legislative and other reforms were underway to develop family services for children. In contrast, 65% encouraged parents to interact and support each other. Only 5% of employees agreed that parents' ideas were used in developing services for children, or that parents understood how the service system works for children. The support for parental empowerment was significantly associated with the participant's education ( $p = 0.009$ ), age ( $p = 0.014$ ), and not working in a managerial position ( $p = 0.004$ ). Employees who were older, less well educated, and not employed in managerial positions were able to better support parental empowerment. No statistically significant associations were

found between parental empowerment and the duration of work experience, workplace location, or the population size in the municipality (Table 2 in Original article II).

## **Cooperative working practices and parental empowerment**

Results showed that well agreed cooperative working practices within services and between different sectors and municipalities and with third- and private-sector actors seem to increase the employees' ability to support parental empowerment.

*Regarding awareness of services*, 83% of the employees were aware of special education services, 79% were aware of family counseling services, and 76% were aware of child protection services, while they were least aware of services provided by the third sector. Most of the participants were unfamiliar with financial support and disability allowance. With 91%, school health care services demonstrated the best functionality of cooperation with other services. Cooperation with psychiatric and mental health care services was poor, suggesting that employees' perceptions of this were a critical issue. Employees' enhanced awareness of services was statistically significant and associated with the support of parental empowerment within the family ( $p = 0.001$ ), the service situation ( $p = 0.001$ ), and service system ( $p < 0.001$ ).

*Functionality of cooperation* with health services, as well as with social and educational services, was estimated as rather good. It was found that 53% of employees most often cooperated with a child health clinic nurse and 52% with a school nurse. Most often, cooperation with other health services was in maternity clinics, child health clinics, and school health care ( $F [342, 6] = 103, 26, p < 0.001$ ). The least cooperation was with home nursing services, with 82% of respondents reporting almost no cooperation. Cooperation with psychiatric and mental health services, substance abuse services, disability services, third sector actors, or with the police was also relatively rare. Good functionality of cooperation was statistically significant and associated with support of parental empowerment within family ( $p = 0.006$ ), the service situation ( $p = 0.002$ – $0.006$ ), and service system ( $p = 0.005$ – $0.010$ ).

*Shared cooperation practices* were better implemented within sectors than between sectors. Among the respondents, 78% fully or partially agreed that common goals for services for families with children had been agreed within the industry, and 48% fully or partially agreed that common goals had been agreed with families with children. However, less than 5% of the respondents had used concurrent working practices with the third sector or private sector or engaged in any cooperation between municipalities. In preschool education, common goals were most often agreed in writing with other actors ( $F [408.6] = 5.25, p < 0.001$ ). The population size of the municipality was not related to commitment to common goals. Shared cooperation practices such as agreement on shared goals were statistically significant and associated with support of parental empowerment within the service situation ( $p = 0.010$ ) and within service system ( $p = 0.002$ ).

*Joint practices* were also better implemented within sectors than between sectors and implemented worst with private and third sector actors, with 79% of respondents fully or partially agreeing that common policy had been agreed within sectors, and 45% fully or partially agreeing that common policies had also been agreed with families with children. In daycare, common operating practices between the site and other actors were most often agreed upon in writing ( $F [391, 1] = 2.91, p = 0.009$ ). Joint practices were statistically significant and associated with support of parental empowerment within the service situation ( $p = 0.015$ ) and within service system ( $p = 0.017$ ).

Regarding *commitment to common goals*, 86% of respondents fully or partially agreed that there was a commitment to common goals within the sectors. Moreover, 53% of employees estimated that there was a full or partial agreement with the commitment to common goals with families with children. Within the sectors, 43% of the employees agreed that cooperation practices included written common goals, 45% agreed that they included concurrent working practices, and 46% were committed to common goals. Between sectors, only 16% had common goals in writing, and 14% had concurrent working practices. The workplace location and the population size of the municipality were not related to commitment to common goals. Commitment to common goals was statistically significant and associated

with support of parental empowerment within the family ( $p = 0.025$ ), the service situation ( $p = 0.002$ ) and within service system ( $p < 0.001$ ).

*Agreement on monitoring and evaluation* was estimated as rather good. Within the sector, 69% of employees fully or partially agreed with the written joint monitoring and evaluation of activities and 36% of employees fully or partially agreed with the written monitoring and evaluation of activities with families with children. Daycare workers ( $F [391, 6] = 3.57, p = 0.002$ ) and supervisors ( $F [391, 1] = 5.96, p = 0.015$ ) were more likely to agree on joint monitoring of activities and evaluation with different actors. No association was found between agreement on monitoring and the evaluation and support of parental empowerment.

### **Empowerment in management and parental empowerment**

The average score of empowerments in management was between 3.5 and 4.0 ( $SD = 0.6\text{--}0.9$ ), meaning that employees agree that they had the opportunity to make decisions at work and that they were supported and treated fairly by their supervisors. The *opportunities to make decisions at work* were quite good, with 55% of the employees believing that they had reasonable opportunities to make decisions about their work. Moreover, 52% thought there were, good opportunities to influence decisions about their work activities. Nevertheless, 24% of employees had no opportunities to participate in the supervision of work, 19% thought that opportunities to participate in job rotations were poor, and 17% felt that they had little influence on their work tasks. Opportunities to make decisions at work seem to be slightly better in rural areas ( $F [429, 3] = 2.91, p = 0.034$ ) and are clearly better in preschool and primary education ( $F [431, 6] = 4.12, p < 0.001$ ). Those working in frontline managerial positions felt that they could better influence their work ( $t [430] = 2.22, p = 0.027$ ).

Employees were asked about their ability to receive support and feedback from their supervisor for their work, to develop themselves, and to influence the operations of their site, and asked for their opinions on the management of the site, and the fairness of treatment. The majority of respondents considered that they had at least satisfactory opportunities to receive

*support from their supervisor* as well as to develop in their work. The best opportunities for employees were to act according to professional principles; 91% of respondents thought that their chances in this regard were excellent or good. There were the fewest opportunities for job counseling and job rotation, for which 32% had excellent or good opportunities. Supervisors had better opportunities than other employees to receive support and to develop in their work ( $F [418, 1] = 56.55, p < 0.001$ ). Employees in daycare centers had significantly better opportunities to receive support and to develop at work than those in other workplaces ( $F [414, 6] = 6.18, p < 0.001$ ). The population size of the municipality was not related to development opportunities and support from the supervisor.

Furthermore, 83% of the employees felt that the supervisor treated their subordinates kindly and fairly and that the supervisor respected the employee's rights. About one-fifth (27%) felt that the supervisor did not communicate the decisions and their effects on time. Management fairness was achieved slightly more often in primary education ( $F [433, 6] = 3.27, p < 0.001$ ) than in other workplaces.

In all the subscales, parental empowerment was supported most by those who reported that their managers respected their rights and treated them fairly (Table 3 in Original article II). The support of parental empowerment was statistically significant and associated with the fairness of treatment ( $p = 0.031-0.001$ ). No association was found between the support of parental empowerment and employees' opportunities to make decisions at work or receive supervisory support (Table 3 in Original article II).

## **Predictors of supporting the empowerment of parents**

Based on regression analyses, statistically significant factors were employees' awareness of family services ( $p = < 0.001-0.001$ ), commitment to common goals ( $p = < 0.001-0.025$ ), and fairness of treatment ( $p = 0.001-0.031$ ). These variables explained 9%, 11%, and 11% of the variance in the support of parental empowerment, respectively (Table 4 in Original article II).

## **5.2 EMPOWERING LGBTQ PARENTS IN MATERNITY AND CHILD HEALTH CARE SETTINGS**

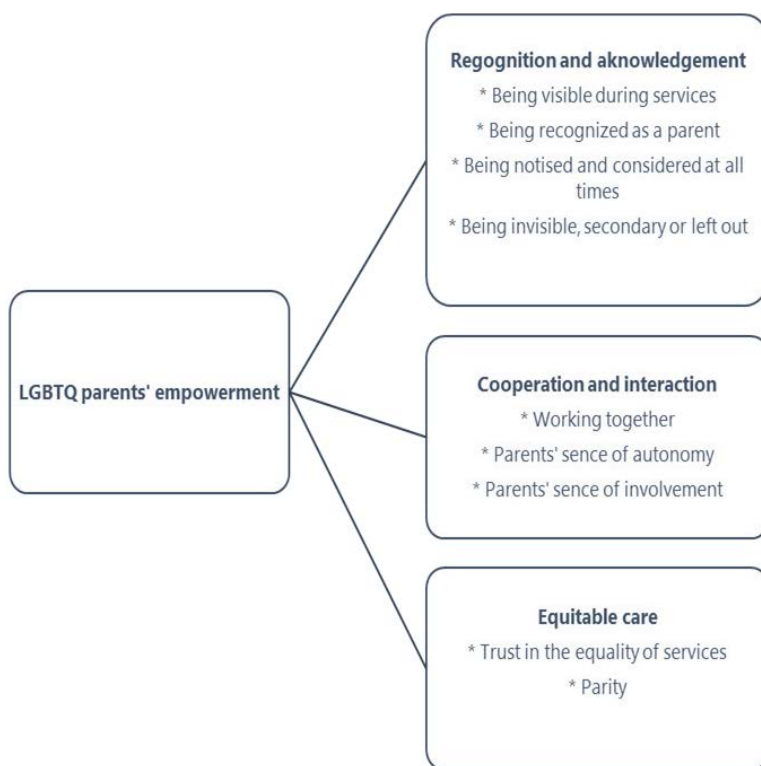
### **5.2.1 Participants**

Supporting LGBTQ parents' empowerment in maternity and child health care (Sub-study III, Original articles III and IV)

In total, 22 parents participated in this part of the study. One parent identified as bisexual, one as transgender, and two as non-binary. Eleven were non-biological parents, and three had had a biological child of their own and were also social parents to their partner's children. Two were not the guardians of their children. Individuals who had become parents once or several times were included. The participants were not questioned regarding demographic details, such as work, education, or age. The children's ages ranged from 0 to 16 years; the average age was 5 years. The participants' maternity and child health care experiences had occurred between one month and 10 years prior to the study. The parents lived in several different areas of Finland. All the participants were from Nordic countries and spoke Finnish, while some had an immigrant background (Table 1 in Original article IV).

### **5.2.2 LGBTQ parents' empowerment in maternal and child health care (Sub-study III, Original article III)**

The LGBTQ parents described their empowerment in maternity and child health care as 1) recognition and acknowledgment, particularly in the context of being treated as a parent irrespective of biological or legal ties to their child; 2) cooperation and interaction, such as working together, respecting parents' autonomy, and supporting parents' full involvement; and 3) equitable care, such as parents' trust in services, but also health care professionals' knowledge of the family's unique needs (Figure 2).



**Figure 2.** LGBTQ parents' empowerment in maternal and child health care

## Recognition and acknowledgment

According to participants, *being visible* in services meant having the ability to define themselves, their parenting roles, and their family constellation in the service situation and also informs and medical records. All parents needed to be *recognized as a parent* whether the parent had a biological or legal bond with the child or not. Furthermore, the participants perceived it as essential that their family and different parenting roles were seen and acknowledged as they are from the very beginning of service use. Non-biological parents usually reported that they worried that professionals did not see them as real parents or that they are not given an equal role in their children's services. *The sense of being noticed and considered at all times* included parents' sense

of belonging to the client group, as well as being acknowledged in both actual practice and communications.

Empowerment was also described by its absence. *Being invisible, secondary, or left out* included a lack of recognition of their legal status as parents. Due to a lack of recognition of the parents' gender identity, parental role, the parents felt left with a feeling of "not fitting the regular mold." Almost all the routines were based on and planned around heterosexual couples or families with two parents. This viewpoint was communicated in forms, brochures, and medical records, that provided only normative options for families, parents, and genders. For example, questionnaires were designed in a way that they only recognized the pregnant person as the "mother." The participants also reported that non-biological parents were not included in the reception discussions. In addition, the participants noted that toilets were only designated for either men or women, and reception rooms were typically furnished to accommodate two parents and the professionals.

## Cooperation and interaction

Empowerment included *working together with* professionals to gain knowledge, help, support, and cooperation. Individual information was perceived as essential. Professionals needed to recognize and consider parents' opinions and multiple needs. Elements such as showing an interest in the parents, active listening were mentioned as ways for professionals to optimize the participation of parents.

*Parents' sense of autonomy* referred to parents' opportunities to make decisions and to give feedback while having the ability to influence the service situation. Parents required professionals to trust their expertise concerning their lives while accepting their experience-based knowledge and valuing their feelings and opinions regarding their children's care. Parents' involvement included rights and responsibilities, and the willingness to participate. Filling out forms and expecting to receive the same information and support as biological parents were considered as one of these rights. It was also their responsibility as parents to be present in the services.

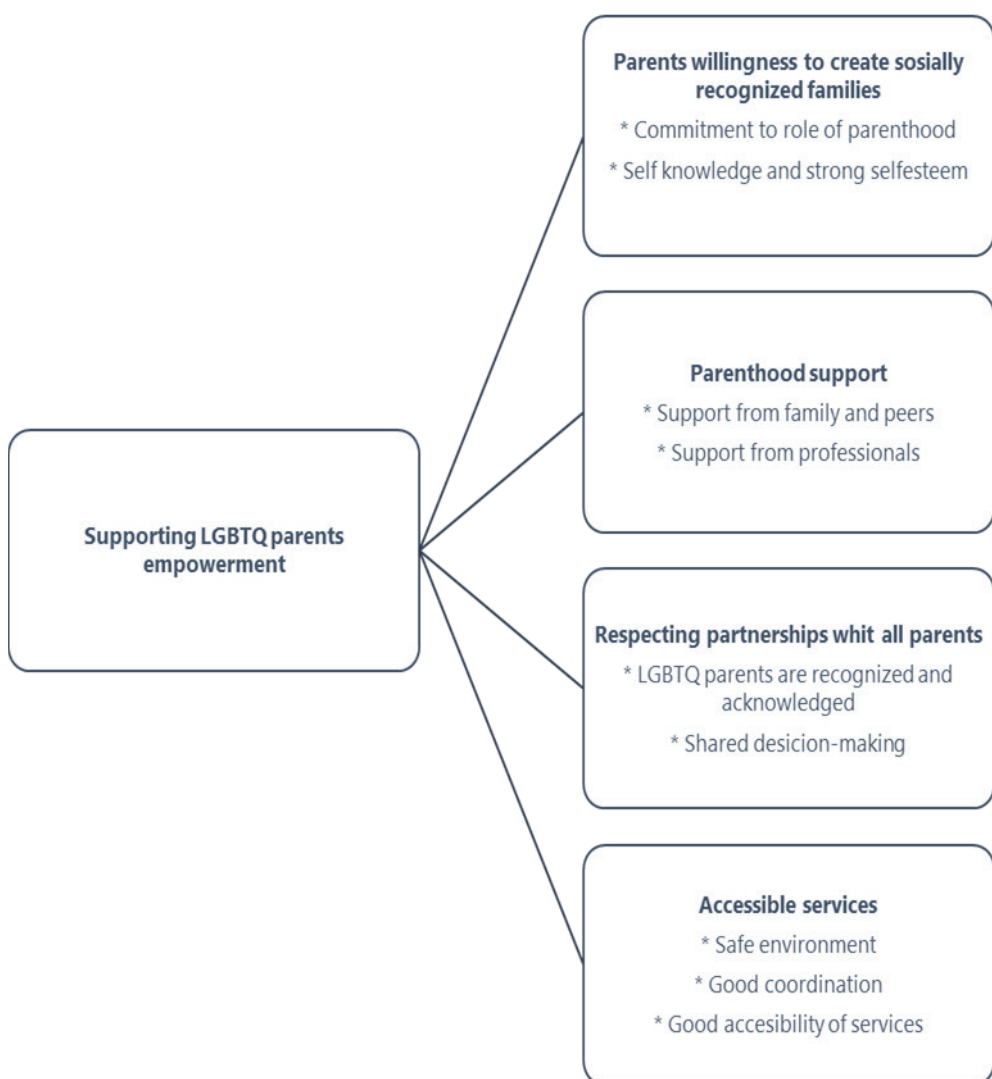
## Equitable care

*Trust in the quality of services* such as a sense of security, good quality of care, and sufficient access to health care were considered essential parts of empowerment. A safe environment provided parents with a sense of security, with an opportunity to talk openly about life. The professionalism of the staff guaranteed the quality of care. It was essential that the entire family was taking care of. The participants described how they repeatedly have to explain themselves, their families, and family situation to professionals, and how they end up educating professionals even though they highlighted that they did not want that. Parents wanted to be “in good hands.” The participants described situations in which they had received inadequate treatment, which was typically related to insufficient language or assumptions about the gender identity of clients. Moreover, employees had shortcomings in their skills in legislation on assisted reproduction in Finland and abroad.

Access to services was important, especially in the case of any health concerns. *Parity* included receiving the same services as other families. Moreover, it was being respected and accepted in those services. Participants described that they had contradictory expectations and worries about being discriminated against because of their sexual identity and family situation. They had heard a different kinds of stories from their peers and friends about heteronormative values and attitudes and even discrimination in family services and parent education classes. Parents wanted to be sure that their family form or sexual orientation did not affect the care or treatment they received during either appointments or group meetings.

### **5.2.3 Support of parental empowerment and related factors (Sub-study III, Original article IV)**

The factors supporting LGBTQ parents’ empowerment were identified as: 1) the parents’ willingness to create socially recognized families; 2) parenthood support; 3) respectful partnerships with all parents; and 4) accessible services (Figure 3).



**Figure 3.** Factors supporting LGBTQ parents' empowerment in maternity and child health care

## Parents' willingness to create socially recognized families

*Commitment to the role of parenthood.* The decision to build a socially recognized family was important for all participants. The desire for a family and the desire to become a parent existed even though they understood that there was prejudice and discriminatory attitudes toward their sexual orientation, relationships, or family configuration. In addition, participants mentioned that they were aware and that they had to raise their children in the absence of specific laws that protect same-sex couples and families.

Becoming and being a parent required good *self-knowledge and strong self-esteem*. The parents highlighted that they were aware of the sociocultural reality of LGBTQ people and their shared history, as well as how these factors affect their lives as a parent and as a family. The participants also mentioned having a clear and open identity as a minority was empowering. They felt empowered when a health care provider was open and respected their family and all parenting roles. In some cases, however, they had to demand to be treated as LGBTQ parents.

## Parenthood support

*Support from family and peers* was important and particularly necessary when planning a family. Good co-parenting, such as shared responsibilities at home, shared financial support, and mutual respect, and good communication between parents, was essential. Parents mentioned that it was empowering when they could relay and trust their spouse as a parent. Parents needed to be able to discuss, with both each other and professionals, their concerns about sharing the parenting workload and receiving the necessary financial support, parental leave arrangements, and benefits for LGBTQ families with children.

Due to a lack of support from the family of origin, chosen family, consisting of friends and peers were an essential part of these parents' lives. Support from peers referred to a sense of connection to a broader LGBTQ community, and most of these participants were actively involved in an LGBTQ organization. Participants mentioned that LGBTQ parents are not always supported by their

relatives and that friends may be more important to the parents. Professionals needed to be aware of NGOs that provided support for LGBTQ parents and that they encourage parents to participate in those organizations.

*Support from professionals* was informational, emotional, and practical. Information, practical advices, and discussions were needed about changes in sexual relationships, pregnancy problems, stress, and postnatal depression as well as the parents' work life and financial situation of the family. Individual and understandable information was considered empowering. Parents good awareness of the family services and peer support groups was essential when they needed special care or when the family used several different services. Emotional support was needed especially during the pregnancy when feelings of attachment to the unborn infant were developing. It was mentioned that professionals need to recognize and support a couple's formation of a sense of parental identity and their new roles as parents. The parents appreciated it when professionals showed genuine interest in their well-being and listened to their concerns. Conversely, they felt unsupported if the professionals did not take their concerns seriously. Participants indicated that professionals lacked knowledge about infertility and miscarriages, presenting a challenge when having to deal with the related emotions.

Parents value practical advice and the assessment by a professional concerning their infant's growth and development and receiving confirmation that their child is growing and developing normally. Furthermore, the participants reported having needed advice concerning family leave and intra-family adoption counseling. When supporting parents' empowerment, it was necessary to focus on strengths by providing them with adequate feedback regarding their parenting approach. The parents in this study wanted to gain confidence in their parenting abilities and expected professionals to confirm that they were doing well. The parents reported that they needed to hear that they are a good family and that they were coping well as parents.

## **Respectful partnerships with all parents**

*Recognizing and acknowledging all parents* included accepting the parents' self-identification of their parenting roles as well as their gender which was

important with respect to medical records and forms. Empowering health care experiences emerged when all parents were recognized correctly regardless of legal or biological ties to their child. In addition, when professionals avoided using language, which assumed heterosexuality. The parents appreciated it when the professional listened to them and used the language used by the family with them, as well as when they referenced the parenting terms used by the parents when addressing them.

*Shared decision-making* denoted the parents' opportunities to represent their child. In addition, it was important for parents to be able to choose how they participate in decision-making. Empowerment was supported when the professionals supported all parents to participate in the decision-making process but also provided an opportunity to withdraw from it.

### **Accessible services**

*A safe environment* involved parents' sense of dignity and a sense of security. In this context, parental empowerment was supported when parents felt relaxed, confident, and comfortable. It was essential that they were accepted as themselves. Dignity was part of the sense of security. The integrity of the body and respect for personal boundaries, for example, in gynecological examinations and breastfeeding guidance was considered important. Furthermore, creating a safe environment required a respectful attitude by the professionals as well as the use of positive space and other inclusive signage.

*Good coordination* was also perceived as part of empowerment. That included aspects such as sharing information between professionals and services, the continuity of care, and the clarity of follow-up treatments. The sharing of information between professionals and services included an adequate exchange of electronic information and a flow of information between professionals. Parental empowerment was supported when all information about them was included in electronic records and that all those involved in have access to them. The participants mentioned that by pre-reading their files, the professionals saved them from continuously having to provide the same information about their family constellation, circumstances,

and needs to the different nurses responsible for their care. This also allowed them to avoid having to encounter the professionals' reactions and face their possible negative assumptions. Moreover, it was essential that continuity of care was ensured and that parents had sufficient information about follow-up treatments. This was seen as important for the functioning of families' daily life.

*Good accessibility of services* meant local services. Good transportation and short waiting times and same-day appointment times were considered important. Adequate resources, including having a few changes in the professionals responsible for the family's care as possible as this resulted in the parents being able to trust the professionals. Moreover, sufficient time reserved for the families was preferred. Staff exchanges made it difficult to get to know each other and build trust. It was easier to ask for help from a familiar caregiver.

### **5.3 SUMMARY OF THE RESULTS**

According to the employees in substance abuse services, parental empowerment was enhanced within the family and least supported within the service system. Parental empowerment was better supported in special units for children and young people and in the clinics that were open for adults 24 hours a day. Those working in managerial positions had a more positive view of parental support than those who did not. However, older and less well-educated employees thought that they supported parental empowerment better than younger and more highly educated employees. No statistically significant associations were found between the support of parental empowerment and the employees' age, gender, duration of work experience, workplace location, or the population size in the municipality of residence.

Parental empowerment was supported quite well in all child and family services. It was supported better within all studied levels. Within the service system, most of the support was provided by those working in health care, while the least support was evident in the educational services. Based on

the multiple linear regression (MLR), statistically significant factors included employee awareness of family services, commitment to common goals, and fairness of treatment. These variables explained 9%, 11%, and 11% of the variance in the support of parental empowerment, respectively. Furthermore, within the service situation and service system, the support of parental empowerment was statistically significant and associated with improved shared cooperation practices such as better agreement on shared goals, as well as joint practices and good commitment to common goals.

LGBTQ parents described their empowerment in maternity and child health care as 1) recognition and acknowledgment, particularly in the context of being treated as a parent irrespective of biological or legal ties to their child, 2) cooperation and interaction, such as working together, respecting parents' autonomy, and supporting parents' full involvement, and 3) equitable care, such as parents' trust in services, but also the health care professionals' knowledge of the family's unique needs.

The key elements supporting LGBTQ parent's parental empowerment were identified as 1) parents' willingness to create socially recognized families, 2) parenthood support, 3) a respectful relationship with all parents, and 4) accessible services. Empowerment was supported when all parents were recognized with respect to communication, forms, and medical records. Other aspects promoting empowerment included individual information and opportunities to make decisions and choose when and how the parents could participate in decision-making.

## **6 DISCUSSION**

### **6.1 DISCUSSION OF THE RESULTS**

The purpose of this study was to examine how parental empowerment was supported by Finnish child and family services. It was also examined how professionals empower parents in family and substance abuse services. In addition, the study explored how LGBTQ parents described parental empowerment in maternity and child health care services and the various factors involved in supporting parental empowerment.

The main results revealed new knowledge about the association between the support of parental empowerment and collaborative working practices in child and family services by indicating that enhanced awareness of services and improved collaboration between professionals may provide employees with better ability to support parental empowerment. Furthermore, employees who feel empowered are better equipped to empower others.

Moreover, the study findings present LGBTQ parents' views of their experiences of empowerment in using these services. According to the LGBTQ parents participating in this study, parental empowerment in child and family services is particularly concerned with visibility. It consists of being seen and treated as parents regardless of whether the person has legal or biological ties to their child. The factors supporting LGBTQ parents' empowerment included the professionals taking them into account in all practices with respect to gender-neutral communication, forms, and procedures. Good quality of care, such as equality and safety, were highlighted. The parents appreciated having access to the same services as any other parents while their needs as LGBTQ individuals were considered.

