

How Family Members Experienced a Family-Focused Atrial Fibrillation Intervention in an Outpatient Setting—A Qualitative Study

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Abstract

Introduction: Family-focused nursing has gained ground worldwide, and a range of healthcare systems are now practicing family-focused nursing, which has been shown to increase the quality of care. Even so, a lack of research remains into family-focused nursing for various groups of patients in clinical practice.

Objectives: The purpose of this study was to explore how family members (FMs) of patients with atrial fibrillation (AF) experienced a family-focused nursing intervention in a clinical outpatient setting.

Methods: This was a qualitative phenomenological interview study employing Reflective Lifeworld Research (RLR) to explore humans' lived experiences. The data reported herein were derived from semi-structured interviews with seven FMs of patients with AF who participated in a clinical trial which tested a family-focused intervention in a Cardiology outpatient clinic treating patients with AF. The transcribed interviews were analyzed in four phases which is an iterative process as proposed by Dahlberg and Dahlberg.

Findings: The essence of the phenomenon was experiencing less panic and finding peace, which emerged from the following four patterns. (1) The FMs' post-AF experience, (2) Enhanced understanding and knowledge of AF, (3) Personal interaction with a nurse specialist and (4) AF becomes manageable. A space facilitating reflection upon the disease and daily life with the disease was established through group sessions and family conversations.

Conclusion: A family-focused nursing intervention facilitated by specialized nurses with extensive communication skills filled a knowledge gap related to AF thereby reducing panic and increasing peace among FMs. Furthermore, the intervention facilitated family awareness of their resources to bring about change, regain balance, and enhance well-being in their everyday lives and initiated a healing process in the families. Future interventions for patients with AF should consider FMs as well as patients as an entity of care.

Keywords

reflective lifeworld research, qualitative, family-focused nursing, atrial fibrillation

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Background

Atrial fibrillation (AF) is one of the most widespread cardiac arrhythmias. An estimated 33.5 million individuals live with AF worldwide (Chugh et al., 2014; Colilla et al., 2013). When a patient is diagnosed with AF, this also impacts his or her family (Dalteg et al., 2014). AF predominantly affects the elderly population, and the number of individuals with AF is expected to more than double in the coming decades (Sheikh et al., 2015). AF is associated with increased mortality and morbidity. The condition is a major cause of stroke. Furthermore, AF may affect the quality of life of patients and their families due to anxiety

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and depression (Jenkins et al., 2005; Kirchhof et al., 2016; Schron & Jenkins, 2005). AF is also one of the leading causes of hospitalization and is therefore associated with substantial healthcare expenditure (Sheikh et al., 2015). The medical treatment of AF is often complex, and a need exists for integrated care from specialists targeting symptoms, reducing stroke risk and increasing health-related quality of life in patients and family members (FMs) (Dalteg et al., 2016; Hindricks et al., 2020). Moreover, AF may influence FMs by triggering upsetting emotional responses thereby affecting their well-being and perceived health (Dalteg et al., 2016; Ekblad et al., 2014). AF may ultimately cause more illness and pain in patients and FMs alike if support and guidance are lacking (Coleman et al., 2012; McCabe et al., 2011). The importance of involving FMs in the care is therefore considerable (Gusdal et al., 2017). However, studies indicate that nurses do not always involve and support the family in their professional activities (Østergaard et al., 2020). Furthermore, nursing interventions involving FMs who are close relatives to a person diagnosed with AF are understudied (Dalteg et al., 2016).

