



Beliefs of public health nurses about solution-focused parenting support – A questionnaire study

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ARTICLE INFO

Keywords:

Beliefs
Solution-focused
Parenting support
Public health nurse

ABSTRACT

Background: Parenting support guidelines for public health nurses have shifted from a problem-focused to a solution-focused approach. Given the fundamental differences between these two approaches, implementation of solution-focused parenting support is assumed to be difficult. Since the way public health nurses provide parenting support is largely guided by their beliefs, knowledge about their beliefs concerning solution-focused parenting support is important for its actual implementation. This study aims to explore the behavioral, normative, and control beliefs of public health nurses about solution-focused parenting support for future design of implementation interventions and related research activities.

Methods: A theory of planned behavior questionnaire was systematically developed and tested using focus groups. Thematic analysis and nominal group technique were used to analyze the data and to reach consensus. Next, this questionnaire was conducted among 449 public health nurses in the Netherlands. Factor analysis and descriptive statistical analysis were performed.

Results: Factor analysis resulted in three distinguishing subscales: behavioral beliefs ($\alpha = 0.79$), normative beliefs ($\alpha = 0.80$), and control beliefs ($\alpha = 0.64$). Beliefs of public health nurses about solution-focused parenting support were moderately positive to positive (means varying from 4.24 to 5.54, on a 1–7 scale), and differences were statistically significant for various background variables. Control beliefs were less positive than behavioral and normative beliefs. Public health nurses trained in solution-focused parenting support reported more positive control beliefs ($M = 4.34$, $SD = 0.83$) as compared to untrained public health nurses ($M = 4.00$, $SD = 0.82$).

Conclusion: This study is the first to provide insight into public health nurses' beliefs about solution-focused parenting support. The overall moderately positive to positive beliefs of PHNs about solution-focused parenting support suggests that PHNs tend to accept solution-focused parenting support as a viable approach. Compared to behavioral and normative beliefs, PHNs score the lowest on control beliefs.

1. Introduction

Parenting support can be described as any intervention to promote a healthy child development by improving the parenting approach, competencies, and resources (Daly, 2015; Moran et al., 2004), and has been found effective on many different outcomes (Mihelic et al., 2017; Mingebach et al., 2018; Moran et al., 2004; Rayce et al., 2017). In recent years, in connection with the international trend, parenting support guidelines for PHNs in the Netherlands have shifted from a problem-focused to a solution-focused approach (Carr et al., 2017; De Jong & Berg, 2013; Knijn & Hopman, 2015; Oudhof et al., 2013; Polaschek &

Polaschek, 2007; Wells et al., 2014).

Differences between problem-focused and solution-focused parenting support are fundamental. In problem-focused parenting support, the professional is the expert assessing the current problem and its main causes, selecting, and implementing evidence-based interventions to solve the current problem, and evaluating whether the problem is solved. This approach is in line with the traditional medical model (De Jong & Berg, 2013; McAllister, 2003). Solution-focused parenting support can be characterized by a future oriented, positive discourse. Here, parents are the experts on their problems and the solutions. Their perspective on the preferred future is central. Current strengths and

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<https://doi.org/10.1016/j.chilyouth.2022.106693>

Received 7 April 2021; Received in revised form 8 April 2022; Accepted 10 October 2022

Available online 15 October 2022

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resources are assessed and used to establish small goals of progress toward the preferred future. Solution-focused approaches solve problems as effectively as other approaches and are probably more time-efficient (Bond et al., 2013; Gingerich & Peterson, 2013; Kim, 2008; Stams et al., 2006). Moreover, they increase goal approach, positive affect, and action planning, and decrease negative affect (Grant, 2012; Neipp et al., 2016). Solution-focused parenting support aims at empowering parents by increasing their motivation, self-confidence, competencies, and problem-solving skills. This new approach in parenting support not only addresses current, but also future parenting problems (De Jong & Berg, 2013; McAllister, 2003).

Public health nurses (PHNs) play an important role in the delivery of parenting support (Hanson et al., 2019; Novilla et al., 2006). They provide parenting support as primary prevention to all parents (e.g., general, standardized oral and written parenting education) and as secondary prevention to parents with specific parenting questions or problems (e.g., indicated one-hour-support sessions, and indicated Video-Interaction-Guidance). The way PHNs provide parenting support is largely guided by their beliefs (Connors & Halligan, 2015; Fishbein & Ajzen, 2011; Gottlieb & Gottlieb, 2017; Henderson, 2002). Sustainable implementation of solution-focused parenting support in the daily practice of PHNs is challenging, given the fundamental differences of this approach with the traditionally more common problem-focused approach of parenting support in the youth healthcare (YH). Grol et al. (2013) developed a model to support sustainable implementation of the complex process of innovations in healthcare. They distinguish different stages in the process of change for professionals that include different aspects of effective implementation. These stages are orientation, insight, acceptance, change, and maintenance (Grol & Wensing, 2004, 2013). In the acceptance stage, after passing the stages of orientation and insight, the formation of beliefs around the innovation play a central role according to Grol et al. (2013). Therefore, positive beliefs about solution-focused parenting support could be viewed as a prerequisite for PHNs to change their routine problem-focused parenting support practice to the empowering solution-focused approach (Fishbein & Ajzen, 2011).

According to the theory of planned behavior (TPB) beliefs are “subjective probabilities” and the most elementary explanation of behavior (Ajzen, 1991; Fishbein & Ajzen, 2011). Within this theory, beliefs are assumed to be factors that causally influence a person’s attitude, subjective norm, and perceived behavioral control, which subsequently affects a person’s (intention toward a) given behavior (Ajzen, 1991).

The TPB distinguishes between three types of beliefs: behavioral, normative, and control beliefs. Behavioral beliefs are “the likely consequences or other attributes of the behavior” that “produce a favorable or unfavorable attitude toward the behavior.” Normative beliefs are “beliefs about the normative expectations of other people” that “result in perceived social pressure or subjective norm.” Control beliefs are “beliefs about the presence of factors that may further or hinder performance of the behavior” that “give rise to perceived behavioral control, the perceived ease or difficulty of performing the behavior” (Ajzen, 2002, p. 665).