### **6.1.1 Supporting parental empowerment in child and family services (Sub- studies I and II)**

#### **Support of parental empowerment within family**

According to the findings of this study, parental empowerment was rather well supported in substance abuse services, as well as in all child and family services. The support received in the health care sector was assessed to be better than that provided in education services, social welfare as well as in larger municipalities. Further, support received in the health, social and education services was assessed to be better than that provided in substance abuse services. Supporting parental empowerment was best achieved in maternity and child health clinics and the Federation of Mother and Child Homes and Shelters but rarely in primary education. Moreover, service units' 24-hour accessibility was associated with better support of empowerment.

The results of the present study show that in all the studied units, employees believed that they were better able to support parents' empowerment within the family than within the service system. Support of parents was quite similar in all units. However, small differences could be found. First, employees in substance abuse services and child and family services had different views on the support of parental empowerment, especially within family. Second, employees' age was not associated with support of parental empowerment in substance abuse services as it was in health, social and education services, where older employees thought that they supported parental empowerment slightly better than other respondents.

In substance abuse services, the support of parents focused on "getting family life in order" and parental empowerment was supported by strengthening parents' control over their family life, whereas there was low support for a parent to support the child's growth and development. In child and family services, the situation was seen as almost the opposite, as parents were encouraged to trust their abilities to help their child grow and develop. This result could be explained by the purpose of these services. In substance abuse treatment, an attempt is made to see one's substance use from the child's point of view and to learn to live in everyday life so that children also feel well. The regularity of the rhythms of life and one's own life management

become the most important. Most often, help is needed in various everyday activities and the construction of everyday life. These results are important especially when families are using different services and the work is done together in multi-professional teams. Supporting families requires common goals and mutual understanding of the concept of empowerment.

### **Support of parental empowerment within service situation**

Within the service situation, employees' views were quite similar in all the studied units. In both substance abuse services and child and family services, parents were encouraged to be in contact with the service providers. They were also told how to proceed if they had received poor-quality care. Although employees felt that they were able to take parents' opinions into account, there were shortcomings concerning equality between parents and employees and informing parents about the services their child needs. These findings support previous research which has shown that employees' attitudes and working methods affect how encouraging parents to be involved in service meetings can be realized (Mäenpää & Åstedt-Kurki, 2008). It also shows that employees do not always want parents to cooperate or expect parents to be proactive partners instead of supporting and encouraging them to cooperate (Jacobsen & Severinsson, 2007; Mäenpää & Åstedt-Kurki, 2008).

Furthermore, the results of this study support earlier findings concerning the importance of access to information (Denboba et al., 2006; Fordham et al., 2012) by suggesting that employees who work with families can and should work with parents. They should share decision-making and encourage parents to influence over service. (Vuorenmaa, 2016.) Active and spontaneous participation in the child's affairs and decision-making requires resources and information from parents (Jackson et al., 2008; McKenna et al., 2010), which may be lacking, especially for less empowered parents. However, parents' empowerment in decision-making about their own family life can strengthen parenting (Koelen & Lindström, 2005) and promote the functioning of family life (Duncan et al., 2006; Wallerstein, 2006). Moreover, earlier studies indicate that supporting parents' in decision-making concerning their own or their child's life may strengthen their capacity to manage and improve their daily

life (Duncan et al., 2006; WHO, 2006) as well as encourage them to enhance their role in their own family (Halme et al., 2012; Koelen & Linström, 2005).

### **Support of parental empowerment within service system**

Support of parental empowerment was worst within the service system in all the studied units. Shortcomings were found in particular in the employees' ability to ensure the parents' understanding of the functioning of the service system and to utilize the parents' competence in developing services. According to previous studies, the parents themselves have assessed their involvement in the development of services as rather small (Perälä et al., 2011; Vuorenmaa et al., 2014). It has also been shown that the financial situation of the municipality and the views of the management are important in both decision-making and the planning and development of services and that the views of families are of little importance, especially in decision-making (Kanste et al., 2014).

Parents' involvement in the development of services should be made a natural part of service meetings so that all parents can genuinely participate in the evaluation and development of services. Feedback from parents on the functionality of the service should be collected and used more often and in different ways. Parents could also be invited to participate in various customer workgroups in connection with service meetings. Furthermore, good results have been obtained from groups consisting of residents and municipal employees working on the Internet (Virtanen et al., 2011), so such groups could also be developed in the service system for children and families as one of the channels of parental influence.

#### **6.1.2 Cooperative working practices and empowerment in management support parental empowerment in child and family services (Sub-study II)**

In Finland, the responsibility for providing family services lies with the municipalities. The services are provided by various branches of the municipality, as well as the private sector, parishes, and NGOs. All those services, multidisciplinary professionals are about supporting family empowerment

and well-being in various everyday situations. In this study, the sample was compiled from Finnish municipalities that provide maternal and child health care, school health care, daycare, and pre-and primary school services. According to this study, cooperative working practices and empowerment in management offer good conditions for parents' empowerment in all studied units. In this study, cooperative working practices were at a moderate level. Cooperative working practices were found most often within the service and less frequently between services or with the third or private sectors. Common practices need to be created more widely between different actors.

### **Employees' awareness of services**

In this study, the employees' awareness of services was quite good in all studied units. The results showed that the better employees rate their awareness of services, the more likely they were to be able to support parental empowerment within all studied levels. Employees were highly aware of family counseling, child protection services, and special education. This makes sense since these are services that are the most commonly used or needed by families in Finland. However, the employees' awareness was poor regarding various social services, such as services for people with disabilities or mental health issues.

Furthermore, the employees had less knowledge of the services provided by nonprofit organizations, and there was relatively little collaboration with them. However, parents were encouraged to meet each other regularly. This may be a result of differences in the roles of public and nonprofit organizations, as well as ongoing organizational changes of these services. The lack of knowledge in this area may also be related to the voluntary nature of nonprofit organizational activities. In Finland, NGOs play a significant role as providers of parenting and relationship services and as developers of new forms of services. Organizations work close to people's everyday lives, and with the partnership of organizations, it is possible to get activities closer and closer to people. The interaction and community provided by the organizations generate social capital, and the voice of the people who are otherwise poorly heard will be heard in the organizations.

These results are consistent with previous studies, which indicate that employees' better awareness of services may enhance families' abilities to applying for help (Halme et al., 2014; King & Meyer, 2006). In all studied units, parents were encouraged to interact and support each other as well as to contact service providers regularly. Knowledge and use of existing services and seeing peers can improve parents' sense of their ability to cope in their daily lives with their children. These results confirm the idea that family service professionals should be better aware of all the service options available for families, including those provided outside the public sector. This is critical, especially when working with families who use multiple services, as they are at greater risk of receiving fragmented or poor-quality care. (Institute of Public Health, 2011; Munro, 2011.)

### **Commitment to common goals**

In this study, there were more shared cooperation practices such as agreements and more common goals within services than between services. Cooperation with the third sector was almost non-existent. Within sectors, there may be more stable multidisciplinary teams, that meet regularly and work close together (Axelsson & Axelsson, 2006). It has been shown that membership in these well-structured teams, where the members usually have similar values, interests, and goals, prevent the intention to leave the job, reduce employee stress as well as increase job satisfaction (Buttigieg et al., 2011).

Collaboration across organizations or between municipalities was more difficult. This may be related to the existence of different administrative boundaries, different rules, laws, and regulations, as well as different budgets and financial streams, and differences in databases and information flow (van Raak et al., 1999, 2003). Moreover, there may be differences in organizational or professional cultures, values, and interests as well as differences in the commitment of the individuals and the organizations involved (Glendinning, 2003). Despite these obstacles, this study showed that commitments to common goals, written agreements on shared goals, and joint practices were all associated with better support of parental empowerment in service

situations and service systems. Based on these results those may enhance parents' outcomes of services. To collaborate effectively, professionals may benefit from training and should be mindful of common barriers to collaboration. This requires managers to take an active role. It is important that the manager supports collaboration across the organization and between municipalities, setting an inspiring culture of support and learning. (Alimo-Metcalf & Alban-Metcalf, 2001.)

These findings highlight the need for more education and cooperative working practices between services. The provision of services and access to services for families with children in the municipality would be clarified by jointly agreed goals, resources, clear responsibilities, operating methods, and a monitoring system that enables uniform practices and monitoring of activities in the service as a whole, not just individual services (Perälä et al., 2011, 2014). As the number of private service providers increases in the future, it is necessary to develop national monitoring and quality control. This ensures the evidence-based nature of operations regardless of the service provider.

### **Empowerment by managing**

Supervisory support seems to be essential in providing professional and high-quality health care. This study found that the more empowered employees felt, the more able they considered themselves to be in supporting parental empowerment. Such empowerment increases employees' own professional growth and development (Manley, 2004; Manley et al., 2011). The results are consistent with previous research that found it important for the managers to empower, encourage and motivate employees to successfully develop processes to improve the quality of care (Cummings et al., 2010).

In this study, employees not working as an immediate superior evaluated their ability to support parental empowerment better than those working as managers. It seems that working in a managerial position is very demanding. Although many supervisors also work with families' they have their duties and responsibilities as a supervisor and their evaluation may arrive from the strategic perspective whereas employees arrive at their evaluations from the

level of customer perspective (Atkinson et al., 2007). Therefore, to cope at work, it would be important to pay attention to the support of managers as well. This could be providing social support and treating people fairly.

Most of the respondents in this study assessed their relationships with managers as positive. Supervisory support was perceived as fair. According to employees, they have the opportunity to make decisions about their work and influence decisions about their work activities. Those views can be considered important as they affect the quality and efficiency of services provided to families (Axelsson & Axelsson, 2006; Halme et al., 2014; Perälä et al., 2011). In addition, the importance of the views is underlined by the fact that they can increase the meaning of work and increase the willingness of young people to seek employment in these municipal services in the future. This all is important, while employees are aging and competition for skillful personnel will be forceful (Halme et al., 2014).

In this survey, half of the respondents were over 50 years old. In all studied services older employees thought that they supported parental empowerment slightly better than other respondents. This may be because of the employees' level of autonomy and the strong commitment to their organization's values. Moreover, because of their experience and a better understanding of child and family well-being, policy, and practice. Employees are the most important resource in management and attention should be paid to their well-being and support. The result of this study indicated that employees received good support from managers. However, there is a need to provide emotional and educational support, especially for younger employees. This could support them in their professional growth, such as critical reflection and self-awareness (Young et al., 2011), and expand their understanding of their clients' complex needs.

Results showed that fairness of treatment seems to increase the employees' abilities to support parental empowerment. These findings support the idea that when working conditions support the employees' authority and when people are treated with respect, they can utilize their professional skills to the best of their ability and deliver high-quality care, resulting in better outcomes for families and employees (Aiken et al., 1994; 2002; 2011). Based on these results managers must be visible and available. That they encourage

and promote the informal and formal flow of information. Moreover, that they support employees' further education and facilitate the sharing of their learning.

### **6.1.3 Supporting LGBTQ parents' empowerment in Finnish child and family services (Sub-study III)**

#### **Visibility in the service system**

In this study, LGBTQ parents' definitions of empowerment represent the parents' willingness to create a family and commitment to parenthood, as well as the perception of their position in the service system. Parental empowerment in child and family services was defined as visibility in the services and also in terms of feeling invisible, secondary, or excluded. Parental empowerment appears to be a result of being recognized as a parent, having equal care in all relevant routines considered, and being able to exist as one's true self.

Participants in this study reported that being visible in services meant having the ability to define themselves, their parenting roles, and their family constellation in the service situation and also in forms and medical records. Recognition and acknowledgement were essential especially to non-biological parents who usually reported that they worried that professionals did not see them as real parents or that they are not given an equal role in their children's services.

It was mentioned that parents had more positive healthcare experiences when they had been open about their sexuality and their same-sex relationship. The disclosure was relevant to the care of the child and made a political statement and commitment. Participants found that honesty enabled the co-parent to be fully involved in the consultation and therefore reduced the stigma associated with LGBT relationships and parenting. This result is supported also in earlier studies (Andersen et al., 2017; McNair et al., 2008; Rawsthorne, 2009). As in previous studies, the challenges in recognition and acknowledgement were seen in non-inclusive documentation and the lack of representation of LGBT parents on healthcare forms (Malmquist & Nelson 2014). Administrative systems used in healthcare are inflexible and outdated

since they do not consider the variety of genders that exists in modern family structures (McNair et al., 2008; Chapman et al., 2012; Malmquist & Nelson 2014).

Although parents indicated general satisfaction with child and family services, fear of discrimination and experiences of feeling invisible were common. Participants mentioned their frustration that their type of family was not recognized in administrative systems and widely described the use of the words 'mother' and 'father' on healthcare forms, thereby demonstrating the prevalence of heteronormativity. Few participants felt they had experienced overt homophobia. Most of them had experienced discrimination in a sense and that they were asked excessive and invasive questions. As in previous studies, feelings of discrimination, previous negative experiences or fears of facing heteronormative values and attitudes affected parents willingness to be involved in the treatment of their child and underutilize certain services (Brennan et al., 2012; Olin et al., 2010; Scheel & Rieckmann, 1998; Shields et al., 2012; Singh, 1995). Several parents who participated in this study said they did not participate in the parent groups, and some of them did not participate in doctor appointments. Parents highlighted that participation in those meetings was considered difficult because of heteronormative structures, language used, or other parents' responses in group meetings. These results are important since it has been shown that counseling groups during pregnancy and other parent groups after having a child are promising forms of work that promote parental empowerment, parent-child interaction, and peer support, and reduce parental stress (Barlow et al., 2014; Barlow et al., 2016; Entsieh & Hallström, 2016; Liyama et al., 2018). Fathers' groups have also been found useful (Hakulinen et al., 2018). Traditionally, these groups give parents the opportunity to discuss their expectations and experiences with other families (VNA 338/2011; Klemetti & Hakulinen-Viitanen, 2013).

## **Commitment to parenthood**

The parents who participated in this study were proud of their identity as LGBTQ parents. They were also aware of their socio-cultural reality and the shared history of LGBTQ people, and how this affected their lives and

their capability to raise children. Becoming a parent was empowering, and commitment to a child and family was mentioned as one of the most important things in their life. A commitment was described as the presence in a child's life, as well as love and shared parenting, and mutual support between spouses, both in domestic work and financially. These factors were significant everyday resources for parents and supported their empowerment. These results support previous studies which suggest that parental empowerment is associated with improved parenting resources (Gallant et al., 2009; Øien et al., 2009) with functioning family life (Anderson & Minke, 2007; Ingberg & Most, 2012) and with stronger parental engagement in childcare (Faith et al., 2012; Franck et al., 2011). Parents in this study stated that confidence that parenting was built on commonalities, agreements, and commitments was empowering. Empowerment was supported when everyday work was shared with all parents. The results suggest that empowerment may support parents in coping with everyday challenges, such as time use and adequacy of resources.

The commitment to parenthood and family was strengthened by age, life experiences, and youthful experiences even when parents had faced discrimination or homophobia. It seems that with age, the challenges of gender or sexuality or encountering homophobia in adolescence have turned into a resource, such as strong self-confidence. This differs from previous studies, which show that negative experiences of youth, such as bullying at school, increase the risk of lower self-esteem and lower maternal empowerment (Vuorenmaa et al., 2016). There is also evidence that childhood difficulties increase the risk of lower self-confidence (Caldwell et al., 2011), depressive symptoms, and anxiety in adulthood (Copeland et al., 2013), which, in turn, are associated with lower parental empowerment (Martinez et al., 2009; Minnes et al., 2015). Commitment to parenthood can also be seen in previous studies (Aarnio, 2017; Baiocco et al., 2015; Biblarz & Stacey, 2010). According to Aarnio (2017), LGBTQ parents, especially lesbian mothers, and lesbian couples, seem to support and encourage their children more than other parents and, for example, help them more often in school matters. They also seem to talk more often with their child's friends. This high level of commitment can be explained by the fact that LGBTQ people are particularly

motivated to become parents (Mazrekaj et al., 2019). Having a child in a same-sex relationship or without a partner is planned and requires a lot of time. Similarly, this can be explained by the “compulsion to succeed” experienced by LGBTQ parents, namely the need to show outsiders the functionality of the family so that prejudices turn out to be wrong (Moring, 2013).

## **Supporting parenthood**

Parental empowerment was supported when more support from professionals and friends and peers were available in the immediate environment. The result of this study confirmed previous studies, and clearly emphasize the urgent need to improve the provision of individual information (Halme et al., 2014; Hook, 2006; Nachshen & Minnes, 2005). The result of this study also confirmed previous knowledge that the healthcare needs of families with LGBTQ parents, and the challenges they potentially face when accessing healthcare services for their children, may be different from those of heterosexual parents (Golombok, 2015; Mellish et al., 2013). And it seems that having individual knowledge and emotional support improves parental empowerment. Parents in this study respond favorably to encouraging and not judgmental providers who respected the diversity of families. They stated that it is important to have support in the early stage of parenthood. Support was needed especially concerning parenting roles, as ready-made models for parenting in LGBTQ families are still lacking. Emotional support was of particular importance to social parents. Their stories highlighted the different structures of parenthood during pregnancy and finding their role. These findings are significant. Previous studies (Cabrera et al., 2018) show, for example, that early interaction and good interaction between parents or with other adults protect the child from mental health problems. Identifying and supporting family resources (things that work) increases parents' sense of ability and reduces stress (Stewart-Brown & McMillan, 2011). This will also make it easier for parents to receive the help and other support they need. It is cost-effective to help the child and parents as early as possible, even before problems arise. If problems are only tackled after years of waiting,

the situation tends to escalate and worsen, receiving help becomes more difficult, and costs multiply (Sauni et al., 2014).

Similarly, as shown in previous studies, parents valued the support they receive from the maternal and child health settings, but they found the amount of support they receive insufficiently (Barnes et al., 2008; Börjesson et al., 2004; Eronen et al., 2007; Eronen et al., 2010; Fägerskiöld et al., 2003; Tammentie, 2009; Viljamaa, 2003; Warren, 2005). Sometimes, as mentioned in previous studies, parents were afraid to raise the need for support, as they felt a strong need to cope well with parenting (Ministry of Social Affairs and Health, 2004; Tammentie, 2009). Expertise on specific issues for LGBTQ parents was rarely found in the maternal and child health services. Informational and emotional support was sought from social services and outside these services. Parents highlighted that professionals lack knowledge about LGBTQ people's special needs regarding their sexual relationship or satisfaction with it, which were not discussed at all at the appointments. This finding is significant since, in Finland, about half of marriages end in divorce (Official Statistics of Finland, 2016). In addition, previous studies indicate that female couples are more likely to end up divorced than male or mixed-sex couples (Aarnio et al., 2018; Andersson et al., 2006; Farr, 2017; Gartrell et al., 2011; Wiik et al., 2014). It's argued that despite the improvements in LGBTQ people's life and legal rights in many Western countries, they do not receive the same structural, legal, and social support as those of mixed-sex couples. Moreover, heteronormative practices (Kolehmainen, 2019a) and the fear of discrimination by service providers prevent LGBTQ couples from seeking help (Kuosmanen & Jämsä, 2007). This was also mentioned in this study.

### **Support from spouse and friends**

In this study, spouse and friend support was considered as a significant enabler of empowerment. Love and shared parenting at home was important. Interviewees described spousal support as most significant during pregnancy and when the child was small. The common experience of parenting was seen as important to growth and commitment. In addition to traditional core families, divorced parents, or families with more than two parents

emphasized the importance of shared parenting and supporting each other in co-parenting. The result confirms the findings of several previous studies regarding the importance of help and support from loved ones (Dempsey & Dunst, 2004; Nachshen & Minnes, 2005; Wakimizu et al., 2011). Help from loved ones can contribute to the functioning of the family's daily life and increase parents' confidence in their parenting skills. However, access to help is not without problems for all families. Previous studies have shown that LGBTQ parents have fewer close relatives and that support from relatives is not evident (Kuosmanen & Jämsä, 2007; Power et al., 2015). The results suggest that support for parents' family life may assist parents in coping with everyday challenges, such as time and resource adequacy.

## **Decision-making**

Regarding decision-making, it was essential that professionals trusted parents' expertise and encourage them to make decisions concerning their child's care (Cawley & McNamara, 2011). In this study, the legitimacy is made even more obvious by the fact that the LGBTQ parents, as service users, are fully aware of all aspects of their socio-cultural reality and the attitudes toward them and their families (Kontula, 2009; Nikander et al., 2016). In particular, social parents considered it was important that they had the same rights to decide on their child's care. It was important that they felt they were equal parents and that they had responsibilities in the process of how the child's affairs are decided, even if they were not their biological parent. Participants reported that professionals often had little awareness of how to engage with, and/or refer to, lesbian, gay, and transgender parents; however, some participants found it easier than others to manage this type of indirect discrimination because they had developed resilience from having previously had challenging experiences.

Parental empowerment was supported when the employees' listened to their opinions and responded to their concerns. As found in previous studies, it was also important that the parent had the opportunity to withdraw from decision-making and leave the responsibility for care to the professionals, especially when it came to the child's medication or serious illness. These

results confirm previous knowledge that parents want to be considered as an expert in their own child's affairs within service situations (Mäenpää & Åstedt-Kurki, 2008) and have the important experience of being heard even if they are unwilling or unable to participate in decision-making (Rosenthal & Nolan, 2013). These findings correspond with previous studies which indicate that parent's abilities to be involved in decision-making concerning their own or their child's care may improve their parenting in everyday life (Duncan et al., 2006; WHO, 2006) as well as encourage parents to enhance their role in their own family (Halme et al., 2012; Koelen & Lindström, 2005.) This can be perceived as very important, especially within same-sex families that do not have enough models for all parenting roles.

## Equality

Sense of security, sufficient access to services, and good quality of care were considered essential parts of empowerment. Parents reported that they needed to be respected and accepted. It was essential that they were treated like everyone else and that they were receiving the same services as other families. As in previous studies, the challenges of equality were seen in the lack of professionals' skills and competencies concerning LGBTQ special needs (Shields et al. 2012). It was mentioned that the good quality of care depended on the qualifications and skills of the professionals in caring for the whole family.

A sense of a safe environment was enhanced by the language used. Treating and speaking to all parents as equals were important. Making eye contact or asking families about their parenting roles or names, were described as making parents feel they belonged to these services, which felt empowering. These small gestures of acceptance offered the parents a sense of security and settings where they could talk about their sexual relationships, families' and life events. Based on those findings, healthcare institutions and professionals need to improve the healthcare environment, making it inclusive of LGBTQ parented families and enhancing staff's education on the challenges faced by LGBTQ families and their right to be treated in a nonjudgmental manner and receive the same quality of care as any family.

## **6.2 VALIDITY AND RELIABILITY OF THE STUDY**

The interest in supporting parenting is well justified in the light of research data. Numerous studies show that supporting parents can effectively prevent and treat many different types of problems for different kinds of families. However, there is little research on how professionals support parental empowerment in different child and family services or how cooperation works between different service providers. Moreover, there is a lack of research on LGBTQ people and Finnish family services, which means that the suitability of the concept in the context of child and family services or LGBTQ parents is still unclear. This study included three data sets gathered from professionals and from LGBTQ parents in different child and family services.

### **The validity and reliability of sampling and the representativeness of the quantitative studies (Sub-studies I and II, Original articles I and II)**

Sub-studies I and II was part of a larger research project carried out by the Finnish Institute for Health and Welfare on Integrated Management in Children, Youth, and Family Services. The data were obtained in 2009 from employees working at substance abuse services and from family services, such as health, social and education settings. A questionnaire was sent to the heads of the service units. In the cover letter, the unit head was asked to choose one respondent who could assess the unit's working methods. In Sub-study I, the original sample size was 372 people working in substance abuse services (Sub-study I, Original article I), and in Sub-study II, the original sample size was 1,220 (Sub-study II, Original article II) people working in health care, social welfare and education services. The questionnaire was sent only to Finnish and Swedish language services.

The final response rate in Sub-study I was 36% ( $n = 132$ ), and in Sub-study II it was 37% ( $n = 457$ ). Responses were obtained from all the contacted units and sectors, as well as from municipalities of various sizes. The appropriate sample size was calculated with a General Power Analysis (GPOWER) (Erdfelder et. al., 1996; Faul et. al., 2007, 2009). A significance level of 95% ( $\alpha = 0.05$ ) and a statistical power of 80% were used (Cohen, 1988). The analysis showed that

the data used were adequate with the methods of analysis. This was done by the Finnish Institute for Health and Welfare, and it's reported elsewhere (Kanste et al., 2016 Perälä et al., 2014).

Attempts were made to motivate respondents to respond to the survey by highlighting the importance of the study in a cover letter. Employees who did not respond were sent a reminder letter and a new questionnaire twice. There is no unambiguous threshold for an adequate response rate, and interpretations of an acceptable response rate vary widely. Some international studies have shown that there is no direct relationship between response rate and study reliability (Holbrook et al., 2007; Mealing et al., 2010; Morton et al., 2012). Poor responsiveness can be explained by many factors. The length of the scale may have affected employees' responses (DeVellis, 2017), which may have had an impact on the validity of the results (Streiner et al., 2015).

There were some limitations in this study. Although the sample was representative, the response rate was relatively low, which is quite common in municipal surveys. In sub-study I more than two-thirds and in sub-study II, about a third of the participants in this study worked as an immediate superior. This must be considered when interpreting the results, although many supervisors also work with families' they have their management duties and responsibilities. Since the data were gathered only from the Finnish municipalities the generalizing this sample must be done with caution. However, previous studies corroborate the findings of this study, and some recommendations can be made. (Burns & Grove, 2009.) Despite the age of the data, information about the relationship between parental empowerment and co-operative working practices or employee's supervisory support remains topical but has been little studied.

## The reliability and validity of used measures (Sub-studies I and II)

In this study, the questionnaire included several scales (Table 3), which were suitable for studying family services in Finnish municipalities. (Kanste et al., 2016; Kausto et al., 2003; Perälä et al., 2011; Perälä et al. 2014; Räikkönen et al. 2007; Toljamo & Perälä, 2008; Vuorenmaa et al., 2014.) Multidisciplinary teams, employees focus group interviews, and pilot tests were used to confirm the validity and the internal consistency of the different scales was evaluated using Cronbach's alpha. The values had varying acceptability levels (0.79– 0.95, Table 3), indicating that the questionnaire had sufficient to high internal consistency. (European Federation of Psychologists Associations, 2013.)