Family system theory offers a framework that may allow us to understand the relationship between the patient and his or her family environment (Bell, 2009). The Calgary models proposed by Wright and Leahey comprise interventions involving the family in non-hierarchical collaboration comprising the nurse, the patient, and FM (Leahey & Wright, 2016; Shajani & Snell, n.d.). The family interventions aim to enhance the visibility of family resources, facilitate change and ensure a focus on positive experiences. The Calgary models are operationalized through therapeutic conversations. A few studies have evaluated the models in settings with chronically ill patients and within palliative care, reporting a positive impact on the quality of care (E. G. Benzein & Saveman, 2008). One study including patients with heart failure found positive results when involving families more systematically by having them come to the outpatient clinic for their relative's medical treatment (Veltelen et al., 2016). No prior studies have evaluated a family nursing intervention targeting patients and FMs confronted with AF. FMs are a resource but can also be a barrier for patients, and that is why it is important to expand the view from the patients to the family to increase well-being and health-related quality of life in patients with AF. Therefore, we tested a family-focused intervention inspired by the Calgary models (Shajani & Snell, n.d.) for patients with AF and their FMs in a Danish outpatient clinic in the Capital Region of Denmark from January 2020 to April 2021. The evaluation design comprised a qualitative evaluation of how the FMs experienced participating in the intervention. The purpose of this study was to explore how FMs of patients with AF experienced family-focused nursing in an outpatient clinical setting.

Methods

Design

This was a qualitative phenomenological interview study employing Reflective Lifeworld Research (RLR) to explore humans' lived experiences (Dahlberg et al., 2008., n.d.). By distancing, reflecting, and remaining open, the investigator may describe the silent and implicit essence of a phenomenon (Dahlberg & Dahlberg, 2020). Uncovering a phenomenon's essence hinges on the researcher's ability to pinpoint and focus on the meaningful topic or topics in the phenomenological interview (Dahlberg et al., 2008., n.d.).

Participants

Data were collected in a cardiology outpatient unit at a university hospital in the Capital Region of Denmark in 2021. In the period from November 2019 until April 2021, 33 patients with AF were enrolled in the family-focused nursing intervention. From this population a purposeful sampling strategy was used to ensure varied data material (Malterud, 2001a). The sampling strategy included the following inclusion criteria: FMs needed to be ≥ 18 years old and they had to have participated in a family-focused nursing intervention targeting newly diagnosed patients with AF (< 6 months) and their FMs. To participate in the family-focused intervention FMs had to be considered "family" by the AF patients according to the following definition: "family are who the patients say they are" (Shajani, & Snell, n.d.), which means that the family relationships did not depend on either consanguineal or legal ties.

Description of the Family-Focused Nursing Intervention Being Evaluated

The family-focused nursing intervention was added to conventional treatment that followed guidelines for treating patients with AF (Hindricks et al., 2020).

The family-focused nursing intervention was based on the Calgary Family Assessment and Intervention Models in which the whole family is considered the unit of assessment and intervention when someone in the family falls ill (Shajani & Snell, n.d.). The intervention focuses on the patient and the interaction and presupposes reciprocity between FMs, the patient, and the nurse (Shajani & Snell, n.d.). Fundamentally, the elements in the family-focused intervention that was tested with a 2-hour group session and family conversations should be understood as a single intervention that cannot be separated from its constituent parts and delivered to patients and FMs according to their needs. The intervention was considered delivered when patients and FMs had attended at least one element of the family-focused intervention.

The family-focused intervention elements comprised of a 2-hour group session for which five patients brought a close family member (Table 1) and a series of one to three family

therapeutic conversations (FNTCs) where patients could bring their close family member and have guidance in order to cope with AF in everyday life. The nurses who conducted the family-focused intervention elements were specialized in AF and trained in performing basic practical and theoretical skills needed to facilitate the family-focused intervention (Duhamel et al., 2009). The contents of and themes for the 2-hour group session were developed according to the European Society of Cardiology's guidelines and also identified by interviewing the FMs (Rosenstrøm et al., 2021). The main themes were AF symptoms, adherence to medication, physical activity, lifestyle, and psychological reactions. Approximately 1 to 2 weeks after the 2-hour group session, patients and FMs were scheduled for the first 60-min FNTC session. If the patient, FM, and nurse agreed on more than one FNTC the next FNTC were scheduled approximately 2 weeks after and lasted 30 min. The content of the FNTCs is shown in Table 2.