Beliefs, thus, explicate the perspectives of PHNs on the importance and feasibility of solution-focused parenting support in their daily practice, and are viewed as antecedents of their professional behavior and behavior change (Ajzen, 2002; Ajzen & Fishbein, 2000; Fishbein & Ajzen, 2011; Grol et al., 2013; Parandeh et al., 2015; Squires et al., 2011). Therefore, knowledge of these beliefs is needed to align implementation strategies with the characteristics of this specific target

group, i.e., PHNs (Fishbein & Ajzen, 2011; Godin et al., 2008; Grol et al., 2013). Unfortunately, to our knowledge, no study has been conducted yet to gain in-depth understanding of PHNs beliefs about solution-focused parenting support. Hence, this study aims to explore the behavioral, normative, and control beliefs of PHNs about solution-focused parenting support to contribute to a knowledge base for future design of implementation interventions and related research activities.

2. Material and methods

In this study, we used a two-stage exploratory study design (Creswell, 2009). The first phase aimed at the development of a solution-focused parenting support beliefs questionnaire (SFBQ). The second phase aimed at assessing the behavioral, normative, and control beliefs of PHNs by applying the SFBQ.

2.1. Procedure

Prior to each stage of data collection, participants were informed about the study aim and procedures, and gave their consent to participate on a voluntary basis. All procedures in this study were approved by the Ethics Review Board of [anonymized for peer review].

2.1.1. Phase 1: Development of the SFBQ

The SFBQ was developed following the steps as recommended by Francis et al. (2004): 1) Define the population of interest; 2) Define the behavior of interest; 3) Determine salient behavioral, normative, and control beliefs, and include items in the first draft of the questionnaire; 4) Test the first draft of the questionnaire regarding clarity, comprehensibility, convenience, and size, and adjust if necessary.

2.1.1.1. Define the population of interest. The population of interest in this study consisted of PHNs occupied at YH organizations in the Netherlands. The Dutch YH is a public health service executed at regional level. The general aim of YH is to promote child health and to prevent or reduce physical, psychological, social, and functional child development problems. YH is available for all families in the Netherlands with children aged 0–18 years old, free of charge. Parenting support as early intervention is at the core of the work of PHNs to prevent more severe problems (Bakker-Camu & van Kuppevelt, 2014). At the time of this study, approximately 3,000 PHNs were employed at 48 different YH organizations in the Netherlands (Jambroes et al., 2015).

2.1.1.2. Define the behavior of interest. A clear definition of solution-focused parenting support appropriate for the aim of content validity in the survey was missing (De Jong & Berg, 2013; Del Greco et al., 1987). Therefore, to reach a consensus definition, two meetings with a jury of solution-focused experts were conducted (McKenzie et al., 1999). In total, six experts in solution-focused support originating from different perspectives (researchers and practitioners) participated in both meetings.

During the first meeting, the main characteristics of solution-focused parenting support were elicited from the experts individually and shared with other group members. After the meeting, the elicited characteristics were clustered into themes by the primary researcher, using the first three steps of a thematic analysis procedure (Table 1) (Braun & Clarke, 2006). This analysis was discussed with two other researchers (J.M. & P.V.) until consensus was reached.

During the second meeting, step four and five of thematic analysis

Table 1
Thematic analysis (Braun & Clarke, 2006).

Phase	Description of the process
1. Familiarizing yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

were executed collaboratively. The initial themes were discussed with all participants, and consensus was reached about an appropriate name for each theme (Braun & Clarke, 2006). Finally, during the second meeting, a nominal group technique was used to create consensus about the final definition of solution-focused parenting support based on the identified themes. This nominal group technique included five consecutive stages: 1) Introduction and explanation, 2) Silent generation of ideas, 3) Sharing ideas, 4) Group discussion/clarifying, and 5) Voting and ranking (Harvey & Holmes, 2012).

The final definition, presented below, was used during all further data collection procedures in this study.

Solution-focused parenting support implies for public health nurses a cooperation with parents based on an attitude of appreciation, genuine interest, and without prejudice. The public health nurse is confident that parents can achieve their preferred changes with help of their social network.

Solution-focused parenting support aims at the best wishes of parents and at discovering, activating, and strengthening parents' ability to grow toward their preferred future. The public health nurse uses specific language to invite parents:

1. *to tell their current story*
2. *to express their preferred future*
3. *to discover their current positive exceptions to the problem*
4. *to boost their available strengths and resources through one first step toward their preferred future*

2.1.1.3. Determine salient behavioral, normative, and control beliefs. Two focus groups with PHNs were held to elicit the most common behavioral, normative, and control beliefs about solution-focused parenting support (Francis et al., 2004). A convenience sampling method was used to recruit eighteen PHNs from two YH organizations in different large regions of the Netherlands (South and South-West, each comprising > 350.000 inhabitants) (Daniel, 2012). The sample consisted of females who were all educated as registered nurse (RN). Their mean age was 41.8 years old (Min = 24, Max = 61), and their mean work experience as PHN was 14.25 years (Min = 1, Max = 32).

During the focus group meetings, open-ended questions were used to elicit the beliefs about solution-focused parenting support (Table 2). Next, all expressed beliefs were analyzed by the primary researcher using a thematic content analysis (Braun & Clarke, 2006). Six belief

Table 2
Beliefs eliciting questions (Francis et al., 2004).

Behavioral beliefs
When parents share their mild parenting problems with you ...
1. What would you like or enjoy about providing solution-focused parenting support?
What would you dislike or hate about providing solution-focused parenting support?
What do you believe are the advantages of solution-focused parenting support?
What do you believe are the disadvantages of solution-focused parenting support?
Is there anything else you associate with providing solution-focused parenting support?
Normative beliefs
When parents share their mild parenting problems with you...
1. Are there any individuals or groups who would approve of you providing solution-focused parenting support?
Are there any individuals or groups who would disapprove of you providing solution-focused parenting support?
Control beliefs
When parents share their mild parenting problems with you ...
What factors or circumstances enable you to provide solution-focused parenting support?
What factors or circumstances make it difficult or impossible for you provide solution-focused parenting support?
Final question
Are there any other issues that come to mind when you think about providing solution-focused parenting support to parents with mild parenting problems?

categories were used as a framework for the analysis: positive behavioral beliefs, negative behavioral beliefs, positive normative beliefs, negative normative beliefs, positive control beliefs, and negative control beliefs. In the first step of the analysis, the beliefs mentioned were assigned to one of the belief categories. Next, beliefs within one category were grouped based on their similar content. A theme that covered their content was assigned to each group of beliefs. Finally, the 75 % most mentioned behavioral, normative, and control beliefs were determined as the most salient beliefs. These salient beliefs were converted into belief statements and included in the first draft of the SFBQ (Francis et al., 2004). This analysis was discussed with all co-authors until consensus was reached.