The support of parental empowerment in substance abuse services (Original article I) and health and education services (Original article II) was evaluated using the version of the FES aimed at professionals (Vuorenmaa et al., 2014). The scale was chosen since it corresponded best to the empowerment of parents described in theoretical starting points. It should be noted, however, that neither the FES nor the modified G-FES evaluates any empowerment of parents. For example, the indicators do not assess the amount or quality of child-parent coexistence (Gavin & Wysocki, 2006; Perry & Langley, 2013), or the parent's contribution to the development of a safe and child-friendly environment (El Nokali et al., 2010; Noble & Frankenberg, 2009). The modification of the FES was carried out and pretested by a group of multidisciplinary experts. The construct, convergent and discriminant validities, reliability, and responsiveness of the FES had been assessed by researchers from Finnish Institute for Health and Welfare and the psychometric properties were acceptable. This work has been reported elsewhere (Health care and social services and educational settings; Vuorenmaa, 2016 and substance abuse services; Perälä et al., 2014).

In this study, the internal consistency of the FES aimed at professionals (Vuorenmaa et al., 2014) was evaluated using Cronbach's alpha. Alpha coefficients ranged from 0.92–0.95 (Table 3) indicating that the FES had high internal consistency. (European Federation of Psychologists Associations, 2013.) In addition, the coefficients were similar to those of previous FES studies

among parents ( $\alpha = 0.81\text{--}0.94$ , Koren et al. 1992, Nachshen & Minnes 2005, Wakimizu et al. 2011), which suggests acceptable reliability of the personnel version of the FES.

Factors related to parental empowerment were assessed using several pretested scales and several statistical methods. The power analysis showed that the data were adequate with the methods of analysis. The independent samples t-test and parallel analysis of variance were used to examine differences between groups (Sub-studies I and II, Original articles I and II). The multiple linear regression (MLR) was used to estimate the associations between support of parental empowerment, cooperative working practices, and empowering management. All the predictive variables used in the MLR were continuous. The assumption of no multicollinearity was verified before performing the MLR (January 2005; Nummenmaa, 2009). The R squares of the regression models were quite low (9%, 11%, 11%; Table 4 in Original article II), supporting the idea that associations between family services and supporting parental empowerment are highly complex phenomena. Although no limit values have been defined for good explanatory proportions from the point of view of the reliability of the result, when explaining a multidimensional phenomenon such as empowerment, explanatory proportions of 20% are considered significant (Ketokivi, 2009). Due to differences in the service systems, it would be necessary to test the psychometric properties again before using this instrument internationally (So et al., 2011; Wolfe et al., 2013).

### **Trustworthiness of the qualitative study (Sub-study III, Original articles III and IV)**

Qualitative studies depend on their trustworthiness, such as credibility, dependability, transferability, and reflexivity. The key choices affecting the credibility of a study typically relate to the selection of study participants and data collection methods. (Elo et al., 2014.) In this study, the participants were LGBTQ parents, whose perspective has received little attention in previous studies, and awareness of their perspective was needed to gain a deeper understanding of the concept of parental empowerment. Applying qualitative approach and inductive content analysis, new knowledge, and

dimensions of the concept of parental empowerment in the context of family services were revealed (Kelly, 2010; Sandelowski, 2000). During the interview, the participants were able to discuss their perspectives and experiences of their empowerment in maternal and child health care and this gives a more detailed understanding of a phenomenon seldom studied before.

The data were collected and analyzed at the same time. This helped identify when saturation was achieved. The resulting data set was rich, detailed, and multidimensional (Burns & Grove, 2005). The author of this thesis was responsible for the analysis and the findings were discussed until a consensus was reached. The recruitment of participants, the inclusion criteria, the data collection, the data analysis, and participant characteristics were reported. The transparency and trustworthiness of the findings were added with original quotations. (Original article III, Original article IV). (Elo & Kyngäs, 2007; Elo et al., 2014; Mays & Pope, 2000, Tong et al., 2007.)

This study's strengths lie in its inclusiveness. The participants consisted of children's biological and non-biological parents from both urban and rural areas. Open interviews were selected to obtain knowledge of the participants' thoughts about parental empowerment and related supportive factors in Finnish maternity and child health services. To ensure the validity of the data, the researcher allowed the interviewees to freely express their ideas. (Kvale & Brinkman, 2009.) Moreover, this was the first study in Finnish involving the empowerment of LGBTQ parents, and it provided important new knowledge in the context of child and family services. The results highlight the complexity of issues related to empowerment and can be regarded as a strength of this study.

A potential weakness of the study was caused by the fact that the participants were recruited online (Polit & Beck, 2012). Recruitment through a specific organization introduces a risk of skew concerning the participants' cultural background, education, and financial stability. In this study, all the participants were Finnish, and some of them had an immigrant background. However, this type of sampling is useful when populations are marginalized since individuals might be more willing to participate if they trust the organization carrying out the study (Kvale & Brinkman, 2009).

## **6.3 ETHICAL CONSIDERATIONS**

### **The research integrity**

The research process followed ethical guidelines, such as the Declaration of Helsinki (World Medical Association, 2013) and the guidelines of the Finnish Advisory Board on Research Integrity (TENK, 2012) in all phases of the study (Wager & Wiffen, 2011). The study is based on relevant scientific literature and good design. For the two quantitative studies, Sub-studies I and II, ethical approval was obtained from the ethics committee of the Finnish Institute of Health and Welfare (§ 43/2009). Permission to collect the quantitative data used in Sub-studies III and VI was obtained from The University of Eastern Finland (UEF) Committee on Research Ethics (13/2016).

### **Voluntariness and information**

Participation in the qualitative and quantitative studies was voluntary. In the quantitative study (Sub-studies I and II, Original articles I and II), the voluntary nature of participation was communicated by cover letters. These provide information about the study and its purpose, as well as anonymous participation. The cover letters also provided information concerning the maintenance of confidentiality, and the right of participants to withdraw at any stage from the study. Moreover, research group members' contact information was given for possible questions or the need for clarifications (Grove et al., 2013). A filled out and returned survey was interpreted as an indication of the respondent's consent to participate in the research (Finnish Advisory Board on Research Integrity, 2012).

In a qualitative study (Sub-studies III and IV), all the participants received both written and oral information on the study's purpose and process to ensure their voluntariness and informed consent. They were told that their participation was voluntary, anonymous, and confidential and that they could withdraw at any time without consequences. None of the participants withdrew. Participants signed a written consent form at the beginning of their interview.

When discussing sensitive topics, it was noticed that the interview can be emotional or distressing (Munhall, 1991). Participants in this study stated that

they found interviews to be helpful or very helpful, implying some evidence of therapeutic benefit (Josselson, 2007). Sense of empathy and altruism were also considered as motivating factors for parents deciding to participate in this study. Participants frequently experience feelings of satisfaction or enhanced well-being in their belief that they are benefitting others or increasing understanding of the experience of LGBTQ parents (Carrera et al., 2018).

## **Data protection**

In Sub-studies I and II, the data were collected as a part of a Finnish Institute of Health and Welfare (THL) project, and the Institute granted authorization to use its data based on an application that included a research plan. Relevant security procedures for storing the study data were followed. For this study, the data were provided in an anonymized form, including no names, social security numbers, location data, occupations, or email addresses of the participants. The THL is the controller of the data and has the right to use the collected personal data for research purposes.

For Sub-studies III and IV, the data were gathered through interviews. The interviewees were recruited via the Internet, through an organization whose members identify as LGBTQ families, a sexual-political organization (SETA) website, and on Facebook. Participation and specific information about the study was confirmed by email. All interviews were audio-recorded. Due to the sensitivity of the study, interview information and the data were processed anonymously and confidentially (Polit & Hungler, 2001). To ensure participants' and/or health care professionals' anonymity and full confidentiality, all names, including nurses, doctors, or services, were removed from the data (Polit & Beck, 2010). This makes it unlikely that a person could be identified.

Any paper or email documents collected during this study were stored in a locked file cabinet. Three years after acceptance of this thesis, paper data and recorded audiotapes will be shredded, and electronic data will be erased using commercial software applications designed to remove all data from the storage device.

The results of all the sub-studies were published so that no single participant or service provider could be recognized, dialect expressions were anonymized, and regionally recognizable information was not used.

## 7 CONCLUSIONS

### 7.1 CONCLUSION DERIVED FROM THE MAIN FINDINGS

The findings of this study produced new knowledge of empowerment in child and family services and substance abuse services based on quantitative and qualitative research data. According to the results, it is possible to support parental empowerment by strengthening parenthood, supporting the functioning of families' daily lives, and securing access to social support.

Targeting, integration on services requires that different actors have good awareness of each other's work and the services available. There are still gaps in the knowledge, however, especially in the knowledge of social services and Nongovernmental Organizations (NGO). Improving the functioning of cooperation is a challenge in municipalities, but the better the cooperation, the better the opportunities for parents to participate and to receive the support and help they need early. Special attention should be paid to the management, organizational boundaries, and cooperation in services. Moreover, additional training across all child and family services on both the nature of collaboration and the awareness of services and LGBTQ families' unique needs could be vital for supporting parents' empowerment.

Based on these study findings, the following conclusions can be made:

1. Parental empowerment is rather well supported in the context of child and family services and substance abuse services. Empowerment is supported better within families than within the service situation, while it is least supported within the service system.

2. Employees' awareness of services, commitment to common goals and supervisory support, especially fairness in treatment are related factors to supporting parental empowerment. Therefore, it is important to ensure that organizations support ongoing education to promote effective collaboration in child and family services.

3. Parents play an essential role in supporting their own empowerment in child and family services. Therefore, all parents should be actively encouraged to take part during appointments, as well as in the decision-making process involving their children and service use.

4. This study revealed the failure of professionals to engage with LGBTQ parents and the inability to understand their needs related to special issues. Supporting parental empowerment in different types of families requires more knowledge and education. There is also a need for inclusive and sensitive practices.

## **7.2 FUTURE RESEARCH**

In the future, there is a need to explore the understanding of empowerment and cooperation between child and family services among professionals. Comprehensive approach is needed to gain a clear understanding of the factors that could promote or prevent cooperation. Moreover, it is important to use a in the joint work.

In addition it is important to explore families 'views on collaboration between the professionals. Careful attention should be given to organizational borders and collaboration with the third sector. In addition, it is essential to determine the need for and readiness of professionals to change their behavior. Since families are different and their support requirements vary, it is crucial to deepen the understanding of the concept of empowerment in various services and diverse families.

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**APPENDICES**

**APPENDIX 1. TABLE 1. CONCEPT ANALYSIS OF EMPOWERMENT**

**Table 1.** Concept analysis of empowerment

| Author        | focus / context   | Definition of empowerment / Findings   |
|---------------|---|--|
| Gibson, 1991  | A concept analysis of empowerment.  | Empowerment within a midwifery and nursing perspective is a social process of recognition, promoting and enhancing people's abilities to meet their own needs, solve their problems and mobilize the necessary resources in order to feel that they are in control of their lives. This process encompasses both the individual responsibility in health care and the broader institutional, organizational or societal responsibilities in enabling people to assume responsibility for their own health. |
| Hawks, 1992   | Empowerment in nursing education: concept analysis and application to philosophy, learning and instruction. | Empowerment occurs between two or more people: the person who empowers and the person(s) who is (are) empowered.   |
| Rodwell, 1996 | An analysis of the concept of empowerment.  | Effect of empowerment on the value of self and others, mutual decision-making and freedom to make choices.   |

| Author                              | focus / context  | Definition of empowerment / Findings  |
|-------------------------------------|--|---|
| Ellis- Stoll & Popkess-Vawters 1998 | A concept analysis on the process of empowerment.                              | <p>Mutual participation, active listening and individualized knowledge acquisition by nurse-client dyad.</p> <p>Anecdotes; client's maladaptation that brings them into the health care system, motivation to change maladaptive behaviors, ability to problem solve, interpretation of personal significance to the behavior change needed, and autonomous choice to continue poor health behaviors or to make a behavior change.</p> <p>Attribute is participation by both clients and nurse. Process of empowerment is composed of (1) mutual participation, (2) active listening, and (3) individualized knowledge acquisition by the nurse-client dyad. Consequences of the empowerment process are self-determined, independent health-promoting behaviors.</p> |
| Ryles 1999                          | A concept analysis of empowerment: its relationship to mental health nursing.  | <p>Empowerment is a positive concept that suggests a growth in competencies in negotiating and expressing, with and to, our fellow human beings as a means of gaining access to scarce resources. It is the raising of political consciousness and the realization that one's life chances are being undermined for reasons of politics, economics and disenfranchisement that here acts as the primary antecedent of empowerment practice or activity.</p>   |
| McCarthy & Freeman, 2008            | A multidisciplinary concept analysis of empowerment: implications for nursing. | <p>Attributes; a) reciprocal interaction, b) autonomy linked with accountability, c) shared or transferred power, and d) ultimately greater access to financial or intangible resources such as knowledge and influence.</p> <p>Antecedences; respectful, trusting relationships and willingness to accept change</p> <p>Consequences; power and access to resources, accountability, responsibility, willingness to see beyond the bedside, and the pursued of effective advocacy skills for patients and for the profession.</p>  |

| Author                        | focus / context  | Definition of empowerment / Findings  |
|-------------------------------|--|---|
| Nishida, 2010                 | A concept analysis of empowerment in mothers of concern in parenting. (Japanese)   | Six categories were extracted as the attributes of 'empowerment for mothers of concern in parenting': 'acquisition of knowledge,' 'construction of partnerships,' 'awareness,' 'sense of positivity,' 'acquisition of problem-solving skills,' and 'self-directed action.   |
| Dowling et al. 2011           | A concept analysis of empowerment in chronic illness from the perspective of the nurse and the client living with chronic obstructive pulmonary disease. | Empowerment in chronic illness is a process with both the nurse and client contributing to its evolution. The nurse must feel empowered, communicate effectively and surrender control in the empowerment process. The client must be motivated to change and possess specific competencies to engage in the empowerment process. Both the nurse and client experience a transformation when empowered.   |
| Hermansson & Mårtensson, 2011 | Empowerment in the midwifery context—a concept analysis.   | <p>Attributes; Developing a trustful relationship, Starting a process of awareness, making it possible to reflect on the changing situation, Acting based on the parents' situation on their own terms, getting them involved and able to make informed choices, Confirming the personal significance of becoming parents.</p> <p>Empowerment;</p> <p>An ongoing dynamic and social process of acting, creating, confirming, facilitating, listening and negotiating between the midwife and the couple, in which they develop a trustful relationship based on mutual respect and integrity. By dialectic learning, an awareness of the changing situation will materialize, making it possible to mobilize the necessary resources and enhance the couples' own abilities. The woman and her partner are thus participants in a growth process and are enabled to make their own informed choices. The personal significance of becoming parents will then emerge. A nurturing, caring and supporting environment and professional knowledge and skills are necessary components in this process.</p> |
|                               |  |   |

| Author                   | focus / context  | Definition of empowerment / Findings   |
|--------------------------|--|--|
| Jefroke, 2013            | Concept Analysis of Empowerment from Survivor and Nurse Perspectives Within the Context of Cancer Survivorship.                        | Empowerment is defined as power-with that is actualized through a beneficial relationship of mutual trust and respect for autonomy that develops within a dynamic and patient-centered process. The attributes, along with the antecedents and consequences, provide a foundation for future theory development of empowerment in the context of cancer survivorship.  |
| Castro et. al. 2016      | Patient empowerment, patient participation and patient-centeredness in hospital care: A concept analysis based on a literature review. | Antecedents; dialogue, patient centered approach, enhancing patients' competences, active participation.<br>Attributes; enabling process, personal change, self-determination.<br>Consequences; integrated self, sense of mastery and control, quality of life.<br>Empowerment is a relational construct that comprises different levels.  |
| Sakanashi & Fujita, 2017 | Empowerment of family caregivers of adults and elderly persons: A concept analysis.  | Antecedents; Individual characteristics of caregivers, Status of caregivers' mental and physical self-control, Relationship with the care receiver, Personal characteristics of the care receiver and support from other people surrounding them.<br>Attributes; Positive control of mind and body, cultivating a positive feeling, Proactive caregiving, Improvement in caregiving capabilities, Support for the independence of the care receiver, Constructive relationships with other people surrounding them.<br>Consequences; Continued physical and mental stability, Confidence in providing caregiving, Personal growth, Improvement in the quality of the relationship between the care receiver and family members, Acquisition of ongoing social support.<br>Empowerment of a family caregiver; "the positive control of a mind and body, cultivating a positive attitude, proactive to attempt to understand one's role as a caregiver to improve caregiving capabilities, focusing on others as well as oneself, supporting the independence of care receiver and conducting constructive relationship with other people surrounding them". |

| Author                             | focus / context  | Definition of empowerment / Findings   |
|------------------------------------|--|--|
| Wählin, 2017                       | Empowerment in critical care - a concept analysis                    | <p>Attributes; a supportive relationship, knowledge, skills, power within oneself and self-determination. Antecedents; strain, motivation and at least a certain degree of internal and external resources were identified as antecedents. This means that deep unconscious or heavily sedated patients probably cannot experience empowerment.</p> <p>Empowerment generates a mastery over the distressing or demanding situation, ill health or difficult task, a decreased level of strain, an increased feeling of autonomy, and the propensity to act. Empowerment also generates an increased sense of coherence and control over the situation and the future, as well as personal and/or professional development and growth, together with increased comfort, quality and inner satisfaction.</p> |
| Aktopor & Johnson, 2018            | Client Empowerment: A concept Analysis.                              | <p>Client empowerment is a process by which the community health nurse and her client institute a therapeutic relationship within a supportive social climate characterized by respect, mutual decision making, and power sharing leading to client independence, increased confidence, self-reliance, and self-management</p> <p>Antecedents; social motivation, availability of information or choices, participation by all parties and willingness to share power with others.</p> <p>Consequences; social justice independence and confidence.</p>  |
| Nieuwenhuijze & Leahy-Warren, 2019 | Women's empowerment in pregnancy and childbirth: A concept analysis. | <p>External attributes; Gender equality, Access and control of resources, Facilitation of women's choice and decisions.</p> <p>Internal attributes; Women's belief in own abilities, Control over situation, self and others</p> <p>Antecedents; emancipated environment, supportive alliances, education, birth choices and reverence.</p> <p>Consequences; birth experience, overall health, self-advocacy, healthcare services.</p> <p>Empowerment includes three dimensions; sosio-cultural, economic and psychological.</p>   |

| Author               | focus / context  | Definition of empowerment / Findings   |
|----------------------|--|--|
| Weisbeck et al. 2019 | Patient Empowerment:<br>An Evolutionary Concept<br>Analysis. | Attributes; self-determination, mutual partnership and supportive relationship, an enabling process.<br>Antecedents; motivation, presence of patient competency, partnership.<br>Consequences; an integrated self, increased quality of life, hope and value in living.  |
| Woodward, 2020       | Individual nurse<br>empowerment: A<br>concept analysis.      | Attributes; autonomy, goals, influence, and engagement.<br>Antecedents; a sense of meaning and opportunities.<br>Consequents are; job satisfaction and intended or actual turnover.<br>As individual professional, empowerment moves from a passive process where power is received to an active process where power is used or claimed. |



# Articles

## ARTICLE I

Kerppola J, Halme N, Pietilä AM and Perälä ML. Paljon päihteitä käyttävien vanhempien osallisuuden tukeminen. Sosiaalilääketieteellinen aikakauslehti, 51 (2): 76–87, 2014.

## ARTICLE II

Kerppola J, Halme N, Pietilä AM and Perälä ML. Do co-operative working practices and empowerment in management support employees in family services to reinforce parental empowerment? International Journal of Caring Sciences, 9 (1): 9- 21, 2016.

## ARTICLE III

Kerppola J, Halme N, Perälä ML and Pietilä AM. Parental empowerment – lesbian, gay, bisexual, trans or queer parents’ perceptions of maternity and child healthcare settings. International Journal of Nursing Practice, 25 (5): e12755, 2019.

## ARTICLE IV

Kerppola J, Halme N, Perälä ML and Pietilä AM. Empowering LGBTQ parents: how to improve maternity services and child healthcare settings for this community” ”She told us that we are good as a family.” Nordic Journal of Nursing Research, 40 (1): 41-51, 2020.

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## **ARTICLE I**

Kerppola J, Halme N, Pietilä AM and Perälä ML. Paljon päihteitä käyttävien vanhempien osallisuuden tukeminen. Sosiaalilääketieteellinen aikakausilehti, 51 (2): 76–87, 2014.



# Päihdepalvelujen piirissä olevien vanhempien osallisuuden tukeminen

Vanhempien osallisuuden vahvistaminen sekä oikeus tulla kuulluksi ovat keskeisiä lasten palveluja ohjaavia periaatteita. Osallisuuden toteutumisessa on kuitenkin edelleen puutteita. Tämän tutkimuksen tarkoituksena oli selvittää päihdepalvelujen esimiesten käsityksiä siitä, miten päihdepalvelujen piirissä olevien vanhempien osallisuutta tuetaan. Osallisuuden tukemista arvioitiin työntekijöille modifoidulla Family Empowerment Scale -mittarilla (FES). Aineisto kerättiin päihdepalveluissa toimivilta esimiehiltä ( $n=372$ ). Vastausprosentti oli 36. Taustamuuttujien perusteella määräytyvien vastaajaryhmien väliset erot analysoitiin riippumattomien otosten t-testillä sekä yksisuuntaisella varianssianalyysillä.

Vanhempien osallisuuden tukeminen toteutui kohtuullisesti kaikissa toimipisteissä. Merkittävimmät kehittämiskohteet liittyivät perheiden riittämättömään tiedonsaantiin, heikkoihin palauteen antomahdollisuuksiin, perheen ja henkilöstön välisen yhteistyön sekä vanhempien yhteiskunnallisten vaikutusmahdollisuuksien lisäämiseen. Vastaajien mukaan toimipisteen luonne oli yhteydessä osallisuuden tukemiseen päihdepalveluissa.

**JENNI KERPPOLA, NINA HALME, ANNA-MAIJA PIETILÄ, MARJA-LEENA PERÄLÄ**

## JOHDANTO

Lapsiperheiden palveluissa vanhemman osallisuuden tukeminen nähdään palveluita ja toimintaa ohjaavana keskeisenä periaatteena. Sen avulla voidaan vahvistaa ja ylläpitää perheen terveyttä edistäviä tekijöitä (Cribb ja Duncan 2002, Pelto-Huikko ym. 2006) ja luoda vanhemmalle mahdollisuus osallistua omaan tai lapsensa saamaan hoitoon, palveluihin ja laajemmin yhteiskuntaan (Lahtinen ym. 2003, Savola ja Koskinen-Ollonqvist 2005, Sirviö 2006). Tukemalla vanhemman osallisuutta voidaan myös lisätä hoidon kustannustehokkuutta, edistää palvelujärjestelmän kehittymistä ja uusien resurssien käyttöönottoa (Dahlberg ja Vedung 2001, Heikkilä ja Julkunen 2003, Tuorila 2007, 2009, Leimumäki ym. 2010, Virtanen ym. 2011) sekä parantaa asiakkaan asemaa ja oikeuksia palvelujärjestelmässä (Dahlberg ja Vedung 2001, Sirviö 2006, Tuorila 2007, Mattila- Aalto 2009, Tuorila 2009, Laitila 2010, Laitila ym. 2012).

Asiakkaan osallisuuden tukemisen tärkeys on osoitettu useissa tutkimuksissa ja sitä korostetaan kansallisissa ohjeissa ja suosituksissa. Käytännössä, sosiaali- ja terveystieteissä, se kuitenkin usein toteutuu puutteellisesti (Laitila 2010, Perälä ym. 2011, Laitila ym. 2012). Puutteita on havaittu erityisesti palveluissa, jotka kohdistuvat yhteiskunnasta syrjäytyneisiin kuten vankeihin ja päihteidenkäyttäjiin, joilla on todettu olevan muita ihmisiä heikommät mahdollisuudet vaikuttaa yhteiskunnalliseen päätöksentekoon (Karsikas 2005, Knuuti 2007, Granfelt 2008, Mattila-Aalto, 2009). Näiden asiakasryhmien kohdalla saadun tuen merkitystä voidaan kuitenkin pitää erityisen suurena (Lester ym. 2006, Niiranen 2002), sillä tuki vähentää asiakkaisiin kohdistuvaa leimaamista ja syrjintää (Truman ja Raine 2002) ja auttaa asiakkaita integroitumaan yhteiskuntaan.

Osallisuuden käsite on ollut usean tieteenalan kiinnostuksen kohde viime vuosina. Se on osoittautunut moniulotteiseksi ja vaikeaksi määritellä

ja mitata. Osallisuus on määritelty tiedoksi, tunteeksi ja kokemukseksi sekä tekijäksi, jonka kautta yksilön asema yhteisöissä ja yhteiskunnassa määritellään. (Julkunen ja Heikkilä 2007, Granfelt 2008, Haake ja Nikula 2011.)