Interview Setting

The interviewer, a cardiology nurse and Master's student in Nursing Science from another department (second author, female), was not familiar with family-focused nursing in practice but had gained theoretical knowledge from books and evidence-based literature. Furthermore, second authors' preconceptions about family-focused nursing and reflections on the meaning of the relationship between FMs and nurses were written down to ensure reflection on the phenomenon. The first author (a female PhD student) was not part of the interviews but helped recruiting FMs from the intervention to take part in the interviews. The researchers play a substantial role in the qualitative research process and they have to be aware of how they can influence the results and they have to be reflexive of their intersubjectivity (Malterud, 2001b). In this study none of the researchers had personal experiences with AF in the family only professional, and having a variety in age, theoretical and educational levels as nurses and academics the researchers were able to challenge each other's beliefs about the phenomenon through the research process.

Table 1. Content of the 2-Hour Group Session.

The families' individual experiences with AF
What is AF?
Symptoms of AF
Medication/anticoagulation
Catheter ablation
Cardioversions
Lifestyle: diet, smoking, alcohol, and exercise
Psychological reactions

Note. AF: Atrial fibrillation.

The second author contacted FMs who had previously given their consent to being contacted after the phone intervention. Seven out of 11 FMs accepted to participate in an interview. The FMs who did not participate had one or more chronic diseases and felt too poor to participate in the study. All the FMs had different backgrounds and ages, thereby adding to the diversity of the data (Table 1). A semi-structured interview was performed by the second author 1–1½ years after patients and FMs were included in the family-focused intervention which was spread over a longer period than originally planned due to the COVID-19 pandemic and its several lock-downs. The interviews took place approximately 4–6 months after the family-focused intervention had been delivered. Four interviews were performed by telephone due to COVID-19, and three were face-to-face interviews conducted in the FMs' private homes according to their wishes. The interviews lasted 30–70 min (mean 45 min). A semi-structured interview guide was developed based on an initial literature search. The interview guide

Table 2. Contents of FNTCs Based on *A Guide to Family Assessment and Intervention* (Shajani, Zahra & Snell, Diana, n.d.).

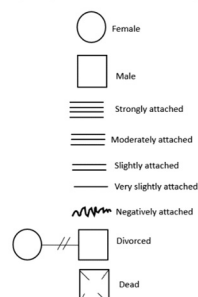
Contents in the Family Nursing Therapeutic Conversations (FNTCs) with patients with atrial fibrillation (AF) and family members

Asking patients and FMs about their expectations regarding the family conversation and exploring which issues and problems they consider most important to discuss in relation to AF and their everyday life.

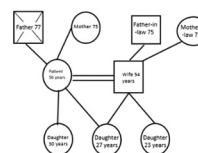
Individual information, supervision, and education in accordance with evidence-based clinical guidelines on AF.

Drawing a Genogram that reflects a model of the family structure and social relationships.

Example of symbols used in attachment diagrams



Example of a Genogram



Encouraging patients and FMs to share their family illness narrative and reflect upon their AF diagnosis beliefs.

Identification of goals for the families' future living with AF.

Conversations about the impact of AF on the family unit and the individual FMs' daily lives.

Circular questions and the One-Question-Question focusing on strengths and resources within the family.

Evaluation of the intervention, based on conversation, observation, goal setting, and perception of the family.