2.1.1.4. Testing the questionnaire. The first draft of the SFBQ included an introduction with an informed consent procedure and the definition of solution-focused parenting support, questions on background characteristics, and behavioral, normative, and control belief questions. Beliefs were measured using a 7-point Likert scale (1 = totally disagree/difficult; 7 = totally agree/easy), which is recommended as preferred rating scale in TPB research (Francis et al., 2004). The SFBQ was developed as an online questionnaire using Qualtrics® XM software (2019).

A convenience sampling method was used to solicit PHNs to test the questionnaire for its clarity, comprehensibility, convenience, and size (Daniel, 2012). First, two YH organizations were purposefully selected based on their location (i.e., relative near to the principal researcher's location). Next, all PHNs in these organization were invited by email to test the questionnaire. In total, eleven PHNs responded positive to the invitation. Five of them were occupied at one of the YH organizations, and six were occupied at the other. Due to sickness and heavy workload, finally five PHNs tested the questionnaire, two from one YH organization and three from the other. After completing the questionnaire, the participants were interviewed individually for information about the clarity, comprehensibility, convenience, and size of the online questionnaire.

2.1.2. Phase 2: Survey SFBQ

2.1.2.1. Participants. For the survey, 20 out of the 48 Dutch YH

Table 3
Characteristics participating YH organizations.

YH organization	Region in the Netherlands	Number of municipalities	Number of inhabitants
1	South	16	696.356
2	South	24	1.000.000
3	South-West	13	385.459
4	South-East	1	122.723
5	South-East	8	245.000
6	Central	13	439.755
7	Central	17	490.486
8	South-East	13	577.372
9	South	6	249.303
10	North-West	8	320.000
11	East	14	554.124
12	North	16	658.000

organizations were randomly selected using the function “random sample of cases” in SPSS Statistics for Windows (Version 24.0) and invited to participate in the survey. In total, twelve organizations agreed to participate, four organizations declined to participate due to work pressure issues, and four organizations did not respond to multiple invitations. The participating organizations together employed 809 PHNs in various regions around the Netherlands (Table 3).

2.1.2.2. Procedure. The SFBQ was distributed digitally to 809 PHNs, using Qualtrics XM software (2019). PHNs first received an email in which the study, its aim, and the procedure were introduced. In direct response to this email, 28 automatic replies from PHNs reported long-term absence due to various reasons (e.g., maternity leave, sick leave), which made participation in this study impossible. One week later, a second email was sent to the remaining PHNs ($n = 781$), which included an invitation to participate and a link to the questionnaire. Data were collected using three reminders in a six-week-period, which was carefully selected to promote the possibility of responding (e.g., no public holidays). The data collection period was extended from November 2018 to May 2019.

2.1.2.3. Data analysis

2.1.2.3.1. Preliminary analysis. Data were analyzed using SPSS Statistics. Initially, the data were screened for missing data. In total, twelve cases were eliminated from the dataset, because 20 % or less of all questionnaire items were completed. Moreover, three cases in the dataset each missed one item. In these cases, mean imputations were performed for the missing values (Polit & Beck, 2008). All other cases were complete. Furthermore, items were recoded, if necessary, to assure all higher scores to associate with positive beliefs. Our data are hierarchical, as PHNs (level 1) are nested within twelve different YH organizations (level 2). Therefore, we tested whether it was necessary to control for organization effect in the analyses (Shek & Ma, 2011). We calculated the intraclass correlation coefficient (ICC), which is the proportion of the total variation in beliefs of PHNs that is due to differences between YH organizations. Multilevel modeling for the YH organization effect would be needed if the proportion of explained variance is 25 % or higher (Heinrich & Lynn, 2001). The result of the ICC of beliefs ranged between 0.5 % and 7.6 %. Thus, multilevel modeling was proved to be not necessary.

2.1.2.3.2. Main analysis. Factor analysis using principal component analysis (PCA) with 26 items and direct oblimin rotation was performed to verify the discriminant validity of the three beliefs constructs from the TPB. The Kaiser-Meyer-Olkin test revealed sample adequacy for PCA, $KMO = 0.85$ (which is “great” according to Hutcheson and Sofroniou (1999)). Furthermore, Bartlett’s test of sphericity was statistically significant, indicating factorability based on the correlations between variables. Factors associated with eigenvalues >1 were retained based on Kaiser’s criterion. Furthermore, within each factor, items with loadings > 0.3 were selected as initially suitable for this specific factor

(Beavers et al., 2013; Williams et al., 2010). Next, the first and second author compared the retained factors to the beliefs constructs within the TPB by the content of the associated items. Based on substantial assessment of the content of each item, factors were established as subscales within the overall belief scale. Finally, Cronbach’s alpha, mean, and standard deviation were calculated for each subscale, and statistically significant differences related to the background variables “age,” “work experience,” and “trained in solution-focused parenting support (or not)” were explored by performing an independent T-test or ANOVA.

3. Results

3.1. Phase 1: Development of SFBQ

3.1.1. Definition population of interest

As mentioned in more detail in the method section, approximately 3,000 PHNs employed at 48 different Dutch YH organizations were identified as study population.

3.1.2. Definition behavior of interest

The definition of solution-focused parenting support as result of the expert meetings is presented in section 2.1.1.2.

3.1.3. Salient behavioral, normative, and control beliefs

In total, 515 beliefs were expressed during the two focus groups. The analysis resulted in eleven positive behavioral belief themes, seven negative behavioral belief themes, six positive normative belief themes, three negative normative belief themes, eight positive control belief themes, and five negative control belief themes (Table 4). Beliefs that could not be grouped with other statements were clustered per category in the theme “other.” In Table 4, the themes presented in *Italic* represent the selection of the 75 % most mentioned beliefs per category that were included in the first draft of the questionnaire.