Sosiaali- ja terveystalvuluissa asiakkaan osallisuudella tarkoitetaan usein asiakkaan itsemääräämisoikeutta sekä laillisia oikeuksia vaikuttaa omassa hoidossaan tehtävään päätöksentekoon. (Sirviö 2006, Thompson 2007, Eldh ym. 2010, Sirviö 2010, Laitila 2010, Moore ja Kirk 2010.) Mielenterveys- ja päihdepalveluissa asiakkaan osallisuutta on tarkasteltu sekä asiakkaan kokemuksina (Fischer ja Neale 2008, Mattila-Aalto 2009, Laitila 2010, Laitila ym. 2012) että työntekijän näkemyksinä (Hickey ja Kipping 1998, Truman ja Raine 2002, Crawford ym. 2003). Näissä tutkimuksissa asiakkaan osallisuus kuvataan usein jatkumona, hierarkkisenä tai lineaarisena mallina, jossa osallisuus vaihtelee tiedonantajan roolin ja osattomuuden sekä täysivaltaisen osallistumisen ja päätöksenteon välillä (Hickey ja Kipping 1998, Truman ja Raine 2002). Vanhempiin kohdistuva tutkimus (Koren ym. 1992, Singh ym. 1997, Lehto 2004, Sirviö 2006) sekä erityisesti lasten, nuorten ja perheiden palvelujärjestelmän näkökulmaa kuvaava tutkimus on vähäistä niin kansallisesti kuin kansainvälisestikin. (Heikkilä ja Julkunen 2003, Julkunen ja Heikkilä 2007, Tuorila 2007, 2009, Perälä ym. 2011.)

Tämän tutkimuksen tarkoituksena on kuvata miten päihdetyä käyttävien vanhempien osallisuutta tuetaan päihdetyön erilaisissa toimipisteissä. Tutkimuksen tiedonantajina ovat päihdetyön ja vankiloiden esimiehet, joilla katsotaan olevan tärkeää tietoa palvelujärjestelmästä, sen toiminnasta sekä palveluiden kehittämisestä. Päihdetyä käyttävällä vanhemmalla tarkoitetaan 0–9-vuotiaan lapsen vanhempaa, joka käyttää päihdetyä tavalla, joka aiheuttaa eriaisteisia haittoja sekä hoidon tarvetta. Päihdetyöllä tarkoitetaan sosiaali- ja terveydenhuollon toimijoiden toteuttamaa ehkäisevää ja korjaavaa päihdehoitoa.

Tutkimuksen pääkäsite on vanhemman osallisuus, jolla tarkoitetaan konkreettisia vanhemmuuden taitoja arjessa, vanhemman kykyä itsenäiseen palveluiden käyttöön sekä mahdollisuutta osallistua palvelujen suunnitteluun, toteutukseen ja arviointiin sekä laajemmin palvelujärjestelmän kehittämiseen ja viranomaistoimintaan. Osallisuuden tukemista tarkastellaan kolmella tasolla: perheessä, asiakaspalvelutilanteessa ja palvelujärjestelmässä. Vanhemman osallisuuden

tukeminen perheessä merkitsee konkreettisten vanhemmuuden taitojen vahvistamista, lasten kasvuun ja kehitykseen liittyvän tiedon antamista sekä palvelujärjestelmään osallistumisen mahdollisuuksien lisäämistä. (Koren ym. 1992, Vuoremaa ym. 2013.)

Asiakaspalvelutilanteessa vanhemman osallisuus konkretisoituu osallistumisen kautta. Osallisuus on aktiivista tai passiivista hoidon suunnitteluun, toteutukseen ja arviointiin osallistumista (Doherty ja Doherty 2005, Thompson 2007), jota voidaan tukea lisäämällä vanhemman itsemääräämisoikeutta sekä parantamalla tietoisuutta palveluista, niiden käytöstä ja niihin hakeutumisesta. Palvelujärjestelmässä vanhemman osallisuuden tukemisella tarkoitetaan vanhemman rohkaisemista, tukemista ja kannustamista osallistumiseen palvelujärjestelmää kehittävään toimintaan ja viranomaistoimintaan (Koren ym. 1992).

## TUTKIMUKSEN TARKOITUS JA TUTKIMUSKYSYMYKSET

Tämän tutkimuksen tarkoituksena on kuvata päihdetyön esimiehen käsityksiä siitä, miten päihdetyä käyttävien alle 9-vuotiaiden lasten vanhempien osallisuutta tuetaan päihdetyön erilaisissa toimipisteissä. Kysytään, miten osallisuuden tukemisen arvioidaan toteutuvan 1) perheessä, 2) asiakaspalvelutilanteessa ja 3) palvelujärjestelmässä.

## AINEISTO JA MENETELMÄT

### TUTKIMUSAINESTO JA SEN KERÄÄMINEN

Tutkimusaineisto kerättiin kyselyllä, joka lähetettiin päihdehoitoyksiköihin sekä vankiloihin vuoden 2010 joulukuun ja vuoden 2011 maaliskuun välisenä aikana. Tutkimusta varten luotiin vastaajarekisteri Suomessa toimivista päihdehoitoa tarjoavista toimipisteistä ja vankiloista hyödyntäen Terveyden ja hyvinvoinnin laitoksen (THL) ylläpitämiä rekistereitä Toimipaikkarekisteriä (TOPI) ja Hoitoilmoitusrekisteriä (HILMO), A-klinikkasäätiön toimipisteluetteloa sekä kuntien ja kaupunkien omia nettisivustoja.

Kyselyyn vastasivat päihdehoitoyksiköiden esimiehet, vankiloiden johtajat tai vastaavissa asemissa toimivat työntekijät. Vastaajia pyydettiin arvioimaan yleisesti työntekijöiden tapaa toimia toimipisteessä. Kyselytutkimuksen perusjoukon muodostivat Manner-Suomessa toimivat päihdehuollon toimipisteet (N=372). Tämän perusjoukon muodostivat: A-klinikoiden toimipisteet (75), päiväkeskukset (56), huumeidenkäyttäjien terveysneuvontapisteet (29), päihdekuntou-

tuslaitokset (42), katkaisuhuitoyksiköt (16), huumehoitoa antavat laitoshoidon yksiköt (33) lastensuojeluyksiköt (22) ja nuorisoasemat (46), päihdeäideille suunnatut ensi- ja turvakodit (7), päihdepsykiatriset toimipisteet (9) sekä suomessa toimivat vankilat (27) ja ruotsinkielisten kuntien päihdepalvelupisteet (10), joissa toteutetaan ehkäisevää ja korjaavaa päihdetyötä kaikenikäisille Suomessa asuville päihdehoitoa tarvitseville.

Tutkimuksella on Terveyden ja hyvinvoinnin laitoksen tutkimuseettisen työryhmän puoltava lausunto (7/2010). Tutkimuksessa noudatettiin hyvän tieteellisen tutkimuksen käytäntöjä huomioiden tutkimuseettiset ohjeet ja suositukset tutkimusprosessin kaikissa vaiheissa. Tutkimuspyynnön yhteydessä osallistujille lähetettävissä saatekirjeessä selvitettiin tutkimuksen tarkoitus ja tavoitteet, osallistumisen vapaaehtoisuus, luottamuksellisuus ja osallistumisen anonyymiyys. Vastaajille annettiin tutkijoiden yhteystiedot tarkempien lisätietojen kysymistä varten. (Tutkimuseettinen neuvottelukunta 2012.) Vastaaminen kyselyyn tulkittiin tietoiseksi suostumukseksi. Tietoturvallisuus sekä vastaajan anonyymiyys turvattiin aineiston tallentamisessa sekä arkistoinnissa siten ettei ulkopuolisilla ollut pääsyä tietokantaan. Raportoinnissa vältettiin yksittäisten toimipisteiden sekä yksittäisten vastaajien tunnistamista. (Burns ja Grove 2005, Polit ja Beck 2006.)

## MITTARIT JA TILASTOLLISET MENETELMÄT

Kyselylomakkeiden saatekirjeessä selvitettiin tutkimuksen tausta ja tarkoitus, tutkimuslupaa koskevat asiat sekä tutkijoiden yhteystiedot tarkempien tietojen saamista ja palautteen antamista varten. Kahden muistutuksen jälkeen palautuneita lomakkeita oli 132. Vastausprosentti oli 36.

Vanhemman osallisuuden tukemista mitattiin lasten ja perheiden palveluissa toimiville työntekijöille modifoidulla Family Empowerment Scale-mittarilla (FES) (Koren ym. 1992, Vuorenmaa ym. 2013). Suomeksi käännetty ja työntekijöille modifioitu Likert-asteikollinen mittari sisältää 32 väittämää (ks. taulukot 2–4) ja mittaa osallisuuden toteutumista kolmella tasolla. Tasot ovat osallisuus 1) perheessä, 2) asiakaspalvelutilanteessa ja 3) palvelujärjestelmässä. Väittämien arvot olivat välillä 1–5 (1=täysin eri mieltä, 5=täysin samaa mieltä) matalien arvojen merkitessä vähempää osallisuuden astetta. Muuttujat luokiteltiin kolmeluokkaisiksi siten, että ensimmäinen ja toinen sekä neljäs ja viides luokka yhdistettiin. Luokka ”ei samaa mieltä eikä eri miel-

tä” jäi ennalleen. Muodostettujen summamuuttujien sisäistä johdonmukaisuutta arvioitiin Cronbachin alfakertoimen avulla ja se sai tässä aineistossa arvot 0,915–0,954 mittarin eri osioissa. Mittaria voidaan pitää näin ollen luotettavana (Heikkilä ja Julkunen 2003, Kankkunen ja Vehviläinen- Julkunen 2009, Metsämuuronen 2007, Polit ja Beck 2006).

Alkuperäisen, 34 väittämää sisältävän, vanhemmille suunnatun FES-mittarin avulla vanhemman osallisuutta on tutkittu yli 50 maassa ympäri maailmaa (Itzhaky ja Schwartz 2000, Walsh ja Lord 2004, Gerkensmeyer ym. 2008, Martinez ym. 2009, Wakimizu ym. 2011). Mittari on käännetty useille eri kielille, kuten hepreaksi (Itzhaky ja Schwartz 2000), japaniksi (Wakimizu ym. 2011) ja espanjaksi (Martinez ym. 2009) ja sen luotettavuus on osoittautunut hyväksi alfakertoimien ollessa 0,81–0,94. Tutkimuksissa tiedonantajina ovat olleet pääasiallisesti kehityshäiriöitä sairastavien tai mielenterveyspalveluita käyttävien sekä pitkäaikaissairaiden lasten vanhemmat.

Kyselylomakkeen taustaominaisuuksina olivat vastaajan toimipaikkaa koskevat tiedot kuten toimipiste, toimipaikan sijainti, kuntakoko ja toimipisteen aukioloaika sekä vastaajaan liittyvät taustatiedot kuten vastaajan sukupuoli, ikä, koulutus, työkokemus vuosina ja esimiesasemassa toimiminen (ks. Taulukko 1).

Taustamuuttujien perusteella määräytyvien vastaajaryhmien väliset erot analysoitiin riippumattomien otosten t-testillä sekä yksisuuntaisella varianssianalyysillä. Ensisijaisena mielenkiinnon kohteena olivat perheille suunnatut palvelut, kuten päihdehoitoa käyttävien äitien ensi- ja turvakotien, päihdehuollon lastensuojeluyksiköiden sekä päihdehuollon nuorisoasemat.

Tilastollisen merkitsevyyden rajana pidettiin viiden prosentin riskitasoa ( $p < 0,05$ ). Aineiston kuvailussa käytetään prosenttiosuuksia, keskiarvoja ja keskihajontaa. Prosenttiluvut esitetään kokonaislukuina.

## TULOKSET

### TUTKIMUKSEEN OSALLISTUNEET

Kyselyyn vastasi 132 päihdetyön ja rikosseuraamuslaitoksen esimiestä tai vastaavassa asemassa toimivaa henkilöä. Vastaajista 77 prosenttia oli esimiesasemassa olevia naisia. Vastaajien ikä vaihteli 25 ja 68 vuoden välillä (ka 48,55 vuotta, kh 9,15 vuotta). Työkokemuksen pituus nykyises-

sä työtehtävässä vaihteli 2kk – 35 vuoden välillä (ka 8,95 vuotta, kh 8,53 vuotta). Vastaajista hie-  
man yli kolmannes (38 %) oli suorittanut ylem-  
män korkeakoulututkinnon ja yli neljänneksellä  
(28 %) oli alemman korkea-asteen koulutus. Tut-  
kijan koulutuksen oli suorittanut kolme prosent-  
tia kyselyyn vastanneista. (Taulukko 1.)

Vastaajista 40 prosenttia työskenteli erimuo-  
toisissa avo- tai laitoshuollon kuntouttavissa  
päihdepalveluissa (katkaisuhuitoyksikkö, päihde-  
huollon kuntoutus, avomuotoinen päihdekuntou-  
tus ja päihdehuollon kuntoutuslaitos). Ensisijai-  
sesti lapsiperheille suunnattujen palveluiden ku-  
ten päihiteitä käyttävien äitien ensi- ja  
turvakotien, päihdehuollon lastensuojelu-  
yksiköiden sekä päihdehuollon nuorisoasemien  
osuus kaikista kyselyyn vastanneista oli 15 pro-  
senttia. (Taulukko 1.)

Yli puolet (56 %) kyselyyn vastanneista työ-  
skenteli toimipisteissä, jotka sijaitsivat suurissa, yli  
15000 asukkaan kunnissa, kaupungeissa, keskus-  
toissa tai taajamissa ja palvelivat vain yhden kun-  
nan asukkaita. Keskisuurten, 4000–15 000 asuk-  
kaan, kuntien edustajia vastaajista oli 41 prosent-  
tia ja pienten, alle 4000 asukkaan kuntien kolme  
prosenttia. Suurimman osan palveluista tuottivat  
kunta (31 %) sekä järjestöt (30 %). Myös sää-  
tiöiden osuus (16 %) palveluiden tuottajina oli  
merkittävä. Vastaajien mukaan toimipisteissä  
asioi 11–14891 asiakasta vuonna 2009.

Iltaisin klo 17 jälkeen palveluita tarjosi 60  
prosenttia vastanneista toimipisteistä ja  
viikonloppuisin tasan puolet. Ympäri vuorokauti-  
sia palveluita oli tarjolla lähes puolella (47 %) kyselyyn vastanneista toimipisteistä. Keskisuuris-  
sa, 4000–15 000 asukkaan kunnissa oli pieniä,  
alle 4000 asukkaan kuntia useammin tarjolla ilta,  
viikonloppu- sekä ympärivuorokautisia palvelui-  
ta. Ero ei ollut kuitenkaan tilastollisesti merkitse-  
vä. (Taulukko 1.)

**Taulukko 1.**

Vastaajien (N=132) taustatiedot

| Muuttuja  | n   | %  |
|---|-----|----|
| <i>Sukupuoli</i>  |     |    |
| Nainen  | 101 | 78 |
| Mies  | 28  | 22 |
| <i>Ikä</i>  |     |    |
| 25–39 vuotta  | 21  | 17 |
| 40–59 vuotta  | 91  | 73 |
| yli 60 vuotta   | 12  | 10 |
| <i>Koulutus</i>   |     |    |
| Alempi tai ylempi perusaste tai kes-<br>kiaste                              | 16  | 13 |
| Alin korkeakouluaste  | 23  | 18 |
| Alempi korkeakoulututkinto  | 36  | 28 |
| Ylempi korkeakoulututkinto  | 48  | 38 |
| Tutkijan koulutus   | 4   | 3  |
| <i>Toimiminen esimiestehtävissä</i>   |     |    |
| Kyllä   | 100 | 77 |
| Ei  | 30  | 33 |
| <i>Työkokemus</i>   |     |    |
| 0–10 vuotta   | 87  | 74 |
| 11– 20 vuotta   | 17  | 14 |
| yli 20 vuotta   | 14  | 12 |
| <i>Toimipaikka</i>  |     |    |
| A-klinikka  | 27  | 21 |
| Katkaisuhuitolaitos   | 5   | 4  |
| Päihdehuollon kuntoutus   | 11  | 8  |
| Avomuotoinen päihdekuntoutus  | 19  | 14 |
| Päihdehuollon kuntoutuslaitos   | 19  | 14 |
| Päihdehuollon lastensuojeluyksikkö  | 6   | 5  |
| Päihdehuollon nuorisoasema  | 4   | 3  |
| Mielenterveys- ja päihdepalveluiden<br>yhdistetty yksikkö päihdepalveluissa | 12  | 9  |
| Päihdepsykiatrian yksikkö erikois-<br>sairaanhoidossa                       | 3   | 2  |
| Päihdeäitien ensi- ja turvakoti   | 9   | 7  |
| Vankila   | 11  | 8  |
| Muu   | 6   | 5  |
| <i>Toimipisteen aukioloaika</i>   |     |    |
| Virka-aika, ilta-aika tai viikonloppu                                       | 61  | 47 |
| Ympäri vuorokautisesti  | 70  | 53 |

## VANHEMPIEN OSALLISUUDEN TUKEMINEN PERHEESSÄ

Vastaajien mukaan vanhemman osallisuutta perheessä tuettiin hyvin. (ka 3,5–4,5 ja kh välillä 0,0–0,7). Osallisuutta tuettiin vahvistamalla vanhempien perhe-elämän hallintaan saamista sekä kannustamalla vanhempia avun pyytämiseen silloin kun he sitä tarvitsevat. Myös vanhempien päätöksentekokykyjen vahvistaminen lapseen liittyvissä ongelmatilanteissa nähtiin tärkeänä osallisuutta perheessä vahvistavana asiana. Vastaajista yhdeksän prosenttia oli kuitenkin sitä mieltä, ettei toimipisteessä kyetty tukemaan vanhempien osallisuutta tukemalla vanhemman luottamusta omiin kykyihinsä auttaa lastaan kasvamään ja kehittymään. (Taulukko 2.)

Ensisijaisesti lapsiperheille suunnatuissa päihdepalveluissa, kuten päihdehuollon lastensuojeluyksiköissä, päihteitä käyttäville äideille suunnatuissa ensi- ja turvakodeissa ja päihdehuollon nuorisotasemilla osallisuuden tukeminen perheessä toteutui paremmin kuin muissa toimipisteissä (F=0,44, df=115, p=0,07).

Ympäri vuorokautisesti palveluja tarjoavissa päihdehuollon toimipisteissä (n=70) työntekijöiden mahdollisuudet tukea vanhemman osallisuutta perheessä arvioitiin paremmiksi (ka 4,0, kh 0,6) kuin muissa toimipisteissä (ka 3,8, kh 0,7). Ero oli tilastollisesti melkein merkitsevä (F=1,021, df=115, p=0,07).

Toimipaikan sijainnilla, kuntakoolla tai vastaajaan liittyvillä muuttujilla kuten sukupuolella, iällä, koulutuksella, työkokemuksella tai toimimisella esimiestehtävässä ei havaittu tilastollisesti merkitsevää yhteyttä vanhemman osallisuuden tukemisen toteutumiseen perheen sisällä.

## VANHEMPIEN OSALLISUUDEN TUKEMINEN ASIAKASPALVELUTILANTEESSA

Osallisuutta asiakaspalvelutilanteessa tuettiin kohtuullisesti kaikissa toimipisteissä. Väittämien keskiarvot vaihtelivat välillä 3,30–3,89 (kh 0,83–0,98). Vastaajista 68 prosenttia oli joko osittain tai täysin samaa mieltä siitä, että vanhemman osallisuutta asiakaspalvelutilanteessa voitiin tu-

### Taulukko 2.

Päihdepalvelujen piirissä olevien vanhempien osallisuuden tukeminen perheessä, päihdetyössä toimivien (n=132) arvioimana

| Osallisuus perheessä  | n   | Täysin tai osittain eri mieltä (%) | Ei samaa eikä eri mieltä (%) | Osittain tai täysin samaa mieltä (%) |
|---|-----|------------------------------------|------------------------------|--------------------------------------|
| Tukevat vanhempien luottamusta omiin kykyihinsä auttaa lastaan kasvamaan ja kehittymään           | 120 | 9                                  | 23                           | 68                                   |
| Antavat tietoa vanhemmille siitä, miten menetellä kun lapsen kanssa ilmaantuu ongelmia            | 118 | 7                                  | 21                           | 72                                   |
| Tukevat vanhempia saamaan perhe-elämänsä hallintaan   | 118 | 4                                  | 19                           | 77                                   |
| Rohkaisevat vanhempia hankkimaan tietoa, joka auttaa heitä ymmärtämään lastaan paremmin           | 118 | 5                                  | 24                           | 71                                   |
| Kannustavat vanhempia pyytämään apua muilta silloin, kun he sitä tarvitsevat                      | 117 | 5                                  | 16                           | 79                                   |
| Kannustavat vanhempia oppimaan uusia tapoja tukea lastaan hänen kasvussaan ja kehityksessään      | 118 | 3                                  | 26                           | 71                                   |
| Tukevat vanhempia tunnistamaan /huomioimaan lapsen heikkouksien lisäksi myös lapsen vahvuudet     | 118 | 3                                  | 25                           | 72                                   |
| Pyrkivät vahvistamaan vanhempien kykyä päättää ja toimia lapseensa liittyvissä ongelmatilanteissa | 118 | 3                                  | 24                           | 73                                   |
| Varmistavat että vanhemmat ymmärtävät lapsensa rajoitteet   | 118 | 8                                  | 35                           | 57                                   |
| Tukevat vanhempien uskoa itseensä hyvinä vanhempina   | 119 | 4                                  | 26                           | 70                                   |

kea kannustamalla vanhempaa oma-aloitteiseen palveluihin hakeutumiseen sekä säännölliseen yhteydenpitoon viranomaisten kanssa. Osallisuutta nähtiin tuettavan myös ottamalla huomioon vanhempien mielipide (65 %) ja kertomalla vanhemmille kuinka heidän tulee menetellä mikäli he kokevat saaneensa huonoa palvelua (65 %). Kuitenkin vastaajista 18 prosenttia oli täysin tai osittain eri mieltä siitä, että toimipisteessä työskentelevät työntekijät varmistavat vanhempien hyväksyvän kaikki lapsensa saamat palvelut. Lisäksi 17 prosenttia vastaajista arvioi, etteivät vanhempien ja työntekijöiden mielipiteet ole yhtä tärkeitä päätettäessä lasten asioista päihdetyössä. (Taulukko 3.)

Lapsiperheille suunnatussa päihdepalveluissa kuten päihdehuollon lastensuojeluyksiköissä, paljon päihhteitä käyttävien äitien ensi- ja turvakodeissa ja päihdehuollon nuorisoseamilla vanhemman osallisuuden tukeminen toteutui paremmin

kuin muissa toimipisteissä ( $F=0,15$ ,  $df=109$ ,  $p=0,005$ ).

Tarkasteltaessa toimipisteiden palveluaikoja toimipisteiden välillä ei havaittu tilastollisesti merkitseviä eroja, vaikkakin arviot vanhemman osallisuuden tukemisesta asiakaspalvelutilanteessa olivat myönteisemmät ympärivuorokautisesti toimivissa toimipisteissä (ka 4,0 kh 0,6) kuin virka- ja ilta-aikaan tai viikonloppuisin (ka 3,5 kh 0,7) toimivissa toimipisteissä. Myöskään toimipisteen sijainnilla, kuntakoolla tai vastaajaan liittyvillä taustamuuttujilla ei havaittu tilastollisesti merkitsevää yhteyttä osallisuuden tukemisen toteutumiseen asiakaspalvelutilanteessa.

#### VANHEMPIEN OSALLISUUDEN TUKEMINEN PALVELUJÄRJESTELMÄSSÄ

Osallisuutta palvelujärjestelmässä koettiin tuettavan heikommin kuin perheessä tai asiakaspalvelutilanteessa. Puutteita havaittiin erityisesti työn-

#### Taulukko 3.

Päihdepalvelujen piirissä olevien vanhempien osallisuuden tukeminen asiakaspalvelutilanteessa, päihdetyössä toimivien (n=132) arvioimana

| Osallisuus asiakaspalvelutilanteessa   | n   | Täysin tai osittain eri mieltä (%) | Ei samaa eikä eri mieltä (%) | Osittain tai täysin samaa mieltä (%) |
|--|-----|------------------------------------|------------------------------|--------------------------------------|
| Varmistavat että vanhemmat hyväksyvät kaikki lapsensa saamat palvelut  | 114 | 18                                 | 42                           | 40                                   |
| Kertovat vanhemmille, miten menetellä, jos he kokevat saavansa huonoa palvelua   | 114 | 9                                  | 26                           | 65                                   |
| Ottavat huomioon vanhempien mielipiteet lapsen tarvitsemista palveluista   | 115 | 10                                 | 23                           | 67                                   |
| Vahvistavat vanhempien kykyä päättää lapsensa palvelutarpeesta   | 113 | 12                                 | 31                           | 57                                   |
| Tukevat vanhempien osaamista viranomaisten ja työntekijöiden kanssa asioinnissa, kun päätetään heidän lastensa palveluista | 115 | 6                                  | 29                           | 65                                   |
| Kannustavat vanhempia olemaan säännöllisesti yhteydessä työntekijöihin, jotka tarjoavat palveluja heidän lapselleen        | 114 | 6                                  | 26                           | 68                                   |
| Kun päätetään lasten asioista, vanhempien ja työntekijöiden mielipide on yhtä tärkeä                                       | 115 | 17                                 | 35                           | 48                                   |
| Pyytävät vanhempia antamaan palautetta lapselleen annetuista palveluista   | 114 | 15                                 | 39                           | 46                                   |
| Varmistavat että vanhemmilla on tietoa lapsensa tarvitsemista palveluista  | 114 | 10                                 | 32                           | 57                                   |
| Tukevat vanhempia hakemaan oma-aloitteisesti palveluja lapsilleen ja perheelleen   | 114 | 7                                  | 25                           | 68                                   |
| Varmistavat että vanhemmilla on tietoa kunnassa olevista lasten palveluista  | 114 | 11                                 | 26                           | 63                                   |
| Kysyvät vanhemmilta, mitä palveluita he haluavat lapselleen  | 113 | 12                                 | 32                           | 56                                   |

tekijöiden mahdollisuuksissa varmistaa vanhemman käsitys palvelujärjestelmän toimivuudesta sekä työntekijöiden kyvyissä hyödyntää päihdepalveluissa asioivien vanhempien taitoja ja tietoja palveluiden kehittämisessä. Yli neljännes vastaajista (27 %) oli täysin tai osittain eri mieltä siitä, että työntekijöillä on mahdollisuus tukea vanhemman osallisuutta varmistamalla vanhemman käsitys lasten palvelujärjestelmän toimivuudesta. Myös vanhempien osallistuminen sekä palveluiden kehittämiseen osallistumisen tukeminen oli vastaajien mukaan vähäistä. Heistä 24 prosentin mukaan vanhempien käsityksiä ei hyödynnetä palveluiden kehittämisessä. Merkittävää on, että 13 prosenttia vastaajista oli täysin tai osittain eri mieltä siitä, että osallisuutta voitaisiin tukea hyödyntämällä vanhempien taitoja ja kykyä palveluiden kehittämiseen. Lisäksi 20 prosenttia vastaajista näki, ettei vanhempia tueta käyttämään tietoaan ja kokemuksiaan lasten ja perheiden palveluiden kehittämiseen. (Taulukko 4.)