Table 3. Meaning Units in the Interviews.

| Quotations | Meaning units | Patterns | Essence |
|--|--|--|--|
| Wife 1: "At some point I could tell how ill he was, and then I asked him to call [the doctor]" Wife 6: "If he's calm and thinks he can get through this, then we will" | The family's resources The family member's being worried The patient's worries about atrial fibrillation Being affected by the family members | The FMs' post AF experience | |
| Wife 4: "To hear the others' progress kind of confirms what we've been through" Wife 4: "But I also felt that he benefitted from this, which made me felt that this [the intervention] was right to do" | Hearing stories of other families is a relief Mirroring of selves in other families More knowledges about atrial fibrillation | Enhanced understanding and knowledge of AF | Experience less panic and finding peace |
| Wife 3: "I'm impressed by the time that was given to us, since I know how busy the nurses are" Wife 1: "You have the opportunity to say what's on your mind, that is what I have in mind and what I can contribute with" | Illness reflections followed by therapeutic conversations A different/new way to interacts with a nurse Feeling of being heard by the nurse | Personal interaction with a nurse specialist | |
| Wife 3: "Yes, it (family conversation) calmed me. I don't feel worried anymore. Before I would wake up in the middle of the night to check his breath" Husband 7: "I've always known, that when she gets it (AF), she just has to relax and breathe" | To confirm existing knowledge or actions To be less worried about atrial fibrillation Accepting changes | AF becomes manageable | |

was followed if the participant was distracted from the phenomenon of interest. Open-ended questions were used to explore what was meaningful for the participants. Examples of questions were "How was your experience with the family-focused intervention?" and "How did you experience the family conversation?" The interviews were recorded digitally and transcribed verbatim by the second author.

Data Analysis

The use of RLR in this study focuses on identifying differences and similarities in the participants' experiences to understand how FMs experienced the family-focused intervention. Special emphasis was placed on living and coping with AF in the participants' daily lives. The transcribed interviews were analyzed in four phases of the iterative process as proposed by Dahlberg and Dahlberg (Dahlberg & Dahlberg, 2020). Initially, the text was read repeatedly to build a general sense of the whole. In the second phase, the text was read thoroughly; in this phase, meaning units, which are phrases or paragraphs that describe the phenomenon, were identified and highlighted with a new color each time a new meaning emerged from the contents of the text. In the third phase, various meaning units were clustered into

patterns. We moved back and forth between the phases until no new patterns or meanings emerged. Finally, in the fourth phase, the emerging essence of the phenomenon was described (Dahlberg & Dahlberg, 2020; Dahlberg et al., 2008., n.d.). An example of derived meaning units is presented in Table 3. The second author conducted the analysis in continuous discussion with the other authors. Findings were discussed in an iterative process until all authors reached an agreement. In addition all in the research team agreed on data saturation was reached since the interviews seemed to capture the essence of the phenomenon and no new patterns seemed to emerge (Malterud, 2012).

Rigor

To establish trustworthiness and prevent researcher bias, we evaluated the credibility, dependability, confirmability, and transferability (Graneheim & Lundman, 2004; Shento, 2004) of the study. We strengthened its credibility by acquiring knowledge about family-focused nursing through books and scientific literature. We ensured that the included FMs were reliable sources for elucidating the phenomenon sufficiently and drawing trustworthy conclusions. Furthermore, we ensured dependability by focusing on transparency, explaining how the study was planned, and being explicit

about the researchers' preconceptions. Retaining the researchers' preconceptions was important to avoid the confirmability of the preconceptions would overshadow insights appearing during data collection and analysis. Therefore, the first and second authors' pre-conceptions were uncovered before developing the interview guide. According to Lincoln and Guba (Morse, 2015), transferability lies with the person who wishes to apply the findings to another context. Therefore, it is up to the reader to decide to which extent and in which contexts our findings are transferable. Furthermore, we followed the Standards for Reporting of Qualitative Research (O'Brien et al., 2014).

Ethical Considerations

Following the Helsinki Declaration, all FMs received written and oral information about the interview study, and their written informed consent was obtained (*WMA—The World Medical Association-WMA Declaration of Helsinki—Ethical Principles for Medical Research Involving Human Subjects*, n.d.). The participation of the FMs was entirely voluntary. The participants were informed that data would be stored safely on an encrypted drive, and that their identities would be protected when reporting the research findings. Fictitious FM names were used in the transcribed data. The study was approved by the Danish Data Protection Agency (VD-2019-42) and the local ethical committee (id: 19007769).