3.1.4. Results from testing the questionnaire

As a result of testing the questionnaire, some adjustments to the first draft of the SFBQ were made. Specific textual amendments were made; for example, the introduction text was adapted to be more appealing to PHNs. Furthermore, word order was changed in two questions for clarity purposes. If the same topic was included as both a positive and a negative belief about solution-focused parenting support (e.g., control beliefs “time” and “experience”), these two questions were merged into one question. Questionnaire size and the time needed to fill out the questionnaire were positively evaluated. Table 5 presents the items included in the final questionnaire.

3.2. Phase 2: Survey SFBQ

3.2.1. Sample characteristics

In total, 57.5 % ($n = 449$) of the PHNs who received a link to the SFBQ completed the questionnaire. All twelve YH organizations were represented in the response. Response percentages per organization fluctuated, with a minimum of 43.6 % per organization. The participants were predominantly female (97.8 %), and 70.8 % of the participants have been trained in solution-focused parenting support. Other characteristics of the participants are presented with the results of differences in beliefs in Table 7.

3.2.2. Beliefs scales resulting from factor analysis

The three factors that resulted from the principal component analysis accounted for 38.6 % of the variance. Factor loadings after rotation are presented in Table 6.

Based on the loadings and on the content of each item, the factors “behavioral beliefs” (factor 1), “normative beliefs” (factor 2) and “control beliefs” (factor 3) from the TPB were distinguished.

Table 4
Behavioral, normative, and control beliefs of PHNs about solution-focused parenting support.

Positive behavioral beliefs (n = 133)	Negative behavioral beliefs (n = 91)	Positive normative beliefs (n = 74)	Negative normative beliefs (n = 19)	Positive control beliefs (n = 121)	Negative control beliefs (n = 77)
Themes: Parents become more active (n = 23) Parents' perspective central in support process (n = 13) Adopting a positive support approach (n = 13) Same result is achieved in less time (n = 13) Confirming available strengths in parents (n = 12) Working according to a concrete methodology (n = 11) Stimulates motivation in parents (n = 9) Stimulates good contact with parents (n = 8) Active listening (n = 7) Better problem clarification (n = 7) Appreciative attitude (n = 6) Other	Themes: Not corresponding to parents' expectations (n = 24) Not suitable in every case of parenting support (n = 14) Time-inefficient support approach (n = 13) Difficult to ask correct questions (n = 11) Unable to deploy professional knowledge (n = 9) No flexibility in methodology (n = 6) Does not fit in current organization of care (n = 6) Other	Themes: Colleagues would support (n = 17) Stakeholders would support (n = 16) Management would support (n = 11) Nurseries/Preschools/ Schools would support (n = 11) Parents would support (n = 9) Counsel would support (n = 5) Other	Themes: Parents would not support (n = 13) Colleagues would not support (n = 2) Social network would not support (n = 2) Other	Themes: Enough time (n = 21) Training in solution-focused support (n = 19) Peer supervision sessions (n = 17) Having an appreciative attitude (n = 16) Experience with approach (n = 15) Suitable workspaces in organization (n = 8) Parents that will be open to solution-focused parenting support (n = 7) Same method used by all colleagues/ stakeholders (n = 4) Other	Themes: Lack of time (n = 31) Lack of experience with approach (n = 11) Knowledge gap (n = 6) Unsuitable workspaces in organization (n = 5) Unmotivated parents (n = 3) Other

Factors were finally determined by specific choices of the first and second author after substantial assessments of the items. First, item B15 (*I think parents with mild parenting problems would agree with solution-focused parenting support*) with a factor loading > 0.3 was excluded from factor 1 “behavioral beliefs.” During the focus groups, this item was mentioned as “normative belief.” Since this item loaded high on “behavioral beliefs” in the analysis, but could not be interpreted as such, this item was excluded from further analysis. Second, item B21 (*Having an appreciative attitude toward parents is difficult/easy for me*) loaded high on factor 1 “behavioral beliefs.” However, this item was mentioned as a “control belief” during the focus groups. Since this item could not be interpreted as a “behavioral belief,” it was excluded from further analysis. Third, item B9 (*... the support process is less time-efficient than other support approaches*) exceeded a factor loading of 0.3 on “behavioral beliefs” and “control beliefs.” Since this item loaded highest on “behavioral beliefs” and was mentioned as a “behavioral belief” during focus groups, it was included in factor 1 “behavioral beliefs.” Fourth, item B7 (*... I find it difficult to ask solution-focused questions*) was mentioned as a behavioral belief during focus groups, but loaded high on control beliefs. Since this item reflects a difficulty of performance as a negative evaluation of the behavior, it could be interpreted as a control belief, and was assigned as such. Finally, item B1 (*... I work according to a concrete methodology*) was mentioned as a “behavioral belief” during focus group sessions. However, it loaded high on factor 3 “control beliefs” in the analysis and could also be interpreted as such. This item was therefore assigned to factor 3 “control beliefs” for further analysis. The analysis resulted in three subscales of salient beliefs of PHNs about solution-focused parenting support: subscale 1 “behavioral beliefs” (including items B2, B3, B5, B6, B8, B9, B10, B11, B12, and B13), subscale 2 “normative beliefs” (including items B14, B16, B17, and B18), and subscale 3 “control beliefs” (including items B1, B7, B19, B20, B22, B23, B24, and B25).

3.2.3. Reliability and descriptive analysis

Cronbach’s alpha was determined for each established subscale. Cronbach’s alpha for “behavioral beliefs” was 0.79, Cronbach’s alpha

for “normative beliefs” was 0.80, and Cronbach’s alpha for “control beliefs” was 0.64. Overall, PHNs had positive behavioral beliefs (M = 5.54; SD = 0.65), and moderately positive normative (M = 4.92; SD = 1.08) and control beliefs (M = 4.24; SD = 0.84) about solution-focused parenting support. Paired samples T-tests showed that the means of the subscales differed statistically significantly from each other. Behavioral beliefs were higher than control beliefs (t(448) = 33.0, p ≤ 0.01) and normative beliefs (t(448) = 12.0, p ≤ 0.01), and normative beliefs were higher than control beliefs (t(448) = 12.5, p ≤ 0.01).