**Taulukko 4.**

Vanhempien osallisuuden tukeminen palvelujärjestelmässä päihdetyön esimiesten (n=132) arvioimana

| Osallisuus palvelujärjestelmässä  | n   | Täysin tai osittain eri mieltä (%) | Ei samaa eikä eri mieltä (%) | Osittain tai täysin samaa mieltä (%) |
|---|-----|------------------------------------|------------------------------|--------------------------------------|
| Hyödyntävät vanhempien taitoja ja kykyä palveluiden kehittämiseen toimipaikassamme/kunnassamme                                    | 113 | 24                                 | 43                           | 33                                   |
| Kertovat vanhemmille millaisia lainsäädännöllisiä ja muita uudistuksia lapsiperhepalveluiden kehittämiseksi on vireillä           | 114 | 21                                 | 48                           | 31                                   |
| Varmistavat että vanhemmilla on käsitys siitä, miten lasten palvelujärjestelmä toimii   | 114 | 27                                 | 42                           | 31                                   |
| Hyödyntävät vanhempien käsityksiä lasten palveluiden kehittämisessä   | 114 | 24                                 | 40                           | 36                                   |
| Rohkaisevat lasten vanhempia keskinäiseen vuorovaikutukseen toistensa kanssa  | 113 | 13                                 | 32                           | 55                                   |
| Uskovat, että vanhemmat voivat vaikuttaa lasten palveluiden kehittämiseen   | 114 | 13                                 | 38                           | 49                                   |
| Rohkaisevat vanhempia olemaan yhteydessä viranomaisiin ja päättäjiin ja kertomaan mielipiteensä lasten palveluiden kehittämisessä | 113 | 17                                 | 35                           | 48                                   |
| Kertovat vanhemmille toimintatavoista, joilla voi vaikuttaa päättäjiin ja viranomaisiin   | 114 | 23                                 | 40                           | 37                                   |
| Varmistavat, että vanhemmat tietävät mitkä ovat heidän ja lasten oikeudet   | 114 | 12                                 | 33                           | 53                                   |
| Tukevat vanhempia käyttämään tietoaan ja kokemuksiaan lasten ja perheiden palvelujen kehittämisessä                               | 114 | 20                                 | 37                           | 43                                   |

Toimipisteen luonne, sijainti, aukioloaika tai vastaajaan liittyvät taustamuuttujat eivät olleet yhteydessä kokemukseen vanhemman osallisuuden tukemisen toteutumisesta palvelujärjestelmässä.

## POHDINTA

Tämän tutkimuksen tarkoituksena oli kuvata päihdepalvelujen piirissä olevien, alle 9-vuotiaan lapsen vanhemman osallisuuden tukemisen toteutumista päihdepalveluissa toimivien esimiesten arvioimana. Vanhempien osallisuuden tukemista perheessä, asiakaspalvelutilanteessa ja palvelujärjestelmässä mitattiin FES-mittarista (Koren ym. 1992, Vuorenmaa ym. 2012) modifoidun mittariston avulla.

## TULOSTEN TARKASTELU

Tutkimuksessa vanhemman osallisuuden tukemista päihdepalveluissa tarkasteltiin vanhemman osallisuutena perheessä, asiakaspalvelutilanteessa

ja palvelujärjestelmässä. Osallisuuden tukemisella tarkoitettiin konkreettisten vanhemmuuden taitojen tiedollista ja taidollista tukemista arjessa sekä vanhemman saamaa tukea ja rohkaisua hoidolliseen päätöksentekoon, itsemääräämisoikeuteen, palvelujärjestelmän kehittämiseen ja viranomaistoimintaan

Tulosten mukaan päihdepalveluiden piirissä olevan vanhemman osallisuutta kyettiin tukemaan kohtuullisesti. Osallisuuden tukemisen perheessä nähtiin toteutuvan kaikissa päihdetyön toimipisteissä merkitsevästi paremmin kuin asiakaspalvelutilanteessa tai palvelujärjestelmässä, jossa tuki näytti toteutuvan heikoimmin. Myös aiemmin, tutkittaessa vanhempien kokemuksia heidän saamistaan tuesta lasten ja perheiden peruspalveluissa, on havaittu saadun tuen perheen sisällä olleen suurempaa kuin tuki asiakaspalvelutilanteessa tai palvelujärjestelmässä (Perälä ym. 2011).

Lapsiperheille suunnatuissa päihdepalveluissa vanhemman osallisuuden tukeminen toteutui muita toimipisteitä paremmin. Näissä toimipisteissä työntekijöillä arvioitiin olevan paremmat mahdollisuudet ottaa huomioon vanhempien tiedot ja taidot palvelujen käyttäjinä sekä kuulla heidän mielipiteensä ja palautteensa palveluiden suhteen. Heikoimmin vanhemman osallisuutta kyettiin tukemaan vankiloissa ja avomuotoisissa päihdekuntoutuslaitoksissa.

Vankiloiden sekä avomuotoisten päihdekuntoutuslaitosten heikkoja tuloksia selittää osittain toimipisteiden toiminnan luonne. Palvelurakenteen pirstaleisuus, vähäinen yhteistyö ja kuntien niukat resurssit sekä lisääntyvät nimettömästi saavutettavat palvelut vaikeuttavat asiakkaan osallisuuden tukemista, jonka mahdollistavat pidempiaikainen hoitosuhde perheeseen sekä kokonaisvaltainen hoito ja asiakkaan kohtaaminen.

Vankiloiden päihdevalvontaan kuuluvat muun muassa päihhteettömyyden valvonta ja tarkastustoiminta, joka tapahtuu vankilan sisällä. Ulkopuoliseen päihdehoitoon vanki voidaan lähettää vain vankilan päihdekuntoutuksen läpikäynnin jälkeen, mikäli hoidon katsotaan edistävän kuntoutumista. Huumehoidon osalta vieroitus- ja korvaushoito toteutetaan yhteistyössä vangin ja vapauden aikaisen terveydenhuollon kanssa ja vangin osallistuminen päihdekuntoutukseen arvioidaan viranomaisten toimesta. Tutkimustulokset vahvistavat aiempaa tietoa perheen ja lasten institutionaalisesta näkymättömyydestä vankeinhoidon käytännöissä (Enroos 2008). Vaikka perhe on tunnustettu keskeiseksi voima-

varaksi vankilassa ollessa ja yhteiskuntaan sijoittumisessa, on vanhemmuuden tukeminen vankilassaoloaikana edelleen puutteellista.

Taustamuuttujia tarkasteltaessa toimipisteen palveluajoilla havaittiin olevan merkitys vanhemman osallisuuden tukemiseen. Työntekijöiden mahdollisuudet tukea päihdepalvelujen piirissä olevan vanhemman osallisuutta arvioitiin paremmiksi ympärivuorokautisesti palvelevissa toimipisteissä kuin niissä toimipisteissä, joissa palvelu tapahtui virka- ja/ tai iltai- aikaan ja viikonloppuisin. Tulos selittyy osittain toiminnan luonteella ja päihdehuollon toimintakulttuurilla ja vahvistaa aiemman tutkimuksen havaintoja organisaation rajallisten resurssien vaikutuksesta asiakkaan osallisuuteen (Goodwin ja Happell 2008).

Tutkimustulosten mukaan vanhemman osallisuuden tukemisen keskeisimmät kehittämisalueet liittyivät vanhemman itsenäisen päätöksenteon tukemiseen, tietotaidon ja mielipiteiden hyödyntämiseen, palveluiden kehittämiseen ja palautteenantomahdollisuuksiin. Kehitettävää oli myös vanhemman vaikutusmahdollisuuksien lisäämisessä, viranomaistoimintaan vaikuttamisessa ja siihen osallistumiseen rohkaisemisessa. Nämä esiintyvät kehityshaasteina myös aiemmassa osallisuutta koskevassa tutkimuskirjallisuudessa, jossa tärkeänä on pidetty asiakkaan osallisuutta palveluiden suunnitteluun, toteutukseen, johtamiseen ja hallinnointiin (Lammers ja Happell 2003, Toikko 2006, Fischer ja Neale 2008). On todettu, että palveluiden käyttäjillä olevaa kokemusperäistä tietoa tulisi käyttää laajemmin palveluiden kehittämiseen ja niiden laadunvarmistukseen (Lammers ja Happell 2004, Weinstein 2006, Nevalainen 2010). Tämän toteuttamiseksi Poulton (1999) on esittänyt työntekijälähtöisistä menetelmistä luopumista, jotta osallisuus voisi kehittyä konsultoinnista kohti osallistumista ja voimaantumista. Myös ajankohtaisen Kansallinen Mielen-terveys- ja päihdesuunnitelman 2009–2015 mukaan asiakkaan aseman ja osallisuuden vahvistaminen nähdään merkityksellisenä. Mieli 2009 -suunnitelma korostaa palveluiden käyttäjien ottamista mukaan palveluiden suunnitteluun ja arviointiin sekä kansalaisten mahdollisuuksien lisäämistä vaikutettaessa itseä koskeviin ratkaisuihin (Moring 2009, Sosiaali- ja terveysministeriö 2009, Nevalainen 2010).

## PÄÄTELMÄT

Tulosten perusteella voidaan päätellä, että päihdetyössä vanhemman osallisuuden tukemisen toi-

votaan olevan konkreettista vanhemmuuden taitojen vahvistamista, riittävän ja ymmärrettävän tiedon ja tuen antamista, lapsen kasvuolojen turvaamista ja vanhemman omien voimavarojen lisäämistä. Lisäksi sen toivotaan olevan vanhemman vaikuttamisen mahdollisuuksien lisäämistä asiakaspalvelutilanteissa sekä laajemmin palvelujärjestelmässä.

Päihdehuollossa vanhemman osallisuutta voidaan tukea palvelurakenteilla, joiden toiminta rakentuu asiakkaan ja hoitavan henkilöstön väliselle kumppanuudelle. Asiakaspalvelutilanteissa erityistä huomiota tulee kiinnittää vanhemman kykyyn ja mahdollisuuksiin osallistua omaan hoitoonsa, riittävään tiedonsaantiin sekä vanhempien palautteenantomahdollisuuksiin.

Tulokset tuovat uutta tietoa vanhemman osallisuuden tukemisen toteutumisesta päihdetyössä. Saatuja tuloksia ei voida yleistää, mutta niitä voidaan hyödyntää kehitettäessä lapsiperheiden kanssa tehtävää päihdetyötä, koulutusta, käytäntöjä ja johtamista. Tutkimustulokset ovat myös yhteiskunnallisesti merkityksellisiä, sillä päihdeongelmat ja päihdeiden käyttöön liittyvät laajalaiset sosiaaliset ongelmat ovat merkittävä kansantaloudellinen ja -terveydellinen haaste, johon palvelujärjestelmässä tulisi voida puuttua entistä tehokkaammin ja varhaisemmassa vaiheessa.

Tulosten pohjalta jatkotutkimusehdotuksina esitetään vanhemman osallisuuden tukemisen toteutumisen tutkimista asiakkaana olevan, paljon päihdeitä käyttävän vanhemman näkökulmasta, mutta myös perheen ja lasten näkökulmia tarkastellen. Myös vanhemman osallisuutta edistävien työmenetelmien kehittäminen sekä niiden vaikuttavuuden arviointi ovat merkityksellisiä, monitieteisiä tutkimushaasteita tulevaisuudessa.

#### TUTKIMUKSEN LUOTETTAVUUDEN TARKASTELU

Tutkimuksen luotettavuuden arviointi kohdistui tutkimusprosessin luotettavuuteen, erityisesti ai-

neiston keräämiseen sekä käytetyn mittarin luotettavuuteen ja siitä saatujen tulosten analysointiin. (Metsämuuronen 2007). Työntekijöille modifioitun FES-mittarin (Koren ym. 1992, Vuoremaa ym. 2013) käyttöä puolsi kansallisissa tutkimuksissa testattu validiteetti sekä sen antamat mahdollisuudet.

Tutkimuksen luotettavuutta heikentäviä tekijöitä ovat aineiston keruuseen liittyvät ongelmat, matala vastausosuus (36 %) sekä kyselylomakkeen pituus ja FES-mittarin aikaisempi käyttämättömyys vastaavanlaisissa kontekstissa. Saatujen tulosten luotettavuutta heikentää myös otoskokojen vaihtuvuus, joka johtuu palautuneiden lomakkeiden osittaisesta vajavaisesta täytöstä.

Aineiston keruuseen liittyvät ongelmat liittyivät osoiterekisterin luomisen sekä yhdenmukaisten taustatietojen saamisen ongelmiin, jotka osaltaan estivät kattavan katoanalyysin suorittamisen. Ongelmia havaittiin muun muassa ajantasaisten osoitetietojen saamisessa, toiminnan olemassa olon ja luonteen selvittämisessä sekä kyselyn kohdistamisessa palvelusta vastaavalle esimiehelle. Matalaan vastausosuuteen sekä lomakkeiden vajavaiseen täyttöön saattoivat vaikuttaa kyselylomakkeen pituus (Burns ja Grove 2005), kyselyn ajoittuminen vuodenvaihteeseen sekä mahdollisesti esimiesten riittämätön asiakastyön tuntemus. Lomakkeiden vajaan täyttöön voidaan hakea syytä myös sen sopimattomuudesta kyseisen toimipisteen toiminnan luonteelle. Saatuja tuloksia ei voida näin ollen yleistää koskemaan kaikkea Suomessa toimivaa päihdehuoltoa. Tulokset antavat kuitenkin viitteitä vanhemman osallisuuden tukemisen toteutumisesta päihdehuollossa ja näin tukevat aiempaa näyttöä asiakkaan osallisuudesta sosiaali- ja terveydenhuollon asiakaspalvelutilanteissa ja palvelujärjestelmässä (Mattila-Aalto 2009, Laitila 2010, 2012).

Kerppola J, Halme N, Pietilä A-M, Perälä M-L. Parents as clients of substance abuse services: supporting parent involvement  
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In promoting the health and wellbeing of families with children, reinforcing parental empowerment and the parents' right to participate in everyday life and to be heard are key principles guiding services and operation. There are, however, still deficiencies in the actual realization of parental

empowerment, especially when it comes to socially excluded groups such as substance abusers. This study aims to depict how parents' involvement is supported from the perspective of those working in managerial positions in the substance abuse services. This was assessed by a Family Em-

powerment Scale modified for the employees. The data were collected from those working in managerial positions within substance abuse services (n=372). The response rate was 36 percent. Differences between various employee groups were analysed using independent samples' t-tests and one-way analyses of variance.

According to the study, the implementation of support for parental empowerment was moder-

ately successful in all studied units. There is still room for improvement especially in families' access to information, the ability to give feedback, the relationship between the family and the attending staff and in increasing parents' abilities to influence on social issues in municipalities. The nature of a specific office and its service profile affected the employees' possibilities to reinforce parent empowerment.

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## **ARTICLE II**

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## Original Article

# Do Co-Operative Working Practices and Empowerment in Management Support Employees in Family Services to Reinforce Parental Empowerment?

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## Abstract

**Background:** Reinforcement of parental empowerment is a guiding principle in family services. It is shown that more empowered employees are more likely to empower their clients, which, in turn, produces better service system outcomes.

**Objective:** This study examined how employees reinforce parental empowerment, and how co-operative working practices in family services and empowerment in management support employees in empowering parents.

**Methods:** The study was conducted using a cross-sectional survey design. Data were gathered using postal surveys from employees working in health care, social welfare and education settings. In total, 457 employees responded.

**Results:** Employees reinforced parental empowerment rather well. We found a positive relationship between co-operative working practices, empowerment in management and employees possibilities to reinforce parents' empowerment in their work.

**Conclusions:** Empowerment in management and co-operative working practices, like well-functioning cooperation and employee awareness of available services, are key elements for supporting employees to reinforce parental empowerment.

**Keywords:** parental empowerment, co-operative working practice, empowerment in management

## Introduction

The concept of empowerment has been studied since 1980. It manifests as attitudes, knowledge, feelings, and behaviour (Koren, DeChillo & Friesen 1992) varies with the individual, context, and time. Empowering is a core value in family services. It is a collaborative process, by which families access knowledge, skills and resources that enable them to gain positive control over

their lives. It can promote the participation of people and communities to towards goals of increased individual and community control and improve quality of life. (Wallerstein 2006.)

Reinforced empowerment improves parents' self-efficacy (Wakimizu et al. 2011) and welfare (Benson & Kersh 2011), and migrates stress levels (Nachshen & Minnes 2005) depressive symptoms (Martinez et al.

2009). It also improves family cohesion, relations, and function (Scheel & Rieckmann 1998), and helps parents develop the ability to make healthy choices (Koelen & Lindström 2005), solve problems in the family (Farber & Maharaj 2005), and take better care of their children's health (Martinez et al. 2009). It seems to be better among highly-educated women (Singh et al. 1997), in families with fewer children (Wakimizu et al. 2011), and in families participating in peer support groups (Banach et al. 2010). Various factors, including age, quality of life, socioeconomic status, or illness affect parents' ability to become empowered via family services (Law et al. 2011).

By reinforcing empowerment, we are able to increase equality and social justice. (Wallerstein 2006.) Strategies for empowering are diverse. It is shown that management, culture and professional advocacy are all associated with it. Also, equal relationship, advocacy, a focus on strengths, support of active participation and decision-making, provision of information, and skill development are all relevant and connected. (Cawley & McNamara 2011)

Co-operative working practices and empowering in management in health and social services has been linked to client empowerment. Organisational factors such as working culture (Axelsson & Axelsson 2007), trust and client awareness of services and other professionals (Axelsson & Axelsson 2009) seems to produce better client empowerment. Furthermore, it is shown that more empowered employees are more likely to empower their clients, which, in turn, produces better service system outcomes and societal health (Lanchinger et al. 2010, Cawley & McNamara 2011).

Thus, reinforcement of parental empowerment, co-operative working practices, and empowerment in management have been studied quite extensively, yet to our knowledge, no studies have examined how these things are related to each other, or whether they are. All this is essential, given that reinforcement of parental empowerment is the core value in family services (World Health Organization 1986, 2005, European

Union 2007, Ministry of Social Affairs & Health 2010).

Co-operative working practices help employees to work together toward a common goal or aim. In this study, this means that employees are aware of other's services, the cooperation functions well between services and there are shared co-operation practices. (Kanste et al. 2013.)

Empowerment in management can be understood as a process that, if employees are given information, resources and opportunity, they will be more empowered to empower parents. That includes employee's opportunities to make decisions at work and to get supervisory support. (Ugboro & Obeng 2000, Räikkönen et al. 2007.)

In Finland, substantial developments in the family services have occurred over the last decade. For example, extensive health examinations in prenatal and child health care clinics and school health care have been statutory since the year 2011. The aims have been to reinforce family empowerment and to ensure well-functioning cooperation between all service providers (Vuorenkoski, Mladovsky & Mossialos 2008).

To achieve these aims we examined:

1. How do employees in family services reinforce parental empowerment within a) the family, b) the service situation, and c) the service system?
2. How are a) co-operative working practices (awareness of services, functionality of cooperation, shared cooperation practices) and b) empowerment in management (opportunities to make decisions at work, supervisory support, fairness of treatment) related to reinforcing parental empowerment?

## Methodology

### Design

The study was conducted using a cross-sectional survey design. Previously developed scales (Karasek & Theorell 1990; Moorman 1991; Räikkönen, Perälä & Kahanpää 2007; Vuorenmaa et al. 2014) as well as scales developed for this study were used. (Table 1.).

Reinforcement of parental empowerment was measured by the personnel version of the Family Empowerment Scale (FES) (Vuorenmaa et al. 2014) which had three subscales and 32 items (10 on family, 12 on the service situation, and 10 on the service system). The 10 items on the family subscale refer to how employees reinforce parents' ability to manage everyday life with their children. For example: *"Service personnel inform parents of the procedures implemented when a problem occurs with their child."* The 12 items on the service situation subscale refer to how employees reinforce parents' ability to obtain and influence the services required for their own child's needs from the service system, for example: *"The employees ensure that parents have information about the services their child needs access to."* The 10 items on the service system subscale refer to how employees reinforce parent's advocacy for improving services for children in general. For example: *"The employees ensure that parents have a clear understanding of how social services function in relation to their child"*. Measurement is based on the original FES -scale of Koren et al. (1992), which measures parents' own sense of empowerment within the family, service system, and community.

*Co-operative working practices* were evaluated with three separate scales developed for this study. The 18-point *Awareness of service* scale was used to assess the employees' awareness of the services available to families. Such services included: psychological support or special education services, parish or charity services, private sector services, and various forms of financial support such as income support or disability allowance.

The *Functionality of cooperation* scale was used to assess cooperation between service providers, including the flow of information during the 12 months prior to the survey. This scale covered a total of 31 different service providers, 15 from education or social settings (teachers, social workers, day care workers), and 16 from health care settings (nurses, doctors, dentists or physiotherapists).

A 30-item tool consisting of six statements was used to obtain information on *Concurrent cooperation practices* from employees. The six statements within the measure evaluated written agreements of shared goals and joint practices, commitments to common goals, information flow, and agreements on joint monitoring and evaluation. We evaluated cooperation occurring within sectors, between sectors, between municipalities, and with third sector and private providers.'

Empowerment in management contains three subscales. *Opportunities for employees to make decisions about their work* were evaluated by Karasek and Theorell's (1990) Job Content Questionnaires. Six items assess the employees opportunities to make decisions about their work, work tasks and procedures, pace, established working methods, division of labour, as well as the procurement of any tools and learning materials needed in their workplace.

*Support received from managers* was evaluated with the 12-item Supervisory Support scale (Räikkönen, Perälä & Kahanpää 2007), which is divided into empowering or competence-improving support. Empowering support, such as the opportunity to develop, receive feedback and be evaluated, or to make an impact on decision-making processes affecting the workplace, was evaluated by six items. Competence in consolidating support, such as the opportunity to enter training, stay in touch with new techniques and working practices, participate in performance reviews, receive support relating to professional development and education, and the opportunity to take part in job rotations and mentoring, was assessed by seven items.

*Fairness of the treatment* (Moorman 1991) was examined with regards to the employee-manager relationship. The employees' perceptions of treatment by and interactions with their managers, including their opinions of whether the relationship was equal, honest, and open, was assessed via seven items. Item, *"My line manager includes subordinates in decision-making processes"* was added to Moorman's original set of six and worked well in the present study.

The background variables included employee age, education level, and managerial position, as well as working sector, workplace location, and amount of population in the municipality. (Table 2).

### Data collection

Data were gathered with a postal survey that was sent to Finnish municipalities (n=332) in 2009. In Finland, municipalities are obliged to provide health, social, and education services for families either independently, jointly with others, or by purchasing services from other service providers (Vuorenkoski, Mladovsky & Mossialos 2008, European Commission 2011).

In each municipality the survey was sent to five units: prenatal and child health care clinics, school health care, day care, pre-schools, and primary schools. In municipalities with more than 4,000 inhabitants (n=209), the survey was sent to all five operational service units (n=1,045). In municipalities with fewer than 4,000 inhabitants (n=123), 35 of each type of service unit were randomly selected to participate. A total of 1,220 surveys were sent to participating units. A total of 457 employee returned fully completed surveys. The response rate was 37%.

### Data analysis

The data were analyzed and processed statistically using the SPSS (statistical software package) for Windows 21.0 program and described using frequency and percentage distributions. Means and standard deviations were used to characterise the participants and summarise the data. Sum variables were formed according to the theoretical categories. The reliability of sum variables was measured by Cronbach's  $\alpha$  coefficient (Table 1). Comparisons of groups were made using the one-way analysis of variance or the independent samples t-test.

The associations between reinforcement of parental empowerment, co-operative working practices and empowering management were estimated by multiple linear regression (MLR). All the predictive variables used in the MLR were continuous. The assumption of no multicollinearity was verified before performing the MLR.

Variables were entered into the MLR if the results from the previous phase (Table 4) indicated that there were statistically significant associations between the variable in question and reinforcement of parental empowerment.

The results are reported here in terms of the effect size, the largest of which was Cohen's  $d$  value, which is achieved when the mean differential is standardised to the standard deviation of the comparison groups. The effect size is deemed to be great if Cohen's  $d=0.8-2.0$ , average if Cohen's  $d=0.5-0.7$ , and small if Cohen's  $d>0.2$ . (Cohen 1988)

The level of statistical significance was set at  $p<0.05$  in all of the analyses. The range of preference for Cronbach's alpha values was between 0.70 and 0.90. (Nunnally 1994) (Table 1.)

The study was part of a larger research project for which the appropriate sample sizes were calculated with a power analysis. The desired effect size, significance, and power of the data set were pre-determined. After calculating the differences in mean values, we determined a summed score of 0.5 for the effect size, which in practical terms can be considered to be the differential in the implementation of reinforcing parental empowerment. The effect size was converted into a standardized, non-metric independent variable by dividing the aforementioned term in half. The actual effect size was 0.8, which corresponds to a large effect. A power analysis was conducted for the t-tests. A 95% confidence interval ( $\alpha=0.05$ ) was accepted for the study, along with the generally accepted power of 80%, which corresponds to 20% probability with false negatives. Accordingly, in order to achieve 80% power, a 95% confidence interval was required for a sample size of 23 groups (Faul et al. 2007). (G\*POWER) The power analysis showed that the data was adequate relative to the methods of analysis.