Results

A total of seven interviews were held with FMs. Their characteristics are presented in Table 4. The essence of the phenomenon emerged as; experiencing less panic and finding peace, which emerged from the following four patterns. (1) The FMs' post-AF experience, (2) Enhanced understanding and knowledge of AF, (3) Personal interaction with a nurse specialist, and (4) AF becomes manageable.

The FMs Post AF Experience

The FMs participating in the intervention had different family relations from the patient, and their thoughts about

AF appeared to vary which seemed to influence their beliefs about AF. The FMs expressed how they felt that they were a resource serving to support and encourage the patients with AF in everyday life situations; for example, remembering to take their medication, asking questions when visiting the doctor and being physically active. Similarly, the FMs had felt supported by their patient in other challenging situations during their life and now felt obliged to help and support the patient in managing the adversities caused by AF.

We have helped and supported each other with different challenges—That is a huge advantage. (Wife 3)

FMs expressed how emotional distress and worries in the patient with AF may negatively influence the FM who were often as much affected by the situation as the patient was. On the other hand, if the patient was optimistic about the situation and presented with very few symptoms or problems and no worries due to AF, this also reduced the FMs' worries. Thus, how the patient and FMs experienced and perceived the nature of AF was closely linked to their constant interaction with each other.

He gets very affected by AF and, of course, that also affects me. (Wife 1)

Furthermore, the mutual experiences and beliefs were essential for what the FM brought into the family-focused nursing conversation and what they explained during their meeting with the nurses.

Enhanced Understanding and Knowledge of AF

The FMs experienced that hearing the experiences of other patients and FMs living with AF greatly affected their mood and well-being. The group sessions and family conversations were described as being tremendously helpful. The FMs felt better equipped to handle difficult situations that could arise due to AF, for example, how to handle acute situations with heavy palpitations or knowing how much exercise the patient may engage in. Through reflections and discussions among the patients, FMs and the nurse who

Table 4. Characteristics of Family Members and Their Relationship to the Patient with Atrial Fibrillation.

| Family members number | Sex | Age | Relationship | Employment status | Numbers of family conversations |
|-----------------------|--------|-----|--------------|-------------------|---------------------------------|
| 1. | Female | 73 | Wife | Retired | 1 |
| 2. | Male | 72 | Husband | Retired | 1 |
| 3. | Female | 71 | Wife | Retired | 1 |
| 4. | Female | 68 | Wife | Retired | 1 |
| 5. | Male | 75 | Husband | Retired | 1 |
| 6. | Female | 54 | Wife | Employed | 1 |
| 7. | Male | 62 | Husband | Employed | 3 |

facilitated the group sessions and FNTCs, the FMs acquired more knowledge; this, in turn, made them feel that AF became more manageable. Another positive aspect expressed during the group sessions was that the FMs felt relieved that their close ones maintained their good mood and did not experience symptoms or attacks as severe as those described by some of the other AF patients and FMs. Thus, meeting other families allowed them to adopt a new perspective on AF.

God, I felt that we were lucky that he [her husband] did not lose his good mood. (Wife 6)

The FMs also experienced the group sessions and the FNTCs as very informative. Even the families who were adept at obtaining information themselves from sources like the Internet felt well informed. These FMs felt safer because they were able to confirm what they had already learned about AF because the information was now passed to them by a trustworthy and specialized nurse.

I felt it [the group sessions and the FNTCs] was very informative, and I was unaware of the fact that there was something called AF and we got so much information and also about the differences in AF. (Husband 2)

The FMs felt that their knowledge about AF was enhanced and they felt safer using the information they had acquired, for example, knowing when it may be relevant for their close one to take extra antiarrhythmics. Even though they had only met once at the group session, FMs expressed how they felt that they were forming a community with the other patients and FMs. The 2-hour group session and FNTCs provided the families with a feeling that they were not alone with AF and that they were able to manage AF like the other families, which gave them a sense of heightened self-confidence.