3.2.4. Differences in beliefs regarding background characteristics

Differences were found between trained and untrained PHNs for control beliefs (t(447) = 4.01; p ≤ 0.01), indicating that trained nurses scored higher (M = 4.34; SD = 0.83) than untrained nurses (M = 4.00; SD = 0.82). Furthermore, differences between age groups were found for behavioral beliefs (F(4) = 5.98; p ≤ 0.01) and control beliefs (F(4) = 7.39; p ≤ 0.01). Finally, differences between the work experience groups were found for behavioral beliefs (F(8) = 3.30; p ≤ 0.01) and control beliefs (F(8) = 3.80; p ≤ 0.01).

Post hoc analyses, using the Bonferroni correction, were performed for in-depth analyses of differences in beliefs between age groups and work experience groups. These analyses showed that the age group 20–30 scored significantly lower on behavioral beliefs than the age groups 41–50 and 51–60 and scored significantly lower on control beliefs than the age groups 41–50, 51–60, and 61–67. Regarding work experience, we found that the mean on behavioral beliefs of group 0–10 was significantly lower than the mean of group 11–20 and 21–30, and the mean on control beliefs of group 0–10 was significantly lower than the mean of group 21–30. The post hoc analyses revealed no further statistically significant differences. The means and SD of beliefs for different training groups, age groups, and work experience groups, and significant mean differences, are presented in Table 7.

4. Discussion

This study is the first to provide more insight into PHNs’ beliefs about

Table 5
Demographic and beliefs questions SFBQ.

Demographic questions	
A1. What is your gender?	o Female Male
A2. What is your age?	o 20–30 31–40 41–50 51–60 61–67
A3. At which organization are you employed?	▼
A4. Have you been trained in solution-focused parenting support?	o Yes No
A5. How many years have you been working as a public health nurse?	o 0–5 6–10 11–15 16–20 21–25 26–30 31–35 36–40 >40
Behavioral beliefs questions	
If I provide or would provide solution-focused parenting support to parents with mild parenting problems ...	
B1 ... I work according to a concrete methodology.	Totally disagree 1–2–3–4–5–6–7 Totally agree
B2 ... the same result is achieved in less time.	Totally disagree 1–2–3–4–5–6–7 Totally agree
B3 ... the motivation of parents is stimulated.	Totally disagree 1–2–3–4–5–6–7 Totally agree
B4 ... it does not correspond to the parents' expectations.	Totally disagree 1–2–3–4–5–6–7 Totally agree
B5 ... it stimulates a good contact with parents.	Totally disagree 1–2–3–4–5–6–7 Totally agree
B6 ... the parents' perspective is central in the support process.	Totally disagree 1–2–3–4–5–6–7 Totally agree
B7 ... I find it difficult to ask correct solution-focused questions.	Totally disagree 1–2–3–4–5–6–7 Totally agree
B8 ... I adopt a positive approach.	Totally disagree 1–2–3–4–5–6–7 Totally agree
B9 ... the support process is less time-efficient than other support approaches.	Totally disagree 1–2–3–4–5–6–7 Totally agree
B10 ... parents become more active in finding a suitable solution.	Totally disagree 1–2–3–4–5–6–7 Totally agree
B11 ... I cannot deploy my professional knowledge.	Totally disagree 1–2–3–4–5–6–7 Totally agree
B12 ... the strengths of parents are being confirmed.	Totally disagree 1–2–3–4–5–6–7 Totally agree
B13 Solution-focused parenting support is suitable in all cases of parenting support.	Totally disagree 1–2–3–4–5–6–7 Totally agree
Normative beliefs questions	
B14 Stakeholders think I should provide solution-focused parenting support to parents with mild parenting problems.	Totally disagree 1–2–3–4–5–6–7 Totally agree
B15 I think parents with mild parenting problems would agree with solution-focused parenting support.	Totally disagree 1–2–3–4–5–6–7 Totally agree
B16 The management of my organization wants me to provide solution-focused parenting support to parents with mild parenting problems.	Totally disagree 1–2–3–4–5–6–7 Totally agree
B17 I assume my colleagues think I should provide solution-focused parenting support to parents with mild parenting problems.	Totally disagree 1–2–3–4–5–6–7 Totally agree
B18 Nurseries, preschools, and schools expect me to provide solution-focused parenting support to parents with mild parenting problems.	Totally disagree 1–2–3–4–5–6–7 Totally agree
Control beliefs questions	
B19 The time available in youth healthcare to provide solution-focused parenting support to parents with mild parenting problems is insufficient.	Totally disagree 1–2–3–4–5–6–7 Totally agree
B20 The training "solution-focused parenting support" as offered by the youth healthcare is sufficient.	Totally disagree 1–2–3–4–5–6–7 Totally agree
B21 For me, having an appreciative attitude toward parents with mild parenting problems is ...	Difficult 1–2–3–4–5–6–7 Easy

Table 5 (continued)

Demographic questions		o Female Male
B22	For me, carrying out peer supervision sessions into solution-focused parenting support is ...	Difficult 1–2–3–4–5–6–7 Easy
B23	For me, providing solution-focused parenting support to unmotivated parents is ...	Difficult 1–2–3–4–5–6–7 Easy
B24	For me, gaining experience in solution-focused parenting support in daily practice is ...	Difficult 1–2–3–4–5–6–7 Easy
B25	I have insufficient knowledge about solution-focused parenting support to parents with mild parenting problems.	Totally disagree 1–2–3–4–5–6–7 Totally agree
B26	The workspaces within my organization are inappropriate for providing solution-focused parenting support	Totally disagree 1–2–3–4–5–6–7 Totally agree

solution-focused parenting support. This paper reports on the salient behavioral, normative, and control beliefs of PHNs about solution-focused parenting support, and on the differences in these beliefs regarding some background characteristics. The results of this study contribute to a knowledge base for future design of implementation interventions and related research activities.