### Ethical considerations

Ethical approval was obtained from the ethics committee of the National Institute of Health and Welfare. The surveys were accompanied by a covering letter that explained the purpose of the research project.

Participation was voluntary and confidentiality was guaranteed. A completed and returned survey was interpreted as an indication of consent to participate in the research.

## Results

### *Participants*

A total of 457 employees responded. Their average age was 48 years ( $SD = 8.37$ ). Ninety- three percent were women. Lengths of experience in their current work position ranged from 0.8–40 years ( $SD = 9.41$  years). A little over half (52%) had completed a lower university level. Half of them worked in health care settings as prenatal and child health care clinics or in school health care, and half in social and educational settings in day care, pre -schools and primary schools or as social workers. The majority (71%) worked in municipalities with fewer than 15,000 inhabitants. (Table 2.)

### *Reinforcing parental empowerment*

According to the family subscale, empowerment was reinforced by encouraging parents to request assistance when it was needed. Almost half (48%) believed that the services function well in this respect. Furthermore, 42% of employees thought that parents were informed on how to proceed if problems with their child occurred. Moreover, 40% agreed that parents were encouraged to trust their own abilities to help their child grow and develop. However, only 22% agreed that parents were supported in gaining control of their family life.

On the service situation subscale, 40% of employees encouraged parents to contact the service providers regularly. Approximately one third (30%) of employees thought that the opinions of parents and professionals are equally important when deciding on matters concerning children. Conversely, only 18% considered that parents approve all services provided for their child. Furthermore, only 17% told parents how to proceed if they felt they had received poor service. And only 19% asked parents about the kinds of services they wanted for their child.

On the service system subscale, 18% of employees encouraged parents to interact with and support each other, and 17% encouraged parents to interact with and support the authorities. Conversely, only 5% agreed that parents' ideas were used in developing services for children, or that parents have an understanding of how the service system works for children.

Parental empowerment was reinforced most in health care, and less in social welfare or education settings. Employees who were older, less well educated, and who were not working in a managerial position thought that they reinforced parental empowerment slightly better. (Table 2).

### *Co-operative working practice and parental empowerment*

Employees from all sectors demonstrated a reasonable awareness of services. They were most aware of special education (83%), family counselling (79%), and child protection (76%) services, least aware of services provided by the third sector, and also unfamiliar with income support and disability allowance. Employees who knew family services well reinforced better parental empowerment within the family, the service situation and the service system. (Table 3).

School health care services (91%) demonstrated the best functionality of cooperation with other services. Pre-school teachers (90%), primary school teachers (87%), public health nurses in child health clinics (88%), and antenatal clinics (81%) also demonstrated good functionality of cooperation. Cooperation with psychiatric and mental health care services was poor, suggesting respondents' perceptions of this to be a critical issue. Good cooperation was connected to better reinforcement of parental empowerment in all sectors and subscales (Table 3).

Shared cooperation practices were better implemented within sectors than between sectors, or between sectors and municipalities, or the third and private sectors. Within sectors, nearly half (43%) agreed that cooperation practices include written common goals and concurrent

working practices (45%), and almost half of them (46%) were committed to common goals. Between sectors, only 16% had written common goals and 14% had concurrent working practices. Furthermore, less than 5% of all of them had concurrent working practices with the third or private sectors, as well as in any cooperation between municipalities. Written agreements on shared goals, joint practices and commitments to common goals were all connected to better reinforcement of parental empowerment in service situations and service system subscales. (Table 3.)

Flow of information and agreement on monitoring and evaluating were both deemed to be satisfactory by respondents. Only 2% viewed the flow of information within the third and private sectors as good. Agreements on monitoring and evaluation was connected to reinforced empowerment on the service situation subscale (Table 3)

#### *Empowerment in management and parental empowerment*

Employees received good support from managers. A majority of employees (83%) thought that their managers respected their rights and treated them fairly. Fifty-five percent of employees believed that they had at least good opportunities to make decisions about their work, and more than half (52 %) that there were, at least, good opportunities to influence decisions pertaining to their work activities. Furthermore, 62% thought that they received information about new practices, and 70% rated their opportunities to take part in employee performance reviews as at least good. However, 24% of employees had no possibilities to participate in supervision of work, and 19% thought that opportunities to participate in job rotations were poor (Table 3).

The employee's capacity to reinforce parental empowerment was better when their managers respected their rights and treated them fairly. (Table 2)

#### *Associations between reinforcement of parental empowerment, co-operative working practices and empowerment in management*

In the MLR, statistically significant factors were employee awareness of family services, sector commitment to common goals, and fairness of treatment. These variables explained 9%, 11%, and 11% of the variance in reinforcement of parental empowerment, respectively (Table 4).

#### **Discussion**

Employees' ability to reinforce parents' empowerment was estimated to be rather good in all family services. The reinforcement of parental empowerment was better within the service situation than within the family and the service system. As in previous studies (Wakimizu et al. 2011), we found that parents participate poorly in decision making in and planning family services.

Employees do not inform parents sufficiently of how to proceed, when they received poor service. These deficiencies may be due to the fact that there is still heterogeneity in the services, discrepancies in service availability, and a lack of cooperation between service providers. Despite this, the importance of the need to allow parents to decide on the services affecting their children has been clearly demonstrated. Honest, coherent information about the different care and treatment options, as well as bilateral openness, are desirable in existing service situations. (Widmak et al. 2011.)

Employees reinforced parent's empowerment better in health care settings and in larger municipalities, where services may more easily be accessed. Younger and more highly educated employees and those working in managerial positions assessed their reinforcement as poorer than older and less-educated employees. Younger and more highly educated employees may have greater expectations and demands for empowering parents. Moreover, those in managerial positions are more likely to receive negative feedback about clients being poorly treated.

Co-operative working practices including awareness of services, cooperation and flow of information were deemed to be rather good. Concurrent cooperation practices were better implemented within sectors where they worked, where nearly half of

respondents agreed that cooperation practices include written common goals and shared working practices, and that employees were committed to common goals. All this is essential, and needs to be noticed, given that reinforcing parental empowerment seems to be connected with the awareness of all service available and the possibility of participating in peer support groups (Banach et al. 2010).

Also, empowerment in management and fairness of treatment was estimated to be good, which confirms the view that more supported employees are more likely to empower their clients. (Lanchinger et al. 2010; Cawley & McNamara 2011) They also prove that more attention should be paid to organizational justice in the workplace. All employees in patient care should be involved in generating shared goals and practicing moral principles (Storch & Kenny, 2007).

Findings show that reinforcing parental empowerment demands the ongoing involvement of all service providers and even more involvement by management, who have a responsibility for employees' abilities and well-being. (Kerber et al. 2007, Koren, DeChillo & Friesen 1992, Vuorenmaa et al. 2014).

### Limitations

The survey was conducted in municipalities across all of mainland Finland. All measures used were suitable for studying family services in municipalities (Kausto, Elovainio & Elo 2003, Toljamo & Perälä 2008).

This study has some limitations. First, the response rate was relatively low. However, all sectors and municipalities of various sizes responded. Second, the coefficient of determination was also low, which confirmed that reinforcement of parental empowerment is a process that is related to both organizational factors and empowerment of employees. As a result of these limitations, our findings cannot be generalised. However, they can be used in education, practice and research.

### Conclusions and implication for practice

The results of this study suggest that

1) Reinforcement of parental empowerment is part of safeguarding everyday parenting skills in a real and concrete manner. Special attention should be given to the provision of information to parents, as well as to their opportunities to participate in an empowered way. Reinforcement of parental empowerment can be consolidated by valuing experience-based expertise and using it to develop family services.

2) Cooperation with other services, employee awareness of services and common goals within sectors are required in order to reinforce parental empowerment. Services must be produced in a client-centred manner, with the client becoming an active subject rather than simply an object of health care. This can more certainly be achieved with integrated working practices, monitoring, and evaluation. Special attention should be given to organisational borders and the awareness of the third sector organisations. Moreover, improved awareness of various social benefits and financial support helps parents receive the assistance they require and better reinforces parental empowerment overall.

3) Empowerment in management can improve an employee's ability to reinforce parental empowerment. Strengthening and consolidating the expertise and resources of employees creates the necessary prerequisites for the reinforcement of parental empowerment and the implementation of multi-professional and client-centred services.

Further research is needed on interventions that promote parental empowerment from the perspectives of children and young adults as well as parents. Appropriate working methods and their effective evaluation also require further development. A more effective consideration of issues relating to inequality in health care is key for future research on parental empowerment.

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Table 1. The internal reliability of the sum score and mean variables expressed as a Cronbach's alpha formula

| Study variables                            | No. of items | Range <sup>†</sup> | Alpha | Mean (SD) | Q <sup>1</sup> | Q <sup>3</sup> |
|--|--------------|--------------------|-------|-----------|----------------|----------------|
| <b>Reinforcing parental empowerment</b>    |              |                    |       |           |                |                |
| in the family                              | 10           | 1–5                | 0.94  | 4.2 (0.6) | 3.8            | 4.6            |
| in the service situation                   | 12           | 1–5                | 0.92  | 3.9 (0.6) | 3.5            | 4.3            |
| in the service system                      | 10           | 1–5                | 0.93  | 3.4 (0.7) | 3.0            | 3.9            |
| <b>Co-operative working practice</b>       |              |                    |       |           |                |                |
| Employee awareness of services             | 18           | 1–5                | 0.89  | 3.6 (0.6) | 3.2            | 3.8            |
| Functionality of cooperation               |              |                    |       |           |                |                |
| with health care services                  | 16           | 1–5                | 0.94  | 3.8 (0.8) | 3.4            | 4.4            |
| with social welfare and education services | 15           | 1–5                | 0.91  | 3.9 (0.6) | 3.5            | 4.3            |
| Shared cooperation practices               |              |                    |       |           |                |                |
| Agreement on shared goals                  | 5            | 1–5                | 0.81  | 3.1 (0.9) | 2.4            | 3.7            |
| Agreement on joint practices               | 5            | 1–5                | 0.82  | 3.1 (0.9) | 2.5            | 3.7            |
| Commitment to common goals                 | 5            | 1–5                | 0.81  | 3.4 (0.8) | 3.0            | 4.0            |
| Flow of information                        | 5            | 1–5                | 0.80  | 3.1 (0.8) | 2.6            | 3.6            |
| Agreement on monitoring and evaluation     | 5            | 1–5                | 0.88  | 2.9 (1.0) | 2.4            | 3.6            |
| <b>Empowerment in management</b>           |              |                    |       |           |                |                |
| Opportunity to make decision at work       | 6            | 1–5                | 0.79  | 3.9 (0.7) | 3.3            | 4.3            |
| Supervisory support                        | 12           | 1–5                | 0.82  | 3.5 (0.6) | 3.2            | 4.0            |
| Fairness of treatment                      | 7            | 1–5                | 0.93  | 4.0 (0.9) | 3.4            | 4.7            |

<sup>†</sup> 1=very poor or strongly disagree, 5=very good or strongly agree

Table 2. Employees' background factors and reinforcing the parental empowerment (N=457)

| Reinforcing the empowerment of parents    |        |           |        |                  |       |                   |        |              |       |                |        |                  |
|---|--------|-----------|--------|------------------|-------|-------------------|--------|--------------|-------|----------------|--------|------------------|
| Background factors                        | % n    | Family    |        |                  |       | Service situation |        |              |       | Service system |        |                  |
|   |        | Mean (SD) | t      | p                | d     | Mean (SD)         | t      | p            | d     | Mean (SD)      | t      | p                |
| Age                                       |        |           | 0.611  | 0.542            | 0.06  |                   | 0.56   | 0.955        | 0.005 |                | -2.457 | 0.014            |
| 50 years or less                          | 50 220 | 4.2 (0.6) |        |                  |       | 3.9 (0.6)         |        |              |       | 3.3 (0.7)      |        |                  |
| More than 50 years                        | 50 223 | 4.1 (0.7) |        |                  |       | 3.9 (0.7)         |        |              |       | 3.5 (0.8)      |        |                  |
| Educational level                         |        |           | -2.308 | <b>0.021</b>     | 0.225 |                   | -1.794 | 0.074        | 0.177 |                | -2.634 | <b>0.009</b>     |
| Lower university level or more            | 52 233 | 4.1 (0.7) |        |                  |       | 3.8 (0.7)         |        |              |       | 3.3 (0.7)      |        | 0.258            |
| Vocational school or less                 | 48 212 | 4.2 (0.6) |        |                  |       | 3.9 (0.6)         |        |              |       | 3.5 (0.7)      |        |                  |
| Working in front-line managerial position |        |           | 3.040  | <b>0.003</b>     | 0.304 |                   | 2.127  | <b>0.034</b> | 0.215 |                | 2.900  | <b>0.004</b>     |
| Yes                                       | 37 165 | 4.0 (0.6) |        |                  |       | 3.8 (0.6)         |        |              |       | 3.3 (0.7)      |        | 0.290            |
| No  | 63 283 | 4.2 (0.6) |        |                  |       | 3.9 (0.6)         |        |              |       | 3.5 (0.7)      |        |                  |
| Sector                                    |        |           | 5.026  | <b>&lt;0.001</b> | 0.490 |                   | 3.153  | <b>0.002</b> | 0.313 |                | 4.283  | <b>&lt;0.001</b> |
| Health care                               | 50 228 | 4.3 (0.6) |        |                  |       | 4.0 (0.6)         |        |              |       | 3.5 (0.7)      |        | 0.421            |
| Social welfare and education services     | 50 226 | 4.0 (0.7) |        |                  |       | 3.8 (0.6)         |        |              |       | 3.2 (0.7)      |        |                  |
| Location of workplace                     |        |           | 1.015  | 0.311            | 0.099 |                   | 0.949  | 0.343        | 0.093 |                | 0.831  | 0.406            |
| Urban                                     | 49 222 | 4.2 (0.6) |        |                  |       | 3.9 (0.6)         |        |              |       | 3.3 (0.7)      |        | 0.081            |
| Rural                                     | 51 231 | 4.1 (0.7) |        |                  |       | 3.8 (0.7)         |        |              |       | 3.4 (0.7)      |        |                  |
| Amount of population in the municipality  |        |           | -1.988 | 0.048            | 0.211 |                   | -1.499 | 0.135        | 0.162 |                | 0.737  | 0.462            |
| 15 000 inhabitants or less                | 71 319 | 4.1 (0.6) |        |                  |       | 3.8 (0.6)         |        |              |       | 3.4 (0.7)      |        | 0.079            |
| More than 15 000 inhabitants              | 29 131 | 4.2 (0.6) |        |                  |       | 3.9 (0.6)         |        |              |       | 3.3 (0.7)      |        |                  |





**Table 4. Integrated working practices and support of management as predictors of reinforcing the empowerment of parents**

|  | Family       |       |              |      | Service situation |              |       |              | Service system |                |              |       |                  |
|--|--------------|-------|--------------|------|-------------------|--------------|-------|--------------|----------------|----------------|--------------|-------|------------------|
|  | $\beta$ (SE) | t     | p            | R    | R <sup>2</sup>    | $\beta$ (SE) | t     | p            | R              | R <sup>2</sup> | $\beta$ (SE) | t     | p                |
| <b>Integrated working practice</b>         |              |       |              | 0.29 | 0.09              |              |       |              | 0.33           | 0.11           |              |       |                  |
| Employee awareness of services             | 0.17 (0.06)  | 3.08  | <b>0.002</b> |      |                   | 0.18 (0.06)  | 3.22  | <b>0.001</b> |                |                | 0.21 (0.07)  | 3.82  | <b>&lt;0.001</b> |
| <b>Functionality of cooperation</b>        |              |       |              |      |                   |              |       |              |                |                |              |       |                  |
| with health care services                  | 0.13 (0.07)  | 1.97  | 0.050        |      |                   | 0.06 (0.07)  | 0.89  | 0.377        |                |                | 0.04 (0.08)  | 0.59  | 0.557            |
| with social welfare and education services | -0.09 (0.07) | -1.39 | 0.167        |      |                   | 0.03 (0.07)  | 0.47  | 0.639        |                |                | 0.07 (0.08)  | 1.03  | 0.305            |
| <b>Concurrent cooperation practices</b>    |              |       |              |      |                   |              |       |              |                |                |              |       |                  |
| Agreement on shared goals                  | -            | -     | -            |      |                   | -0.02 (0.05) | -0.23 | 0.819        |                |                | 0.03 (0.06)  | 0.43  | 0.665            |
| Agreement on joint practices               | -            | -     | -            |      |                   | 0.01 (0.06)  | 0.17  | 0.865        |                |                | 0.00 (0.06)  | 0.03  | 0.976            |
| Commitment to common goals                 | 0.13 (0.05)  | 2.50  | <b>0.013</b> |      |                   | 0.15 (0.06)  | 2.04  | <b>0.042</b> |                |                | 0.14 (0.06)  | 2.07  | <b>0.043</b>     |
| Flow of information                        | -            | -     | -            |      |                   | -            | -     | -            |                |                | -            | -     | -                |
| Agreement on monitoring and evaluation     | -            | -     | -            |      |                   | 0.05 (0.05)  | 0.73  | 0.468        |                |                | -            | -     | -                |
| <b>Support of management</b>               |              |       |              |      |                   |              |       |              |                |                |              |       |                  |
| Fairness of treatment                      | 0.10 (0.04)  | 1.78  | 0.076        |      |                   | 0.05 (0.04)  | 0.96  | 0.338        |                |                | -0.02 (0.05) | -0.37 | 0.710            |

### **ARTICLE III**

Kerppola J, Halme N, Perälä ML and Pietilä AM. Parental empowerment – lesbian, gay, bisexual, trans or queer parents' perceptions of maternity and child healthcare settings. *International Journal of Nursing Practice*, 25 (5): e12755, 2019.



# Parental empowerment—Lesbian, gay, bisexual, trans or queer parents' perceptions of maternity and child healthcare

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## Abstract

**Aim:** Describe empowerment in maternity and child healthcare from the perspective of self-identified lesbian, gay, bisexual, trans, or queer (LGBTQ) parents in Finland.

**Background:** Parental empowerment is a core aspect of maternity and child healthcare. However, knowledge about LGBTQ parents' perceptions about empowerment is still lacking.

**Method:** Qualitative design, 22 parents participating. The interviews were conducted in between July and September 2016 and analysed using inductive content analysis.

**Findings:** Three core categories emerged as follows: (a) recognition and acknowledgment, particularly being treated as a parent, irrespective of any biological or legal ties to a child; (b) cooperation and interaction, such as working together, respecting parents' autonomy, and supporting parents' full involvement; (c) equitable care, such as parents' trust in services, but also a health-care professional's knowledge of a family's special needs.

**Conclusion:** Empowerment was perceived as the parents' sense of being visible and recognized as a parent. This recognition requires education and structures that are inclusive of all families. In addition, the language used by professionals was a key indicator for promoting positive feelings of comfort and safety for all families.

## KEYWORDS

parental empowerment, maternity and child health-care services, LGBTQ parents, family nursing

## SUMMARY STATEMENT

What is already known about this topic?

- Parental empowerment plays an essential role in enhancing the well-being of all families.
- It is a collaborative process, through which parents access knowledge, skills, and resources that enable them to gain positive control over their lives and those of their children.

- How parents appraise their own ability and confidence to manage their children positively impacts their children's services and their growth environment.

What this paper adds?

- Lesbian, gay, bisexual, trans, or queer (LGBTQ) parent empowerment is related to gender and recognition of the parental role and its acknowledgement in health-care services.

- Inclusive language and professional knowledge about LGBTQ parenting issues are key factors for positive parental empowerment.
- A lack of acknowledgement of poor past experiences or concerns related to discrimination in healthcare requires skills to successfully negotiate the heteronormative health-care system, and that lack may affect parents' trust in delivered services and later even parental empowerment related to those services.

The implications of this paper:

- More importance should be attached to the needs and challenges of LGBTQ families in delivery of maternity and child healthcare services.
- There is a need to develop nursing care strategies directly aimed at improving LGBTQ parental empowerment.
- Increasing familiarity with the terminologies and language used within LGBTQ families and parenthood can help create safer, more inclusive environments in practice. Understanding the barriers to healthcare faced by many LGBTQ parents may also reduce the likelihood of perpetuating discriminatory behaviour.

## 1 | INTRODUCTION

Parental empowerment is a core value in family services. It is a collaborative process, by which a family's access knowledge, skills, and resources enable them to have positive control over their lives. This empowerment can promote the participation of people and communities toward the goals of achieving increased individual and community control and improving quality of life for all and particularly this parent group. (Wallerstein, 2006). Empowerment is not simply a process; it is also a psychological state (Menon, 2002) that is linked with the concept of self-efficacy (Bandura, 1977). Falk-Rafael (2001) identifies empowerment as a process of consciousness-raising, characterized by client-centeredness, reciprocity, mutuality, respect, enhancement of dignity, non-judgmental behaviour, and creating a safe environment for the development of a fully trusting relationship. In health promotion discourse, such empowerment usually means encouraging clients to take responsibility for a healthier lifestyle. (Cawley & McNamara, 2011).

Empowerment varies across individuals, contexts, and time (Koren, DeChillo, & Friesen, 1992). It is also positively associated with the well-being of parents and families (Benson & Kersh, 2011), family cohesion, relationships and their function (Scheel & Rieckmann, 1998), and parents' self-efficacy (Wakimizu, Fujioka, Yoneyama, Iejima, & Miyamoto, 2011), lower levels of stress (Nachshen & Minnes, 2005), and the ability to solve family problems (Farber & Maharaj, 2005).

There have been a few studies of parental empowerment for maternity and child healthcare. However, limited attention has been paid to the perceptions of lesbian, gay, bisexual, trans, or queer (LGBTQ) parents (Shields et al., 2012). Further, there is generally a global lack of enough research and understanding of LGBTQ people (Bosse, Nesteby, & Randall, 2015; IOM, 2011) and also a lack of education in nursing related to these groups of parents (IOM, 2011;

WHO, 2013). To fill this gap, the present study investigates how self-identified LGBTQ parents who use maternity and child healthcare services in Finland actually define the concept of parental empowerment in this context. The findings are useful for professionals, as understanding of LGBTQ parents; empowerment and special needs for maternity and child healthcare may increase. The findings can also be used to develop new nursing education and care strategies aimed at improving LGBTQ parent empowerment.

In Finland, maternity and child health-care settings are part of the country's preventive healthcare and provided as part of the country's publicly funded national health-care system. Responsibility for this provision rests with municipalities. Guidance and directions for the service provision are laid down in legislation (Government Decree, 2011; HealthCare Act, 2010) and national programmes (Ministry of Social Affairs and Health, 2015). These services support parents by providing secure, child-focused rearing and assessing the physical, mental, and social conditions of children under school age. Expectant mothers normally meet with a nurse and/or doctor 11 to 15 times during their pregnancies. Childbirth and parenthood classes are also provided for first-time parents. These services are free and reach most families.

## 2 | METHODOLOGY

### 2.1 | Aim

To describe parental empowerment in maternity and child healthcare in Finland from the perspective of self-identified LGBTQ parents.

### 2.2 | Design

A qualitative inductive design was employed for this research.

### 2.3 | Ethics

The study was carried out in accordance with guiding ethical principles, in the Declaration of Helsinki (2016). Ethical approval was obtained from the University of Eastern Finland (UEF) Committee on Research Ethics (13/2016). Voluntary, informed and written consent was obtained from each participant. All participants were aware of the purpose of the study and the structure of their contributions, including the audio-taping of their interviews. All names were removed from the data and then coded with a number to ensure anonymity and full confidentiality.

### 2.4 | Participants

In total, 22 parents participated. One parent identified as transgender, one as bisexual, and two as nonbinary. Both, single- and multiple-time parents were included, and 11 were nonbiological parents. Two were not guardians of their children. Demographics, such as age, work, or education, were not requested. Children ranged in ages from 0 to

16 years. Maternity and child health-care experiences had taken place from 1 month to 10 years previously to the study. Parents lived in several different areas of Finland. All participants were White and Finnish Speaking; some had an immigrant background.

2.5 | Recruitment

The data were collected between July and September of 2016. The study was widely advertised via the Internet and two nongovernmental organizations—SETA and rainbow families. SETA is a national human rights NGO for Lesbian, Gay, Bisexual, Trans, Intersexual (LGBTI) rights in Finland. It seeks a society of equality and individual welfare that includes everyone, regardless of sexual orientation, gender identity, or gender expression. Rainbow families, a member of SETA, is an association for LGBTQ parents and their children in Finland.

Inclusion criteria were (a) parents self-identifying as LGBTQ, (b) parents at least 18 years in age, (c) being a biological or nonbiological parent, and (d) experiencing Finnish maternity or child healthcare during the 2000s. Participation was voluntary and confirmed by email. Parents opted into the study by responding to advertisements and then receiving specific information about the study by return email.

2.6 | Data collection interviews

Audio-taped interviews (45-90 min in duration) were conducted at a time and place convenient to the participants in either a meeting (n = 8) or over the phone (n = 14) and were conducted by the first author (J.K.). Research questions were developed to reflect the goals of this research and the existing literature on parental empowerment (Cawley & McNamara, 2011; Falk-Rafael, 2001; Koren et al., 1992; Perry & Langley, 2013; Vuorenmaa, Halme, Åstedt-Kurki, Kaunonen, & Perälä, 2013; Vuorenmaa, Perälä, Halme, Kaunonen, & Åstedt-Kurki, 2015) and LGBTQ parents' experiences related to maternity and child healthcare (Shields et al., 2012; Wells & Lang, 2016). The interviewees were asked to develop their own thoughts on parental empowerment in maternity and child healthcare and focus on four perspectives: (a) partnering with parents, (b) health-care professional strategies for optimizing parental empowerment, (c) heteronormativity in maternal and child healthcare, and (d) service user involvement. Background questions, including the parent's living conditions, family constellation, and experiences with healthcare, especially maternity and child healthcare, were also asked.