Personal Interaction with a Nurse Specialist

The FMs' experienced that the healthcare professionals were often in a hurry and had little time to talk with the patient and the FMs. The limited time available was often used to focus on the medical aspects of AF. Therefore, the FMs viewed the FNTC as a new treatment that comprised involvement and boosted commitment. Several FM explained that they appreciated and respected this when the nurses signalled that there was time for dialogue, listening and reflecting upon the FMs' questions and beliefs or for the patient with AF.

I am impressed that they [nurses in the family-focused nursing intervention] have used so much time talking with us, and I am impressed that they use resources on this. I think it is a good thing, and I recommend that they keep doing it because it gives the families more insight into AF

and it makes you calm, and it gives you knowledge that you did not have before you came to the conversation. (Wife 3)

The FMs expressed how the FNTCs created a space that allowed them to talk openly about how AF had affected their everyday lives. Furthermore, the FMs felt that the nurses had played an important role in allowing the family to feel secure and able to share their experiences through conversation. The FMs experienced FNTCs as more intimate and personal than the group session. It was easier for them to share more private concerns that they felt unable to present in front of others during a group session. Furthermore, FMs felt that they were actively involved and that their voices were being heard by the nurses, which made them more aware of how they could support their patients with AF and be more in tune with their feelings. Additionally, the presence of the nurse and her questions triggered a deeper level of conversation between the patient and the FM.

She [the nurse] helped us getting more depth into it [knowledge of AF], or else it would have been something that we would talk about briefly. She [the nurse] had another background of how to communicate, and she created depth which we liked, or I liked. I am not sure that we could have done that ourselves. (Wife 1)

Thus, the FMs experienced that the FNTCs contributed to their awareness of the family's strengths and resources and facilitated deeper communication between the FMs.

AF Becomes Manageable

After the group session and FNTCs, the FMs experienced that the intervention had helped them solve AF-related problems in their everyday lives, thereby making AF more manageable. One way this was achieved was when nurses were involved in the FMs. The FMs felt more prepared and capable of acting on various symptoms and of detecting signs of symptoms, complications and side effects:

Because I've always had this thought. When she [his wife] got this flicker, she had to try to relax her body and try to breathe with the diaphragm, even though that's hard, Ehh ... and the good thing about [name of spouse] in connection with this conversation is that she no longer has panic in her eyes? (Husband 7)

Some FMs had felt very anxious about AF and needed to know if AF may cause a heart attack or cause the patient to stop breathing. These doubts triggered constant alertness and tension in everyday life before the interventions. In contrast, after having participated in the intervention, FMs felt safer in the situations in which the patient's flicker returned.

Yes. That [family conversation] has given me more peace of mind. I do not think I am worried anymore. Before, I often woke up at night just to check his breathing and stuff like that. Now, there is complete calm. (Wife 3)

Many FMs expressed that the family-focused intervention had helped them adapt to the situation and regain balance in their daily lives being close to a FM with AF. Furthermore, FMs felt more accepting of the changes in the family that had been caused by AF, for example, rotation of family roles in the home, making lifestyle changes and being physically active. Furthermore, the FMs noted having adopted a more active and healthier everyday lifestyle. FMs also thought they had acquired more significant knowledge of AF from the educational sessions and FNTCs, which contributed to reducing their anxiety and giving them peace of mind.

Discussion

The essence of the phenomenon of the study was that a family-focused intervention with group sessions and FNTCs allowed FMs to experience less panic and find more peace. The mechanism involved may be that as nurses validated and acknowledged the feelings and emotional responses of the FM, they thereby helped reduce or mitigate feelings of isolation, loneliness, or suffering (Gusdal et al., 2017; Voltelen et al., 2016). Furthermore, by connecting the emotional responses of the FM caused by AF, the intervention may have helped reduce stress by supporting alternative beliefs about how to establish new avenues of action and thereby allowing the FM to develop new thought patterns relating to AF or to managing everyday life (Årestedt et al., 2018; E. Benzein et al., 2015).