Behavioral beliefs were evaluated as the most positive, compared to normative and control beliefs. The salient behavioral beliefs of PHNs about solution-focused parenting support included increased parental motivation, parent-centeredness, a positive nurse–parent relationship, a positive approach, confirmation of parental strength, suitability for all cases of mild parenting problems, increased parental problem-solving activities, being able to use professional knowledge, and a time-efficient approach. These beliefs are in line with the basic principles of solution-focused theory, indicating a certain knowledge base of solution-focused parenting support in the PHNs' profession (De Jong & Berg, 2013; Grol & Wensing, 2004). A possible explanation for the positive evaluation of behavioral beliefs is that characteristics of solution-focused parenting support resemble the core values of health promotion within nursing and thus will appeal to PHNs (Wand, 2010). Stressing these beliefs as current strengths of PHNs in future implementation interventions should be motivating to proceed to the next step in the implementation process: i.e., change (Bartholomew Eldredge et al., 2016; Cooperrider et al., 2008; Grol et al., 2013). Lastly, on average, a younger age and little work experience are associated with less positive behavioral beliefs. This indicates that the development of positive behavioral beliefs of PHNs who are young and have little work experience needs special attention in designing implementation strategies. No differences in behavioral beliefs were found between trained and untrained PHNs.

Normative beliefs were evaluated moderately positive, and were related to the management of the organization, colleagues, nurseries/preschools/schools, and stakeholders. It is likely that PHNs expect their management and colleagues to be positive about them performing solution-focused parenting support, since they are all part of the Dutch YH, with its specific mission and goals of parenting support. Furthermore, since strength-based practices are generally promoted in the domain of youth health, welfare, and education, with a focus on inter-professional collaboration, PHNs might also expect their external partners, such as teachers and social workers, to be positive about them providing solution-focused parenting support. No differences between normative beliefs were found based on age, work experience, and training in solution-focused parenting support, which means that it is unnecessary to differentiate with respect to normative beliefs as a motivational factor in implementation strategies to specific age, work experience, and trained-or-not groups.

The control beliefs of PHNs were also evaluated moderately positive. Control beliefs were linked to both internal and external factors. Internal control factors included knowledge, experience, and skills. External control factors mentioned were peer supervision sessions, training, time

Table 6
Factor loadings after rotation.

Rotated component matrix				
Questionnaire item		1	2	3
B3	... the motivation of parents is stimulated.	0.778	-0.028	-0.046
B6	... the parents' perspective is central in the support process.	0.773	-0.030	-0.063
B5	... it stimulates a good contact with parents.	0.765	0.054	-0.056
B12	... the strengths of parents are being confirmed.	0.764	0.039	-0.100
B10	... parents become more active in finding a suitable solution.	0.740	0.029	-0.077
B15	I think parents with mild parenting problems would agree with solution-focused parenting support.	0.622	0.242	-0.070
B8	... I adopt a positive approach.	0.620	0.128	-0.009
B21	For me, having an appreciative attitude toward parents with mild parenting problems is ...	0.506	0.019	0.073
B11	... I cannot deploy my professional knowledge.	0.488	-0.119	0.060
B13	Solution-focused parenting support is suitable in all cases of parenting support.	0.328	0.276	0.128
B2	... the same result is achieved in less time.	0.318	-0.023	0.214
B9	... the support process is less time-efficient than other support approaches.	0.306	-0.179	0.303
B4	... it does not correspond to the parents' expectations.	0.294	0.028	0.006
B26	The workspaces within my organization are inappropriate for providing solution-focused parenting support.	0.178	-0.033	0.101
B17	I assume my colleagues think I should provide solution-focused parenting support to parents with mild parenting problems.	0.147	0.805	-0.068
B18	Nurseries, preschools, and schools expect me to provide solution-focused parenting support to parents with mild parenting problems.	-0.053	0.755	0.111
B14	Stakeholders think I should provide solution-focused parenting support to parents with mild parenting problems.	0.014	0.747	0.032
B16	The management of my organization wants me to provide solution-focused parenting support to parents with mild parenting problems.	0.112	0.726	0.042
B7	... I find it difficult to ask correct solution-focused questions.	-0.004	-0.095	0.629
B24	For me, gaining experience in solution-focused parenting support in daily practice is ...	0.218	0.110	0.597
B23	For me, providing solution-focused parenting to unmotivated parents is ...	-0.001	-0.011	0.561
B22	For me, carrying out peer supervision sessions into solution-focused parenting support is ...	-0.129	0.187	0.510
B25	I have insufficient knowledge about solution-focused parenting support to parents with mild parenting problems.	0.164	0.074	0.509
B20	The training "solution-focused parenting support" as offered by the youth healthcare is sufficient.	-0.101	0.218	0.491
B19	The time available in youth healthcare to provide solution-focused parenting support to parents with mild parenting problems is insufficient.	-0.030	-0.119	0.371
B1	... I work according to a concrete methodology.	0.133	0.101	0.370

Extraction Method: Principal Component Analysis.
Rotation Method: Oblimin with Kaiser Normalization.

available, the concrete character of methodology, and situations with unmotivated parents.

Furthermore, trained PHNs scored significantly higher on control beliefs than untrained PHNs. This result corresponds with the outcome of the study of [Bowles et al. \(2001\)](#) in the context of mental health

nursing. They found that solution-focused support training resulted in increased levels of confidence in nurses to talk to troubled people. Training in solution-focused parenting support thus seems to contribute to self-confidence. Additionally, control beliefs are positively related to age and work experience. A possible explanation of this finding is that experience and self-knowledge are factors known to increase with age. Besides, more experience and self-knowledge are associated with more accurate and stable views of behavioral control ([Notani, 1998](#)). Therefore, older PHNs, and PHNs with more work experience, are more likely to express more positive control beliefs on solution-focused parenting support.

Our study has several strengths and limitations. Some of which relate to the different steps in the development process of our tool. The expert panel and the resulting definition of solution-focused parenting support is a strength in this study. The different perspectives and the level of expertise of the participating experts on solution-focused support resulted in a general definition of solution-focused parenting support, and thus contributed to the content validity of the SFBQ. The in-depth interviewing during focus groups and subsequent thematic analysis to elicit the most salient beliefs of PHNs about solution-focused parenting support was another strength in this study. It could be discussed whether two different organizations and eighteen PHNs, selected using a convenience sampling method, provided sufficient variance in the results. However, the similarity in themes resulting from each focus group analysis indicated data saturation. Moreover, we assume that including more PHNs from other organizations would not have resulted in very different outcomes, given the relatively low ICCs found in the questionnaire study. Testing the first draft of the SFBQ could be viewed as a strength of our study, since we involved the target population in improving the clarity, comprehensibility, convenience, and size of the SFBQ. Furthermore, our study has shown it is possible to distinguish between the three beliefs categories in a questionnaire study, and that they are not merely theoretical constructs. Finally, the large number of participants is a strength of our study. The resemblance of characteristics of our sample with those of the total YH workforce in the Netherlands (including doctors and health assistants) adds to the assumption of generalizability of results to the PHNs population in the Netherlands ([Jambroes et al., 2015](#)). However, since specific characteristics of PHNs are lacking, no firm claims can be done.