The interviews started by asking “If I say parental empowerment, what are you thinking about?” and “How would you describe parental empowerment?” The natural conversational flow was further expanded by asking more specific questions and/or encouraging interviewee reflections on statements relevant to the study. Examples of certain situations, such as the positive and negative aspects of nursing care, were explored, and clarifications and further elaborations were also made.

2.7 | Data analysis

All audiotapes were transcribed verbatim by the first author. The 181 pages (A4) of data were then analysed using inductive content analysis in line with Graneheim and Lundman (2004) and Elo and Kyngäs (2008). All interviews were included in the analysis. However, new information did not emerge to determine the final analysis until after 17 interviews. First, meaning units, eg, a word, sentence, or a whole paragraph with the same meaning, were identified. Then, these meaning units were condensed into a description of their content. Next, all of the data were read fully. Subsequently, the condensed meaning units were analysed and organized into categories, using similarities and differences. The main theme, as an expression of the latent content of the text, was understood to be a common core running through all the categories. The data were coded and categorized by the first author (J.K.). Multiple discussions were held among the research group (consisting of the first author [J.K.] and three supervisors [N.H., M.-L.P., and A.-M.P.]) to reach a consensus and ensure reliability and credibility of the formulated themes. An example of that process is provided in Table 1.

3 | FINDINGS

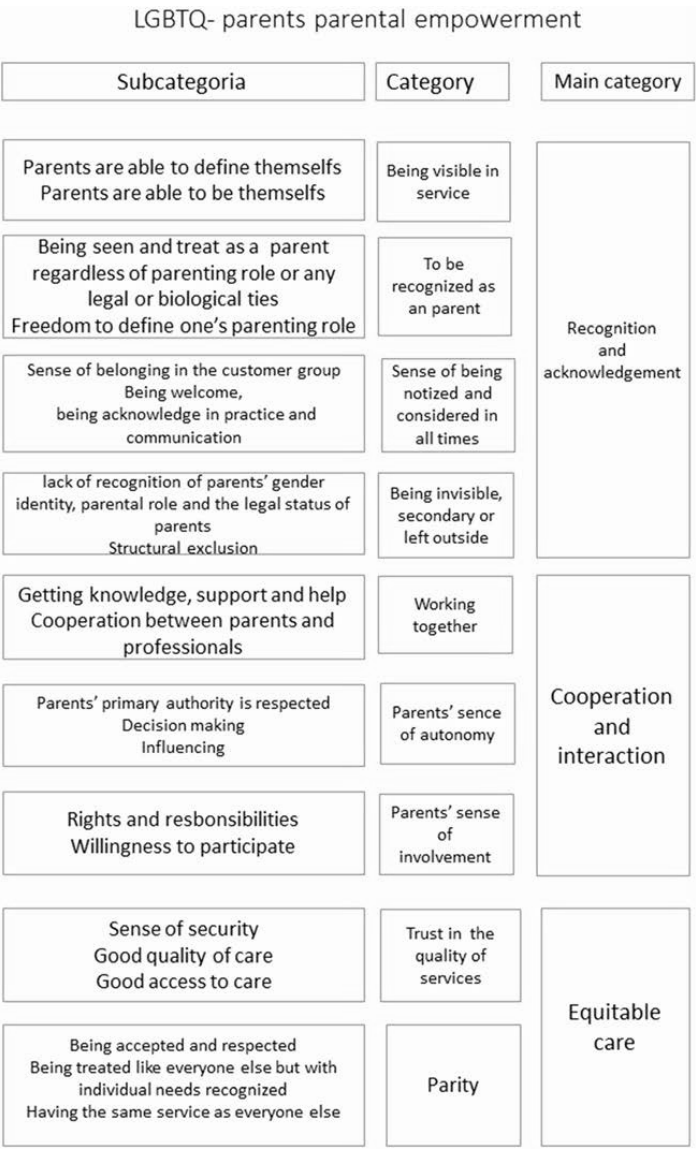
Empowerment of LGBTQ parents for maternity and child healthcare have clear dimensions of recognition, acknowledgement, cooperation, interaction, and equality. These findings are shown in Figure 1.

3.1 | Recognition and acknowledgment

*Being visible in the health-care service sector* means the parent's ability to define themselves. This included an “opportunity to define my own gender identity” (Interviewee 5), but also parents' right to provide their children with a variety of gender. Correct recognition and visibility of their gender identity were also important with respect to forms

TABLE 1 Examples of data analysis

| Original Sentence   | Summarized Theme                     | Subcategories                                    | Main Category                 |
|---|--------------------------------------|--|-------------------------------|
| “That I could define myself on those forms”<br>(Interview 4)      | I can define myself                  | Ability to define yourself                       | Being visible to all services |
| “That I’m able to define my own gender identity”<br>(Interview 5) | I’m able to define my gender         | Ability to define my personal<br>gender identity |                               |
| “That people are able to be who they are”<br>(Interview 2)        | People can be who they<br>really are | People are able to be themselves                 |                               |



**FIGURE 1** Lesbian, gay, bisexual, trans, or queer (LGBTQ) parent empowerment

and medical records; "The choices were 'man' or 'woman,' so I crossed it out and wrote nonbinary instead" (Interviewee 4). Participants pointed out that empowerment includes the right to be who you are and getting services delivered to that identified person. Parents suggested that ensuring intake forms enabled them to state explicitly they were LBGTQ parents, or an LGBTQ family would offer a comfortable way for them to define themselves. Stating family make-up on intake forms and in medical records would also help make this information available to all relevant staff in the health-care system.

*To be recognized as a parent* includes recognition and acknowledgement, such as being treated as a parent, irrespective of any biological or legal ties to the child, namely "Being seen as a parent, whether

father, mother who is pregnant or not, in this system" (Interviewee 18). It was the freedom to define the parenting role in a way that fits each individual's own identity and provides them the opportunity to adopt a parenting style of their own; "The fact that a person is pregnant does not mean that she is a mother, she may identify herself in a different way" (Interviewee 8). It was highlighted that parents need the opportunity to define their family constellation and its members' positions. Furthermore, it was essential that their family was seen as it actually was. If there was more than one parent in a family, it was important that all parents and their different roles were acknowledged from the very beginning. Nonbiological parents usually worried that professionals might not see them as being competent or

even equal parents. Questions like “which of you is the parent, which one of you is the mother?” make them feel that they are not parents at all. Parents also said that certain names validated them as being a parent. Recognition involved professionals’ listening and reflecting back on the language being used by the family and making sure that parents were called by their own parenting names; “I want to be referred to as Mom, not an extra” (Interviewee 1).

*The sense of being noticed and considered at all times* included being welcomed, belonging to the customer group, and being acknowledged in both actual practice and communication. Participants stated that inclusive and sensitive practice is essential. Different genders, parental roles, and family constellations should be taken into account routinely on forms, in medical records, and all communication. All participants were taken into account when providers used gender-neutral language (eg, “parent” instead of “mother” or “father”) rather than gender-specific language. In group meetings where parents were separated by gender or parenting roles, parents appreciated a right to choose which group they would like to participate in; “I wondered about the mother and father groups and thought—where do I belong? So, I asked, and it was my choice” (Interviewee 18).

*Being invisible, secondary, or left outside* included a lack of recognition of parents’ gender identity, parental role, or even their legal status as parents. Participants reported that they did “not fit into the regular mould” because almost all routines were based on and planned around heterosexual couples or families with two parents. This viewpoint was communicated in brochures, medical records, and forms that provide only normative options for families, parents, and genders. In addition, toilets were identified as being for men or women, and reception rooms were usually furnished to accommodate two parents and the professionals. Clearly, “if there are three or four parents and there are two chairs, then it’s a pretty clear sign that you are not welcome, you don’t belong there, or you are too much” (Interviewee 8).

### 3.2 | Cooperation and interaction

*Working together* included gaining knowledge, support and help, and cooperation between parents and professionals. This process meant encouraging parents to ask questions and provide the information and support they need to make decisions about their children’s life or care. Empowerment depended on professionals’ capacity to recognize and take into account parents’ needs, desires, and opinions. Elements like equality, active listening, showing an interest in, and inviting parents to speak were mentioned as ways that professionals could optimize more parents’ participation. Individualized information was experienced as helpful, namely “to be empowered, information should be more individual” (Interviewee 17). Moreover, the participants expected concrete advice and simple straightforward answers, support concerning legal matters, and more discussion and practical support concerning upbringing and childcare, so as “to get support and help with how to take care of the kids” (Interviewee 11).

*The parents’ sense of autonomy* included parents’ primary authority being respected for decision-making and influence. Participants appreciated that health-care professionals had their own professionalism and knowledge, but they also highlighted that they, as parents, had extensive knowledge about their own health, lifestyle, and children. “They are experts in their own field, but I know what is best for me and my child” (Interviewee 21). It was essential that professionals trust the parents’ own expertise with respect to their lives and accepted their experience-based knowledge and also valued their feelings. Sharing information with parents and welcoming them as a partner in decision-making and planning was important. Empowerment involved discussing treatments, decisions, and plans with the parents, not just among professionals. “If there is some treatment, I can decide whether or not to take it” (Interviewee 10). This aspect of empowerment includes parents’ opportunities to make informed decisions about their own or their child’s life or care. When parents experienced worries, empowerment meant the ability to have negotiations with professionals. “The ball was in our court, so I could decide if my child needed some extra services or not” (Interviewee 20). Autonomy was also described as being able to influence the service situation, for example, by determining the topic of conversation. “I can choose what to discuss in the appointment and when.” (Interviewee 5). It was also described as an opportunity to give feedback and evaluate the service situation independently and completely.

*Parents’ involvement* included rights and responsibilities and the willingness to participate. It meant parents, having equal rights to be involved. “That I have the same rights and responsibility to be involved in that process even if I’m not a legal parent” (Interviewee 5). It was described as including the parents’ right to fill out forms and expect the same information and support as biological parents receive. It was also the responsibility to be there as a parent. It was the right as parents’ to have personal participation in appointments and groups, asking questions and sharing worries. “That you are there! And just that if you have any questions then you can ask for yourself and not through the other parent” (Interviewee 22). Usually, parents wanted to be a part of their own, their partners’, or their child’s healthcare. However, some parents described themselves as insecure or concerned about other parents’ responses, especially when participating in parental groups. Sometimes the timetable, chemistry between professionals and parents, and/or the heteronormative structures reduced these parents’ willingness to participate in either appointments or groups.

### 3.3 | Equitable care

*Trust in the quality of services* included having a sense of security, good quality of care, and good access to healthcare. It was these parents’ fearlessness to talk about how they live their lives and whom they have sexual relationships with, for as one said “you can safely talk about your private matters” (Interviewee 2). Parents stated that it was the professionals’ duty to provide a safe environment and make them feel safe. They reported that they felt insecure and concerned

about the responses to the statement that they were LGBTQ and stated that providers needed to be easier to talk to, nonjudgmental and fair. Good quality of care relied on the professionals' competence and skills with respect to taking care of the entire family. None of the interviewed parents said that they expected professionals to have detailed knowledge of their families' special features, but they did want the professionals to be able to trust the parents' knowledge and skills, and indeed, nurses were expected to approach LGBTQ parents naturally. Parents pointed out that they did not want to end up taking on an educational role. They wanted to be "in good hands" (Interviewee 17). Access to care was important, especially for maternity care and in case of any health worries. Phone service was mentioned as one of the most important services in "That someone answers when I call" (Interviewee 15).

Parity included being respected and accepted, being treated like everyone else, and receiving the same services as other families. Parents needed to be sure that being LGBTQ did not affect the way that they and their child were treated in either appointments or group meetings. They wanted to be a "normal" family and have access to the same services as everyone else. Interaction was perceived as being empowering when professionals did not judge or make any assumptions about them and when the parents' identity, sexuality, or sexual orientation was not underscored; "I just want to be like everyone else" (Interviewee 1).

## 4 | DISCUSSION

Based on this study, empowerment was defined as an ongoing process and also a psychological state wherein parents have a feeling that they are visible and recognized as being parents. It involved working together with parents, listening and negotiating, getting knowledge, and developing a trustful relationship based on acceptance and respect. By respecting parents' autonomy, it becomes possible to mobilize the necessary resources and enhance the parents' abilities. The parents are thus involved in a growth process and fully enabled to make their own informed choices. Equitable care, respectful and safe environment, and professional knowledge and skills delivered fully and respectfully are necessary components of this entire process.

Empowerment was these parents' sense that they exist. They were able to define themselves, and their families and were recognized as LGBTQ parents in maternity and child health services. (Andersen, Moberg, Bengtsson, & Garmy, 2017) Coming out was also described as stressful, as it placed parents in a state of emotional vulnerability. Poor past experiences with healthcare, concerns about discrimination, or bullying made them employ certain strategies to shield themselves against such possible negative experiences. (Stewart & O'Reilly, 2017). This could be explained by the fact that previous experiences of discrimination in health-care services will decrease the willingness to be open about who you are, which in turn may affect the parents' level of trust in those services or service providers and later, even ongoing parental empowerment in healthcare for their children.

Several studies have found that LGBTQ adults find the health-care systems heteronormative and professionals' holding negative attitudes toward LGBTQ people due to a lack of knowledge of LGBTQ family issues (Andersen et al., 2017; Wells & Lang, 2016). This study supports that finding. These parents stated that empowerment required inclusive and sensitive policies. Structural exclusions, such as medical records and forms that provided only normative options for families, parents, and genders, heteronormative assumptions, and use of heterosexist language meant that this group is positioned as either invisible or secondary in this system.

As in previous studies, these parents highlighted the importance of health-care staff approving of them as being a family (Dahl, Fylkesnes, Sørli, & Malterud, 2013). Furthermore, equal care, good cooperation, professional knowledge about LGBTQ issues, and the capacity for individual support were all issues that needed to be addressed.

### 4.1 | Study limitations

This study's strengths rest in its inclusiveness. The informants lived in both urban and rural areas and there were both mothers and fathers. They also identified themselves as families whether three parents, transgenders or bisexuals. Participants were recruited via the Internet. This choice allowed us to use existing networks to access participants who met the inclusion criteria and had experience in the topic. However, it also meant that the study was limited to those who have ongoing access to the Internet and/or are connected to LGBTQ-focused organizations.

The 22 informants that participated were unlikely to be representative of all LGBTQ parents in maternal and child healthcare, but they were able to illustrate LGBTQ parents' experiences in this dual context. Different results may be found in those families that are more vulnerable, and by choice, less visible than the groups captured here. However, these parents' experiences were similar and consistent across the entire study, and these findings thus do offer a start toward better understanding how LGBTQ parents describe their empowerment in actual maternity and child health-care settings in Finland.

## 5 | CONCLUSION AND IMPLICATIONS

These findings show that structural changes in maternity and child health services will facilitate LGBTQ parents' empowerment in these services. The results highlight the importance of being seen and treated as a parent, irrespective of the type of parenting role or any legal or biological ties which help them identify themselves as a part of this system. Secondly, inclusive language and explicit reference to LGBTQ parents in maternity documentation, as for example, including the options of "co-parents" and "partners" on service forms are needed changes.

More research is still needed, however, on the specific institutional factors that enhance LGBTQ parents' empowerment in dealing with

family services and nonbiological parents' roles, their recognition, full acknowledgment, and responsibilities in such settings. Further, while research that targets LGBTQ parents is necessary, greater ability to identify LGBTQ people in national, population-based datasets will also help create national benchmarks for the key aspects related to positive and effective LGBTQ parenting.

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## CONFLICTS OF INTEREST

No conflict of interest.


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## AUTHORSHIP STATEMENT

Study design: JK, NH, M-LP, and A-MP; data collection: JK; data analysis: JK; manuscript preparation: JK, NH, M-LP, and A-MP; and final approval: JK, NH, M-LP, and A-MP

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#### **ARTICLE IV**

Kerppola J, Halme N, Perälä ML and Pietilä AM. Empowering LGBTQ parents: how to improve maternity services and child healthcare settings for this community" "She told us that we are good as a family." Nordic Journal of Nursing Research, 40 (1): 41-51, 2020.



# Empowering LGBTQ parents: How to improve maternity services and child healthcare settings for this community – ‘She told us that we are good as a family’

Jenni Kerppola<sup>1</sup> , Nina Halme<sup>2</sup>, Marja-Leena Perälä<sup>2</sup> and Anna Maija-Pietilä<sup>1,3</sup>

## Abstract

Parental empowerment plays an essential role in maternity and child healthcare. Professionals delivering these services are ideally placed to improve parents' empowerment and well-being. This study aims to describe the supporting factors of parental empowerment from the perspective of self-identified lesbian, gay, bisexual, trans, or queer (LGBTQ) parents in Finland. The study was conducted using a qualitative inductive design, and 22 parents participated. Interviews were conducted between July and September of 2016 and analysed using inductive content analysis. Four categories emerged: 1) Parents' willingness to create socially recognized families, 2) Parenthood support, 3) Respectful partnership with all parents, and 4) Accessible services. Services were more empowering when parents were treated with dignity. This focus requires gender-neutral communication and a clear sense of security for parents. The findings indicate more education on LGBTQ-related issues is still needed.

## Keywords

LGBTQ parents, maternal and child healthcare services, parental empowerment

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## Introduction

Empowerment is a complex concept. Fundamentally it is about gaining power and ability in a way that increases capacity, self-efficacy, and decision making. Empowerment is associated with many different aspects of everyday parenting<sup>1–5</sup> and childbirth.<sup>6–10</sup> Used in this context the term has both psychological and social domains.<sup>11</sup> Parental empowerment manifests as attitudes, knowledge, feelings, and behavior<sup>1</sup> and is a collaborative process by which parents access the knowledge, skills, and resources that allow them to gain positive control over their lives. It is a general sense of power that has the ability to influence people, organizations, and environments. It also gives one control over one's life.<sup>1–3</sup>

Parental empowerment is considered crucial to positive family well-being.<sup>12,13</sup> Further, it is considered an important concept for strengthening the position of parents in healthcare delivery.<sup>14</sup> Previous studies indicate that such empowerment plays an important role in how parents manage their everyday lives in the face of unique life changes and different demands.<sup>4</sup> Increased parental empowerment has a positive impact on children's services, environment, and growth.<sup>1,5</sup>

Strategies to support parents' empowerment have been studied previously. It has been shown that supporting parents' empowerment through family services is a

collaborative process where both the professionals and clients are active participants.<sup>1,3</sup> Equal relationships, advocacy, focusing on strengths, supporting active participation and decision making, providing information, and developing skills were all found to be relevant and connected.<sup>15,16</sup> Trust and reciprocity are two characteristics of an environment that leads to support, cooperation, mutual benefit, and better outcomes for children, especially in lesbian, gay, bisexual, trans, or queer (LGBTQ) families. In contrast, lack of trust in the relationship is likely to have a direct effect on quality of care, especially reciprocity between the parent, child, and health professionals.<sup>17,18</sup> Previous studies, however, have focused mainly on specific services, service situations, or groups.<sup>19–21</sup> Further, most of these respondents have been mothers<sup>22</sup> and there are no studies that investigate LGBTQ parents' empowerment in particular. Existing research does investigate and define elements connected to supporting factors of parental empowerment.

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There are, for example, studies about heteronormative communication with lesbian families,<sup>23</sup> attitudes of health professionals towards LGBT persons in a range of healthcare settings<sup>24–26</sup> and those held by nursing and medical students,<sup>27,28</sup> and attitudes of health professionals working in community early parenting services in two states of Australia.<sup>29</sup> Further, there is also research on LGBTQ families' experiences and needs in those settings.<sup>17,18,26,30,31</sup> Typically, those are dominated by studies on same-sex/lesbian motherhood,<sup>31</sup> and studies conducted on the broader group of LGBTQ parents in Nordic countries is still rare.<sup>26,30</sup>

According to these previous studies, LGBTQ parents still suffer discrimination and may not be fully supported within maternity or child healthcare because of heteronormativity and professionals' attitudes and practices. There is also an identified need for continuing education of health professionals in the practice arena.<sup>32</sup> A lack of LGBTQ education and training amongst health professionals may contribute to negative attitudes or apprehension towards caring for this population and ultimately may lead to persistent mistreatment<sup>33–35</sup> and lack of empowerment of these patients in healthcare systems.

Therefore, this current study is focusing on the broader group of LGBTQ parents. Knowledge about different kinds of LGBTQ parents' experiences is necessary, and the results may add the information that can assist clinicians, educators, and hospital management to develop policies and practices that ensure LGBTQ parents and their families will receive equal, non-prejudiced, and holistic healthcare. Moreover, insight into the supporting factors of parental empowerment provides a good opportunity to understand whether implemented care interventions effectively contribute to supporting and strengthening parents.

In Finland, maternity and child healthcare settings are provided as part of the publicly funded national healthcare system there. They are free and reach most families as a part of the country's preventive healthcare system, the responsibility for which rests with the municipalities. Guidance and directions for service provision are laid down in legislation<sup>36,37</sup> and national programmes.<sup>38</sup> These services support parents in providing secure, child-focused rearing and assessing the physical, mental and social conditions of children under school age. Expectant mothers normally meet with a nurse and a doctor 10–15 times during pregnancy. Childbirth and parenthood classes are usually also provided to first-time parents.

At the time of the current study, the number of families for the registered couples was 1500 and 1600 families of same-sex married couples in Finland. Of these families, 67% included female couples.<sup>39</sup> Proper estimates for the number of all LGBTQ parents are difficult to obtain since not all forms are registered. Female couples and single women have legal access to assisted reproduction. Self-insemination is not governed by the rule of law. Same-sex couples have had access to equal marriage and joint adoption since March 2017.

## Aim of study

To describe the supporting factors for LGBTQ parents' empowerment in maternity and child healthcare from the perspective of self-identified LGBTQ parents in Finland.

## Methods

A qualitative inductive design was employed for this research. This design was implemented through open interviews.

## Data collection and participants

The data were collected between July and September of 2016. Inclusion criteria were: 1) parents' self-identifying as LGBTQ; 2) parents being at least 18 years in age; 3) being a biological or non-biological parent; and 4) experiencing Finnish maternity or child healthcare during the 2000s. An invitation to participate in the study was published via the internet through an organization whose members identify as LGBTQ families, a sexual political organization (SETA) website, and on Facebook. Participation was voluntary and confirmed by email. Parents opted into the study by responding to advertisements and then received specific information about the study by email.

In total, 22 parents participated. One parent identified as transgender, one as bisexual, and two as non-binary. Both single- and multiple-time parents were included. Eleven were non-biological parents; three had their own biological child and were also a social parent for their partner's child. Two were not guardians of their children. Demographics, such as age, work, or education, were not requested. Children ranged in age from 0 to 16 years; the average age was 5 years. Maternity and child healthcare experiences had taken place from 1 month to 10 years prior to the study. Parents lived in several different areas in Finland. All participants were from Nordic countries and spoke Finnish, and some had an immigrant background (Table 1).

All interviews were audio-recorded and lasted between 40 and 90 minutes, with the average interview taking 60 minutes. They were conducted at a time and place convenient to the participants, either during a meeting ( $n = 8$ ) or over the phone ( $n = 14$ ). Open interviews were requested to describe participants' own thoughts about supporting factors of parental empowerment in maternity and child healthcare.<sup>40</sup> The effort to gain a deeper understanding about empowerment was highlighted.

The interviews started with, 'If I say parental empowerment, what are you thinking about?' and 'I would like to hear how would you describe supporting factors of parental empowerment in maternal and child healthcare. What would those factors be?' The natural conversational flow was expanded by asking more specific questions and/or encouraging reflections on statements relevant to the study. Examples of situations such as positive and negative aspects of nursing care were explored, and clarifications

and further elaborations were made. To ensure the validity of the data, the researcher tailored the interviewing style to the emotional state of each participant and carefully let them freely express their ideas.

## Data analysis

All audiotapes were transcribed verbatim by the first author. The data were then analysed using inductive content analysis in line with Graneheim and Lundman<sup>40</sup> and Elo and Kyngäs.<sup>41</sup> All interviews were included in the analysis. The text was read thoroughly, and central issues related to the research objective were underlined. First, meaning units (e.g. a word, sentence, or a whole paragraph with the same meaning) were identified. Then qualitative data were organized by using open coding, creating

categories and abstraction. Next, the texts were abstracted into codes through the process of writing notes and headings in the margins of the transcripts. The codes were then transferred into tables and grouped according to similarities and differences, while focusing on the aim of this study phase. Through the identification and interpretation of similarities and differences, further abstraction continued as far as reasonable and possible. Each category was named using content-characteristic words. The data analysis was conducted by the first author and then discussed in a research group to achieve a common understanding of the findings. An example of that process is provided in Table 2.

## Ethical considerations

This study was conducted in compliance with the intentions of the World Medical Association Declaration of Helsinki and standard ethical guidelines and principles.<sup>42</sup> Ethical approval was obtained from the UEF Committee on Research Ethics (13/2016). Voluntary, informed, and written consent was obtained from each participant. All participants were aware of the purpose of the study and the structure of their contributions, including audio-taping of their interviews. All tapes were stored in a locked cupboard that was available only to the researcher. Ethical issues included the protection from psychological harm of all participants and researchers and protecting all privacy and confidentiality. The use of critical reflection and rigor in generating the qualitative data was emphasized throughout the effort.<sup>40</sup>

## Findings

Four main categories emerged: 1) Parents' willingness to create socially recognized families, 2) Parenthood support, 3) Respectful partnership with all parents, 4) Accessible services (see Figure 1).