The pattern captured in *the FMs post AF experience* revealed the importance of nurses to engage the FMs. Building an overview of the FMs' need for involvement and support requires focusing on personal and professional competencies, theoretical tools and communication skills that need to be practiced and reflected upon before as well as after graduating as a nurse (Duhamel et al., 2009; Østergaard et al., 2020). Our findings showed that FNTCs may facilitate family involvement and positively affect the well-being and sense of healing of close FMs to patients with AF. Promoting healing to support the families in taking control over their situation has also been reported in other studies (E. Benzein et al., 2015; E. G. Benzein et al., 2008; E. G. Benzein & Saveman, 2008). Furthermore, when nurses are able to create a space in which the patient and FM may share narratives experienced by both patients and FMs and facilitate a dialogue about the unique understanding of AF, this may help the family develop a mutual understanding. In turn, a mutual understanding may help strengthen communication within the family and enhance their resources and coping strategies (Årestedt et al., 2015). Other studies also found that it has great value and

importance that nurses involve FMs illness beliefs while supporting new coping strategies and self-management (Ahlberg et al., 2020; E. Benzein et al., 2015).

Our study showed that the FMs' illness beliefs were challenged. However, FMs experienced that an enhanced understanding and knowledge of AF was made available to them (Bell & Wright, 2015). From a systemic perspective, AF will affect all FMs when a person in the family is diagnosed with AF (Shajani & Snell, n.d.). Everyone in the family who is close to the person with AF will have to cope with the new situation. We found that the family-focused nursing intervention contributed to expedient knowledge supporting FMs and allowing them to understand what AF is. This finding is supported by several studies having explored how FMs are affected and how they, among others, experience a need for family support to enhance their coping strategies (Ahlberg et al., 2020; Clemmensen et al., 2019; Duhamel et al., 2009). By meeting other families with AF, the FMs gained new insights into how AF affected other people. Mirroring themselves with the other patients and FMs was a positive experience and provided input for further reflection on managing AF in their own everyday life. Being confronted with an arrhythmia may make patients and FMs more vulnerable and they may therefore develop a need for extra support. Another study confirmed that patients and FMs benefitted from being offered self-management interventions when they were confronted with chronic disease (Bartlett et al., 2020).

The pattern of *enhanced understanding and knowledge of AF* was mirrored in how the family-focused nursing intervention helped the FMs regain balance in the family when the nurses offered qualified expertise about AF and employed their communication skills. Daltag et al. also found that uncertainty caused by the lack of knowledge about AF (Dalteg et al., 2014) negatively influenced the FMs. Therefore, the entire family may benefit if specialized nurses with extensive communication skills can facilitate reflection on the family situation (Duhamel et al., 2009; Voltelen et al., 2016). Furthermore, a quantitative evaluation of a family-focused intervention reported significantly higher emotional and cognitive support following an intervention consisting of two family conversation sessions (Petursdottir & Svavarsdottir, 2019). The intervention had parallels to our intervention, even though many of our FMs only participated in a single FNTC and only in the group session. Furthermore, the contents of the two interventions had similarities because the interventions were based on the same theoretical framework where the focus is on the nurse's behaviors and the family's response followed by the nurse's response to the family in an ongoing process (Bell, 2009; Shajani & Snell, n.d.). The studies show that involving the FM in a structured manner has a positive impact on the FMs.