A limitation of this study was that we did not have access to details on the content and scope of the training received. This restricts the possibility of within group analysis to assert the influence of training. Furthermore, no claims about the effectiveness of training on beliefs can be done since beliefs were not measured in advance of solution-focused training activities. Generalizability of the results to other countries than the Netherlands and to parenting support provided by other organizations than YH cannot be assumed. The way YH is organized in the Netherlands cannot be compared to other countries. Moreover, YH has a broader scope on health promotion compared to other organizations in the Netherlands providing parenting support as social intervention.

Since this is the first study assessing the validity and internal consistency of the SFBQ, and first results are promising, it would be a valuable follow-up to test the SFBQ in different – national and international – contexts of parenting support. Furthermore, the SFBQ could, for example, be used as pre- and post-measure to test whether activities to implement solution-focused parenting support changes PHNs' behavioral, normative, and control beliefs. In turn, in line with the [Medina and Beyebach \(2014\)](#) study, these changes in behavioral, normative and control beliefs could be used as predictors of the actual implementation of solution-focused parenting support by PHNs.

Consistent with transformative learning theories, engaging PHNs in action-oriented research strategies is recommended for radical changes in salient professional beliefs, since beliefs could be changed and new (salient) beliefs could be created by experimenting with new behaviors ([Cooperrider et al., 2008](#); [Henderson, 2002](#); [Mezirow, 2003](#)). Given the relatively low scores on control beliefs compared to behavioral and

Table 7

Mean and standard deviation behavioral, normative, and control beliefs related to background variables.

		n (449)	%	Behavioral beliefs		Normative beliefs		Control beliefs	
				Mean	SD	Mean	SD	Mean	SD
Training	Yes	318	70.8	5.55	0.66	4.97	1.07	4.34*	0.83
	No	131	29.2	5.51	0.63	4.81	1.10	4.00	0.82
Age (years)	a 20–30	64	14.2	5.24 ^{c d}	0.53	4.70	1.05	3.81 ^{c d e}	0.84
	b 31–40	93	20.7	5.45	0.57	4.82	1.07	4.11	0.84
	c 41–50	97	21.6	5.58 ^a	0.61	4.96	0.95	4.30 ^a	0.82
	d 51–60	148	33	5.68 ^a	0.69	5.05	1.14	4.40 ^a	0.78
	e 61–67	47	10.5	5.56	0.74	4.97	1.16	4.42 ^a	0.81
Work experience (years)	a 0–10	163	36.3	5.19 ^{b c}	0.56	4.83	1.06	4.29 ^c	0.75
	b 11–20	145	32.3	5.41 ^a	0.58	4.97	1.07	4.52	0.74
	c 21–30	89	19.8	5.57 ^a	0.68	5.04	1.13	4.67 ^a	0.83
	d 31–40	48	10.7	5.34	0.64	4.89	1.11	4.55	0.73
	e >40	4	0.9	5.44	0.41	5.00	0.79	4.63	0.94

* Statistically significant mean difference ($p \leq 0.01$).

The subscript letters indicate which categories differ statistically significantly from each other at the 0.01 level.

normative beliefs, the likelihood of improvement is greatest for control beliefs. Specific methods to increase control beliefs are, for example, guided practice, goal setting, and planning coping responses (Bartholomew Eldredge et al., 2016; Kelder et al., 2015; Latham & Locke, 2007; Marlatt & Donovan, 2005).

5. Conclusion

The SFBQ measures the three distinguishing types of beliefs from the TPB. The overall moderately positive to positive beliefs of PHNs about solution-focused parenting support suggests that PHNs tend to accept solution-focused parenting support as a viable approach. Compared to behavioral and normative beliefs, PHNs score the lowest on control beliefs.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Ethical approval

All procedures in this study were approved by the Ethics Review Board of Tilburg University (Reference number: EC-2017.05).

CRedit authorship contribution statement

Liesbeth Theuns-Boumans: Project administration, Conceptualization, Methodology, Investigation, Data curation, Formal analysis, Validation, Writing - original draft. **Jolanda Mathijssen:** Conceptualization, Methodology, Formal analysis, Validation, Writing - original draft, Writing - review & editing. **Carin Rots-de Vries:** Conceptualization, Methodology, Validation, Writing - original draft, Writing - review & editing. **Ien van de Goor:** Conceptualization, Methodology, Validation, Writing - original draft, Writing - review & editing. All authors gave final approval for this version to be published and agreed to be accountable for all aspects of the work.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Acknowledgement

We thank Petra Veninga (P.V.) for her assistance in the data analysis.