**Table 1.** Characteristics of the participants.

|                              |    |
|------------------------------|----|
| Parents' self-identification | N  |
| Lesbian                      | 13 |
| Gay                          | 4  |
| Bisexual                     | 1  |
| Trans*                       | 1  |
| Queer                        | 1  |
| Non-binary                   | 2  |
| Parenting role               |    |
| Non-biological parent        | 11 |
| Biological parent            | 11 |
| Single-time parent           | 17 |
| Multiple-time parent         | 5  |
| Not guardian                 | 2  |
| Background                   |    |
| Immigrant background         | 2  |

**Table 2.** Examples from the data analysis.

| Original sentence  | Subcategories                                   | Categories                       | Main categories   |
|--|---|----------------------------------|---|
| I have always wanted to have children, and we talked about this on our first dates, so we have spent years on building this dream together. (17) | Desire to become a parent                       | Commitment to role of parenthood | Parents' willingness to create socially recognized families |
| I questioned if it was ok to make a family like this, and we prepared for this effort very actively. (1)   | Openness to create socially recognized families |                                  |   |
| We like to show what it was, being a lesbian couple and having a baby. (19)  | Facing potential discrimination                 |                                  |   |
| We knew that lots of people, like our own families do not accept this and now we are dealing with it. (5)  |   |                                  | Self-knowledge and strong self-esteem                       |
| I hope that if there is something that people do not respect they come to us, not that our child would suffer from this. (3)                     |   |                                  |   |
| I have always known who I am, it has been clear to me. (19)  | Clear identity as a minority                    |                                  |   |
| We wanted that everything was clear and open for everyone before the baby, so we registered our relationship. (6)                                | Being open about same-sex relationship          |                                  |   |
| We always tell people who we are, we like to talk about our family and our child. (16)   |   |                                  |   |

| Subcategoria   | Category                                      | Main category   |
|--|---|---|
| Desire to become a parent<br>Openness to create socially recognised families<br>Facing potential discrimination                                  | commitment to role of parenthood              | Parents' willingness to create socially recognized families |
| Clear identity as a minority<br>Being open about same-sex relationship   | Self-knowledge and strong self-esteem         |   |
| Love and trust between family members<br>Communicative co-parenting<br>Shared responsibilities of a child<br>Close friends<br>support from peers | Support from family, friends and peers        | Parenthood support  |
| Informational support<br>Emotional support<br>Practical support  | Support from professionals                    |   |
| Self-identification of a gender and parenting role<br>Gender neutral language  | LGBTQ parents are recognized and acknowledged | Respectful partnership with all parents                     |
| Parents are a user representatives of their children<br>Parents participation in decision-making is voluntary                                    | Shared decision-making                        |   |
| sense of security<br>voluntary disclosing<br>dignity   | Safe environment                              | Accessible services   |
| continuity of care,<br>clarity of follow-up treatments<br>shared information between services and between professionals                          | Good coordination                             |   |
| Good location and transportation<br>Sort waiting times<br>Walk-in or same-day appointments<br>Adequat recours                                    | Good accessibility of services                |   |

**Figure 1.** Supporting factors for lesbian, gay, bisexual, trans, or queer (LGBTQ) parents’ empowerment in maternity and child healthcare.

*Parents’ willingness to create socially recognized families*

*Commitment to role of parenthood.* None of our participants took the decision to become parents lightly. The desire to have a family was usually there for several years, and participants faced different problems compared to “traditional” families. They had to cope with prejudice and discriminatory attitudes toward their sexual orientation, relationships, or family configuration, and they knew that they had to raise their children in the absence of specific laws that protect same-sex couples and families. Participants also expressed a sense of discomfort about potential impact on their children and their social and emotional health by asking:

Do we have the right to be parents? (Interviewee 5)

Parents’ commitment was described as openness to creating socially recognized families. It was characterized by the

intention to start their own families and an interest in becoming parents despite the fact that these families were not accepted by everyone. The commitment entailed facing prejudice and discriminatory attitudes.

I have always wanted to have children, and we talked about this on our first dates, so we have spent years on building this dream together. (Interviewee 17)

*Self-knowledge and strong self-esteem.* Becoming a parent required good self-knowledge and strong self-esteem, so a clear and open identity noted as a minority was empowering.

It’s empowering, have a child in a family like this ... I mean that I have always known who I am. (Interviewee 19)

Participants reported that life experiences, such as age, were helping them to be a family and live as LGBTQ

people. It was also mentioned that by appreciating their own worth and believing “everyone is equal” they resisted the negative effects of possible discrimination. Parents stated that it was important to have their healthcare provider see them as more than just their gender, sex, or sexual orientation. Having access to at least one professional who valued them was thought to encourage these parents’ self-esteem and empowerment. Sometimes, this required parents to stand up and explain themselves, if needed, be proud of their family and themselves as LGBTQ parents. Sometimes it even required demanding that you be treated as a LGBTQ parent:

I need to be my own self and know who I am to get what we want out of the clinical encounter. (Interviewee 6)

Empowerment was reinforced during appointments whenever professionals demonstrated understanding for parents’ lives and respected their choice to become parents. They stated that having positive, worth-affirming interactions with professionals was important in establishing trusting and open relationships.

### *Parenthood support*

*Support from family, friends and peers.* Home with love and trust was important and needed especially when planning a family. Making a decision about a sperm donor or biological parenting meant there was the other parenting role that was more vulnerable and not supported by any law.

There is always a chance that something goes wrong, and you just have to trust. Well, there is love, but making a family, it is something. (Interviewee 8)

The decision to become parents often involved extensive research, discussion among friends who had already made similar decisions, and researching options online. Further, it involved the fear that a donor might eventually seek custody or would be a threat to the non-biological parent. Some participants said that they and their partner both pursued pregnancy at different times to mitigate these kinds of feelings.

Communicative co-parenting, such as mutual communication, teamwork, and respect for each other as a parent was essential, especially in those families where there were more than two parents and two homes. These arrangements, based on mutual agreement, involve people who are committed to raising a child together, possibly with their respective partners:

There are four of us in this, and it’s all negotiated. We put it all in a paper, it took time, but it was worth it. (Interviewee 20)

Further, divorced parents said that co-parenting gives children the stability, security, and close relationships with all parents. Participants stated that for the sake of their children’s well-being, it was possible to overcome even

co-parenting challenges and develop a new relationship with their ex-partners.

Shared responsibility for a child and shared financial support were important and empowering. Parents stated that their household duties were shared equally and decisions about work or family balance based more on circumstances than on preconceived gender-based ideals. For example, family leaves were taken equally. Shared financial support during the pregnancy was mentioned as extremely important because there was usually only one biological parent during pregnancy, before the adoption. It was mentioned as an important matter that both parents were participating in the costs of fertility treatments. Parents reported an increased understanding of their partner’s everyday life after sharing responsibilities and spending time equally with their child. Empowerment was supported when parents trusted each other as parents and they could discuss together and with professionals their concerns about sharing the parenting workload and necessary financial support, parental leave arrangements, and benefits for LGBTQ families with their children.

Parents stated that friends and peers were important parts of their lives. Most of the LGBTQ-specific information was gained from peers and from the Internet, and participants were actively involved in an LGBTQ organization. Supported by peers meant having a sense of connection to a larger LGBTQ community. That view was associated with increased self-esteem and positive social identity development as a parent and as a family. Having support from families of origin was not that common and most parents did not take this for granted. Further, when they had it, they named their family of origin as a resource and a factor that supported their empowerment; it meant that their families were accepting them for themselves. Further, healthcare professionals were helpful when they supported parents in seeing their peers. It was also noted that professionals should be aware that LGBTQ parents are not always supported by their relatives, that friends as “chosen family” might be more important.

*Support from professionals.* Informational support included suggestions and directives. Further, it suggests that professionals have more knowledge about LGBTQ-specific needs. Parents needed knowledge and discussions about pregnancy as a medical condition, changes in sexual relationships, parenting stress, predictors of postnatal depressed mood and financial pressures as well as parents’ return to work. Information was empowering when it was given individually and in an understandable language. Cases where professionals provided something special, were described as empowering.

She asked if we were familiar with breastfeeding of non-biological mother, that she was thinking that we might want to do that; it felt so nice, she offered us something, that was just for us. (Interviewee 17)

Answering parents’ questions and worries was also essential and empowering. Awareness of available services,

including social workers and LGBTQ organizations and peer support groups was essential. Sometimes knowledge about private services was also needed. Awareness was needed especially when the child needed special care.

She told us where to go, so there was no need to navigate a complex labyrinth of therapy service referrals and appointments. (Interviewee 15)

Empowerment was reinforced when parents were given good information about the targets and policies of maternal or child healthcare and about the health examinations carried out during the pregnancy or the child's first years.

Parents described parenthood as being rewarding, isolating and pressured. Feelings of being incomplete as a parent were common, and in the case of LGBTQ parenting, negative attitudes expressed by community, professionals, and others was typical. Many participants described the transition to parenthood as a time of confusion, as they attempted to define their roles within the context of meeting the needs of their partners and the new infants. Throughout the pregnancies and postpartum periods, the participants also experienced grief for the changes in their relationships. Emotional support was needed to develop feelings of attachment to the unborn infant. Professionals were expected to recognize and support their new roles as parents. Also contributing to the sense of parental identity was seen as important.

I was wondering if I'm going to be as bonded to these children as the biological mother? (Interviewee 8)

Parents felt empowered and emotionally supported when they were listened to and their concerns were taken seriously and responded to. Furthermore, some professionals showed interest in the parent's or the child's well-being by asking questions about life at home.

She was always willing to hear how we are, are we okay, and was there anything we need, like help or something, and I felt she was interested about our well-being. (Interviewee 22)

Practical support, such as advice about routine caretaking of toddlers, child development, and the child's upbringing was empowering. Further, advice was needed about family leave and interfamily adoption counselling. When supporting parents' empowerment, it was necessary to focus on strengths by giving parents good feedback about their parenting. Parents said they needed to hear that they are a good family and that they manage fine as parents. Such support showed a positive attitude and delivered confidence and trust, also focusing on their children's stages of normal development:

We need to hear that our child is normal and that everything is normal in our family. (Interviewee 3)

### *Respectful partnership with all parents*

*LGBTQ parents are recognized and acknowledged.* Being recognized and acknowledged included self-identification of a gender and parenting role that was important with respect to forms and medical records.

The choices were 'man' or 'woman', so I crossed it out and wrote 'non-binary' instead. (Interviewee 4)

It was reported that the healthcare system was heteronormative and that some professionals hold negative attitudes toward LGBTQ people due to a lack of knowledge of LGBTQ family issues. Heteronormativity was conveyed via communication, forms, and group meetings. All participants mentioned the conventional information and questions the professionals had to ask as a possible source of embarrassment for everyone. Some were offended by standardized forms and heterosexist language. Language used in forms was crucial especially for non-binary, trans, and non-biological parents in terms of establishing or undermining their identities as parents:

I'm not in those legal documents ... No one questions the role of the father in a heterosexual family, but I am not only questioned, but also misunderstood and ignored. (Interviewee 8)

Empowering healthcare experiences occurred when all parents were acknowledged correctly, regardless of the parenting role or any biological or legal ties to their child, and further when professionals avoided using gender-specific terms, such as husband or boyfriend, which assume heterosexuality. Parents appreciated that they were listened to, that the language being used by the family was reflected back, and that parents were asked and called by their own parenting names:

They asked us 'How should we call you?' or 'What are your names for the kids?' and I want to be referred to as mom. (Interviewee 12)

*Shared decision making.* Parents stated that they should be given the opportunity to be a user representative of their child but also appreciated that they were able to choose when and how they participated in decision making. Empowerment was supported when professionals acknowledged that all parents had an equal say in and responsibility for the healthcare of their child and when parents felt they were able to choose whether or not to participate in decision making.

### *Accessible services*

*Safe environment.* This involved sense of security, voluntary disclosure and dignity. Being accepted and treated like everyone else, without discrimination or bullying was empowering. Despite these positive experiences, some

participants said that they had expressed an internal fear of the reaction of the system to their sexuality or their family situation. Parents hold 'expectations of prejudice and discrimination'. Non-biological parents in particular had concerns about how they would be treated.

Well, legally we had to be treated, but in reality how would we be treated? I was quite nervous about that. (Interviewee 8)

But it turned out to be fine, they made me feel it was okay to be this kind of a family. (Interviewee 16)

Parents living in rural communities wondered how they would be treated or spoken to by service providers. The role of the religious environment was also mentioned.

Parents stated that they selectively chose to make themselves visible. Nearly all participants in this study wanted to be 'out' to their professionals. They usually voluntarily disclosed their sexual identities from the beginning. Parents thought that hiding the family situation was unnecessary.

We are loving and caring people, and our child deserves to feel proud of this family. (Interviewee 21)

Another respondent identified the effect on the child by saying 'if children are being asked to hide or lie about their family composition, it sends a message of shame and that is not healthy for the children' (Interviewee 19).

Supporting empowerment meant creating an environment in which the parents felt confident, relaxed, and comfortable enough to trust the nurse to disclose and discuss their sexual orientation and family configuration to others.

Dignity was part of having a sense of security. In particular, bodily integrity refers to the level of dignity that individuals feel during healthcare procedures that involve the crossing of personal boundaries, such as a gynaecological exam in maternity care. The ability of professionals to enable parents to feel safe during these exams was essential. Further, making a safe environment that supported empowerment required the use of positive space signage and other inclusive signage and professionals' respect for the individual in a vulnerable state.

**Good coordination.** Parents' empowerment was supported when good coordination, such as continuity of care, clarity of follow-up treatments, and shared information between services and between professionals occurred. Parents having appointments in different units of specialized care felt that it was empowering the professionals to be responsible for their or their child's treatment. Parents needed information about what had been carried out and planned regarding their own or their children's care. However, some parents were told that they had to take responsibility for transferring their follow-up treatment because it was not written down, or the nurse did not have the time to read it. Empowerment was supported when data were available to all those involved in treatment, and parents were informed enough about their responsibilities and appointments. Parents preferred that everything was

written in the electronic records, and the professionals were able to access their information directly.

Shared information between the services and professionals included good electronic health information exchanges and effective flow of information between professionals. Parents stated that inter-organizational collaboration and regional cooperation with social workers was working. The flow of information between professionals meant cooperation and communication in the health centres. It was accomplished between nurses and doctors or therapists who worked with the family. According to participants, shared information between professionals helped parents who were disclosing their family configuration. It was mentioned that when professionals had read their files previously, parents did not have to see the reaction and face the possibility of professionals' negative assumptions. So, good electronic health information changes gave professionals time to adjust to the idea of LGBTQ parents and this empowered parents:

It's important that the nurse or the doctor could see my family composition straight from the computer. Then they know who we are from the start and they don't have to ask or we don't have to explain ... (Interviewee 3)

**Good accessibility of services.** Good location and transportation, short waiting times, and walk-in or same-day appointments were all seen as supporting parents' empowerment. Further, Internet and social networking sites and the knowledge that help is available when needed was important, as one mentioned:

That someone answers the phone when I need it. (Interviewee 11)

Parents thought that there might be disparities in access to health services in urban versus rural areas. It was stated that rural counties may have significantly fewer services or peer support than urban counties have.

Adequate resources, including minimal exchange with professionals and enough time for the families, were preferred because greater consistency in nurses and care often made it easier for the children, the parents, and the professionals to become really familiar with each other. As a result, the parents did not have to explain the family composition, circumstances, and needs several times to several different nurses. It also seemed to be easier for the parents to ask for help or explain their needs when they knew the nurse.

## Discussion

This study provides knowledge and understanding of supporting factors of LGBTQ parents' empowerment in maternity and child healthcare. To our knowledge, it is the first of its kind in Finland. This study addresses many practical ways in which maternal and child healthcare professionals can support parental empowerment and

provide better care to LGBTQ parents. This knowledge can also be used in research and education.

Many aspects of supporting the empowerment of these parents are related to human rights, such as dignity, but also healthcare policy and structures, such as LGBTQ parents' recognition and acknowledgment, further parents' own commitment as a desire to be a parent and using services.

Participants in our study did not take the decision to become parents lightly. Interviews reveal that many parents had faced discriminatory attitudes toward their sexual orientation, relationship, or family constellation and encountered a number of stressors associated with their gender identity or sexuality. Further, these parents also reveal how they cope with feelings of otherness or 'minority stress' – the stress that accrues to members of socially disadvantaged or stigmatized minority groups and compounds general life stress.<sup>43</sup> Our participants reported feeling guilt, worries about being good enough parents, and concerns about how they would be treated in family services. Our parents told that they were committed to parenting, despite the fact that they would have to raise their children in this atmosphere and in the absence of specific laws that protect same-sex couples and their families. Resisting the negative effects of possible discrimination required good self-esteem and self-knowledge which were seen as empowering. Professionals and the healthcare environment, such as structures and policies, were seen as playing an important role in providing safe, high-quality, supportive, and accessible care that empowers all parents. Having access to at least one professional who values them was both important and empowering. These results emphasize the need to understand how stigma impacts LGBTQ individuals when they become parents. Such understanding will facilitate the development and tailoring of interventions aimed at reaching those most at risk. It also raises a question: how is minority stress related to parental empowerment? Can knowledge gained from research contribute to a better understanding of minority stress and otherness, as a point of departure for health promotion?

LGBTQ parents' empowerment in maternity and child healthcare was supported when these parents felt that they were 'part of the system'. Similarly to several previous studies, parents were willing to participate if they perceived this as a normal and acceptable behaviour, within their control. That happened when they were able to define themselves and their families and be recognized as LGBTQ parents regardless of the parenting role or any biological or legal ties to a child.<sup>44</sup> It was important to be regarded and treated as a parent and seen as a family. Therefore, to design interventions to encourage LGBTQ parents' participation, understanding parents' roles, their lifestyle, and special needs is required. Actively giving permission to participate and involving all parents in decision making supported parents' sense of control. Parents believed that they should be the main decision makers with regard to their own or their children's care. However, when discussing special care, most parents

believed it was the professional's duty to make decisions on their behalf. Thus, empowerment was supported when parents were able to choose when and how they participated in decision making. This view may result from the parents generally feeling that they have limited knowledge of special issues in healthcare or what is required when emergency care is needed. If parents find that healthcare providers avoid partnership or leave their concerns unresolved, they lose confidence in professionals and avoid future contact and cooperation. Coming out repeatedly was described as stressful, as it placed parents in a state of emotional vulnerability. Poor past experiences with healthcare, concerns about breach of confidentiality, discrimination, or bullying made them employ certain strategies to shield themselves against such possible negative experiences.<sup>26</sup> This could be explained by the fact that previous experiences of discrimination in healthcare services will decrease willingness to be open about who you are, which in turn may affect the parents' level of trust in those services or service providers and later, even ongoing parental empowerment in healthcare for their children. Similarly to Malmquist, Nelson, and Zetterqvist,<sup>45</sup> parents in our study reject negative experiences to protect their positive ones, and explain poor treatment as a lack of personal chemistry<sup>23</sup> or lack of education rather than discrimination. Therefore, professionals working with parents should be extra-attentive to LGBTQ parents to ensure they receive respectful and inclusive treatment.

Several studies have concluded that some LGBTQ parents, usually lesbian mothers, find the healthcare systems heteronormative and find professionals hold negative attitudes toward LGBTQ people due to a lack of knowledge of LGBTQ family issues.<sup>1,3,16,17</sup> This study supports that finding and included gay, bisexual, trans and queer parents as well. Parents stated that supporting parental empowerment required inclusive and sensitive policies. The language used by professionals was a key indicator. This study also supported the fact that structural exclusions, such as medical records and forms that provided only heteronormative options for families, parents, and genders; heteronormative assumptions; and use of heterosexist language meant that this group is positioned as either invisible or secondary in this system.<sup>17,26</sup> Further, a lack of human respect was seen to contribute sometimes to the absence of parent empowerment. The main concerns for the parents included the attitudes of health professionals when one parent was ignored or excluded from their child's care. Parents reported that it is important to take into consideration a parent's life situation as a whole and approve family units and to ensure that all parents feel comfortable by asking open-ended questions, using inclusive and sensitive language, and offering non-judgmental support. Creating a welcoming environment in which parents feel confident and comfortable disclosing their sexual identity and family composition includes acknowledging LGBTQ parents' relationships and different kinds of parenthood, displaying policies that explicitly protect LGBTQ parents from discrimination in waiting areas and in group meetings, and placing LGBTQ health information materials

alongside materials intended for other patient groups, such as pregnant women. Most family services have policies and structures in place to prevent discrimination; however, it is necessary that administrators and clinicians ensure these guidelines are applied. In order to support empowerment, it was also judged necessary to have enough time to interact and to create and maintain long-term care relationships with professionals. As known from stigma research in general, factors that could mitigate stigmatizing attitudes are attribution beliefs and knowledge of and experience with a stigmatized condition.<sup>46</sup>

Parents in our study reported that feelings of being incomplete as a parent were common. The transition to parenthood was a time of confusion as they attempted to define their roles within the context of meeting the needs of their partners and new infants. Throughout the pregnancies and postpartum periods, the participants experienced grief for the changes in their relationships. Professionals were expected to recognize and support their new roles as parents by giving them information and emotional support. Contributing to the sense of parental identity was also seen as important. Focusing on strengths and giving parents good feedback made them feel empowered. Lack of empowerment emerged when parents were given incorrect information regarding their health concerns and thus felt they had to teach staff about their special needs. Professionals also avoided asking parents about their sexual orientation or gender identity. This finding is important because it requires health professionals not only to be willing to engage families from diverse backgrounds but also to ensure that they have the knowledge and skills to demonstrate sensitivity when caring for these families.

### Study limitations

The concepts of credibility, dependability and transferability have been used in this study to describe aspects of trustworthiness. The participants lived in both urban and rural areas and identified themselves as mothers, fathers, parents, gay, lesbian, transgender, or bisexual whereas earlier studies focused primarily on lesbian mothers and not gay/bisexual fathers.<sup>41</sup> Further, the study participants' various experiences and parenting roles contributed to the rich data increasing the credibility of the study, as did also the quotations from the participants' original interviews.

Credibility of this study was established by selecting the most appropriate method for data collection. Participants were recruited via the Internet and data were collected using interviews. This choice allowed the use of existing networks to access participants who met the inclusion criteria and had experience with the topic. However, it was limited to those who had ongoing access to the Internet and/or are connected to LGBTQ-focused organizations. So those who chose not to participate may have done so on account of their views of empowerment, maternal or child health services, or LGBTQ issues which could have influenced study findings. Recruitment through a specific organization introduces a risk of skew in regard to

education, financial stability and cultural background. However, this type of recruitment is useful when populations are marginalized because individuals might be more willing to participate if they have been referred by another member of their group.<sup>40</sup> The first author collected and analysed the data, after which the other authors evaluated these data to confirm the equivalence of the categories to the original data, which strengthened the dependability of the data.

In total, 22 informants participated in this study. Even though one interviewee's maternity care experience was from the early 2000s, her data were still included because the informants' experiences were similar and consistent across the entire study. Furthermore, the interviewer's pre-understanding of the topic may have affected the additional questions presented during the interviews, selection of the meaning units, and the analysis. To mitigate these limitations, reflection was ongoing, with authors meeting regularly to discuss emerging findings and to examine their own assumptions and bias that could possibly influence the interpretation of data.

Further, the concept of empowerment is multifaceted and diverse<sup>47</sup> and takes different forms in different contexts or settings.<sup>48</sup> Information on context and participants' characteristics was described to enable readers to evaluate whether the findings are transferable to other settings.<sup>41</sup> Because no previous studies on LGBTQ parents' empowerment or factors supporting it were available, these 22 participants are unlikely to be representative of all LGBTQ parents who are regularly involved in maternal and child healthcare. They are, however, able to illustrate many LGBTQ parents' experiences in this dual context. The findings offer a most welcome start toward a better understanding of how LGBTQ parents describe their empowerment in actual maternity and child healthcare settings in Finland now and in the future.

### Conclusions

The results of this study indicate that supporting LGBTQ parents' empowerment in maternity and child healthcare requires policies and structures that recognize and acknowledge multiple family structures and parenting roles. To meet the needs of LGBTQ parents in maternal and child healthcare, professionals must develop awareness and understanding of the issues experienced by these parents and their families. Moreover, targeted education is needed to assist in sensitivity training related to the challenges faced by LGBTQ parents in their sexual and family relationships and parenting roles. LGBTQ parents require support and an environment in which they feel confident and comfortable disclosing their sexual identity and family composition. Most family services have policies and structures in place to prevent discrimination; however, it is necessary that administrators and clinicians ensure these guidelines are applied. In the future, greater ability to identify LGBTQ people in national, population-based datasets would help create national benchmarks for key aspects related to positive and effective LGBTQ parenting.

## Ethical approval

Ethical approval was obtained from the UEF Committee on Research Ethics (13/2016).

## Author contributions

Study design: JK, NH, MLP, AMP, data collection: JK, data analysis: JK, manuscript preparation: JK, NH, MLP, AMP and final approval: JK, NH, MLP, AMP.

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## Conflict of interest

The authors declare that there is no conflict of interest.

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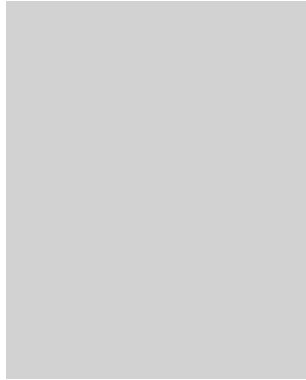
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This study focuses on parental empowerment in Finnish child and family services from the viewpoint of professionals and from lesbian, gay, bi, trans, and queer (LGBTQ) parents. Employees' enhanced awareness of services, commitment to common goals, and fairness of treatment were key elements. Respectful and gender-neutral communication and supporting the functioning of families' daily life were essential aspects of supporting parental empowerment.



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