The pattern *personal interaction with a nurse specialist* underpinned the importance of targeting the education and

support needs of families facing AF, the family system nursing framework creates a positive space for the patient, FM and nurse. The FMs experienced feeling more confident about the nature of AF and expressed that AF became more manageable. Our findings may be interpreted in relation to the theory of sense of coherence (Antonovsky, 1987, n.d.). In short, a sense of coherence is the individual's ability to manage stress and promote health, which depends on the use of resources within the individual. The individual's feeling of sense of coherence may be determined by how he or she experiences the manageability, meaning, and comprehensibility of a situation.

The pattern of *AF becomes manageable* was captured by how the FMs experienced how the family-focused nursing intervention provided them with a better understanding of how they may live with AF. In addition, they became more aware of personal resources, allowing them to create change or regain balance in everyday life (Shajani & Snell, n.d.). Filling a knowledge gap related to AF seems to make the illness trajectory more meaningful. Furthermore, the framework of family system nursing gave the nurse a more explicit role in involving the FMs, which, in turn, is reflected in satisfied FMs (Ostlund & Persson, 2014). Even so, studies have shown that nurses may experience challenges in relation to involving FMs (Østergaard et al., 2020). The nurse's educational level along and her personal and professional experiences impact how she involves the FMs (Duhamel et al., 2009). Therefore, education, personal experiences and competencies influence how nurses communicate and involve the FMs.

Strengths and Limitations

Rich and detailed data from in-depth interviews provided insights into the FM's life world. This represents a strength of the study. Moreover, the second author who conducted the interviews and the analysis was not involved in the intervention and may therefore be considered objective. The first author had some contact with the patients and FMs when she recruited them for the intervention, but she was not involved in the delivery of the family-focused intervention. Anyhow, we chose the first author not to be involved in the interviews in order for the patients and FMs to be able to speak freely and able to also express negatively about the intervention. The last author newer had any contact with either patients or FMs which is considered a strength. However, the study also carries some limitations. The inclusion of seven FMs may be viewed as a small sample, but in studies using RLR, obtaining rich and varied data is more important than obtaining a large number of participants (Guest et al., 2006; Malterud, 2001a). A critical selection of FMs was undertaken to obtain data portraying different perspectives and to achieve data saturation (Guest et al., 2006). Even so, the risk of memory bias exists, which may potentially have impacted what the FMs remembered about the intervention

as the interviews were conducted about 6 months after they completed the intervention. However, the interview revealed that the FMs clearly remembered which elements in the intervention had been essential for them in building an understanding of AF. The ongoing COVID-19 pandemic caused most of the interviews to be conducted by telephone. The telephone interviews could possibly limit holistic sense-making because non-verbal language is missing. Therefore, the first author attended the first telephone interview to ensure that the interview was conducted in accordance with the intended phenomenological approach. Following that interview, phone interviews were assessed as being a feasible approach. In addition, the findings were strengthened by the involvement of all authors; firstly, because they all participated in drafting the interview guide and, secondly, because they were all involved in discussing the findings until agreement, which contributed to credible and trustworthy findings.

Implications for Practice

The findings from this study may inspire how nurses in future can involve the patient and their FMs in patient education and patient consultations when confronted with AF. Family-focused nursing may when delivered in a structured way potentially reduce emotional distress and anxiety in FMs of patient's with AF. Family-focused nursing is a way to establish a positive relationship with the FMs and the patient underpinning family collaboration and supporting the families' ability to manage their everyday life with AF.

Conclusion

A family-focused nursing intervention, facilitated by specialized nurses and comprising extensive communication, successfully filled a knowledge gap related to AF, thereby reducing panic and increasing the feeling of peace among FMs. Furthermore, the intervention facilitated the family's awareness of their resources and therefore their ability to change, regain balance, and enhance well-being in their everyday life as well as initiate a healing process in the family.

The personal interaction and communication with the nurse specialist were essential in building a strong relationship between the nurse, FMs, and the patient. The FMs experienced feeling more confident about the nature of AF. They also felt that AF became more manageable and that the intervention helped the family regain their sense of balance and well-being. Future nursing interventions for patients with AF should consider FMs and patients as an entity of care.

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