References

- Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes*, 50(2), 179–211. [10.1016/0749-5978\(91\)90020-T](https://doi.org/10.1016/0749-5978(91)90020-T).
- Ajzen, I. (2002). Perceived Behavioral Control, Self-Efficacy, Locus of Control, and the Theory of Planned Behavior. *Journal of Applied Social Psychology*, 32(4), 665–683. <https://doi.org/10.1111/j.1559-1816.2002.tb00236.x>
- Ajzen, I., & Fishbein, M. (2000). Attitudes and the Attitude-Behavior Relation: Reasoned and Automatic Processes. *European Review of Social Psychology*, 11(1), 1–33. <https://doi.org/10.1080/14792779943000116>
- Bakker-Camu, B., & van Kuppevelt, M. (2014). Expertisegebied jeugdverpleegkundige. [Field of expertise public health nurses in youth healthcare]. V&VN. <https://www.venvn.nl/media/ze5p310/20140411-expertise-jeugdverpleegkundige.pdf>.
- Bartholomew Eldredge, L. K., Markham, C. M., Ruiter, R. A., Fernández, M. E., Kok, G., & Parcel, G. S. (2016). *Planning health promotion programs: An intervention mapping approach* ((4th ed.)). John Wiley & Sons.
- Beavers, A. S., Lounsbury, J. W., Richards, J. K., Huck, S. W., Skolits, G. J., & Esquivel, S. L. (2013). Practical Considerations for Using Exploratory Factor Analysis in Educational Research. *Practical Assessment, Research, and Evaluation*, 18, Article 6. <https://doi.org/10.7275/qv2q-rk76>
- Bond, C., Woods, K., Humphrey, N., Symes, W., & Green, L. (2013). Practitioner review: The effectiveness of solution focused brief therapy with children and families: A systematic and critical evaluation of the literature from 1990–2010. *Journal of Child Psychology and Psychiatry*, 54(7), 707–723. <https://doi.org/10.1111/jcpp.12058>
- Bowles, N., Mackintosh, C., & Torn, A. (2001). Nurses' communication skills: An evaluation of the impact of solution-focused communication training. *Journal of Advanced Nursing*, 36(3), 347–354. <https://doi.org/10.1046/j.1365-2648.2001.01979.x>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp0630a>
- Carr, A., Hartnett, D., Brosnan, E., & Sharry, J. (2017). Parents Plus Systemic, Solution-Focused Parent Training Programs: Description, Review of the Evidence Base, and Meta-Analysis. *Family Process*, 56(3), 652–668.
- Connors, M. H., & Halligan, P. W. (2015). A cognitive account of belief: a tentative road map. *Frontiers in Psychology*, 5, 1588–1588. <https://doi.org/10.3389/fpsyg.2014.01588>
- Cooperrider, D. L., Whitney, D. K., & Stavros, J. M. (2008). *Appreciative inquiry handbook: for leaders of change* (2nd ed.). Crown Custom Publishing & Berrett-Koehler Publishers.
- Creswell, J. W. (2009). *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches* ((3rd ed.)). Sage Publications.
- Daly, M. (2015). Parenting support as policy field: An analytic framework. *Social Policy and Society*, 14(4), 597–608. [10.1017/S1474746415000226](https://doi.org/10.1017/S1474746415000226).
- Daniel, J. (2012). *Sampling Essentials: Practical Guidelines for Making Sampling Choices*. SAGE Publications, Inc. <https://doi.org/10.4135/978145272047>
- De Jong, P., & Berg, I. K. (2013). *Interviewing for Solutions* (4th ed.). Brooks/Cole.
- Del Greco, L., Walop, W., & McCarthy, R. H. (1987). Questionnaire development: 2. Validity and reliability. *CMAJ: Canadian Medical Association journal = journal de l'Association medicale canadienne*, 136(7), 699–700.
- Fishbein, M., & Ajzen, I. (2011). *Predicting and changing behavior: The reasoned action approach* (1st ed.). Taylor & Francis. <https://doi.org/10.4324/9780203838020>
- Francis, J., Johnston, M., Eccles, M., Walker, A., Grimshaw, J. M., Foy, R., & Bonetti, D. (2004). Constructing questionnaires based on the theory of planned behaviour: A manual for Health Services Researchers. *Quality of life and management of living*

- resources; Centre for Health Services Research. <https://openaccess.city.ac.uk/id/eprint/1735/>.
- Gingerich, W. J., & Peterson, L. T. (2013). Effectiveness of solution-focused brief therapy: A systematic qualitative review of controlled outcome studies. *Research on Social Work Practice*, 23(3), 266–283. <https://doi.org/10.1177/1049731512470859>
- Godin, G., Belanger-Gravel, A., Eccles, M., & Grimshaw, J. (2008). Healthcare professionals' intentions and behaviours: A systematic review of studies based on social cognitive theories. *Implementation Science*, 3(36), 12. <https://doi.org/10.1186/1748-5908-3-36>
- Gottlieb, L. N., & Gottlieb, B. (2017). Strengths-Based Nursing: A Process for Implementing a Philosophy Into Practice. *Journal of Family Nursing*, 23(3), 319–340. <https://doi.org/10.1177/1074840717717731>
- Grant, A. M. (2012). Making positive change: A randomized study comparing solution-focused vs. problem-focused coaching questions. *Journal of Systemic Therapies*, 31(2), 21–35. <https://doi.org/10.1521/jsyt.2012.31.2.21>
- Grol, R., & Wensing, M. (2004). What drives change? Barriers to and incentives for achieving evidence-based practice. *Medical Journal of Australia*, 180, 57–60. [10.5694/j.1326-5377.2004.tb05948.x](https://doi.org/10.1056/94.j.1326-5377.2004.tb05948.x).
- Grol, R., & Wensing, M. (2013). Effective implementation of change in healthcare: a systematic approach. In *Improving Patient Care: The implementation of change in health care* (2nd ed., pp. 40–63). Wiley Blackwell. <https://doi.org/10.1002/9781118525975.ch3>.
- Grol, R., Wensing, M., Eccles, M., & Davis, D. (2013). *Improving patient care : the implementation of change in health care* (2nd ed.). Wiley-Blackwell/BMJ Books. <https://doi.org/10.1002/9781118525975>.
- Hanson, C. L., Crandall, A., Barnes, M. D., Magnusson, B., Novilla, M. L. B., & King, J. (2019). Family-Focused Public Health: Supporting Homes and Families in Policy and Practice. *Frontiers in Public Health*, 7, 59–59. <https://doi.org/10.3389/fpubh.2019.00059>.
- Harvey, N., & Holmes, C. A. (2012). Nominal group technique: An effective method for obtaining group consensus. *International Journal of Nursing Practice*, 18(2), 188–194. <https://doi.org/10.1111/j.1440-172X.2012.02017.x>
- Heinrich, C. J., & Lynn, L. E., Jr. (2001). Means and Ends: A Comparative Study of Empirical Methods for Investigating Governance and Performance. *Journal of Public Administration Research and Theory*, 11(1), 109–138. <https://doi.org/10.1093/oxfordjournals.jpart.a003490>
- Henderson, G. M. (2002). Transformative Learning as a Condition for Transformational Change in Organizations. *Human Resource Development Review*, 1(2), 186–214. <https://doi.org/10.1177/15384302001002004>
- Hutcheson, G., & Sofroniou, N. (1999). The multivariate social scientist : Introductory statistics using generalized linear models. *Sage Publications*. <https://doi.org/10.4135/9780857028075>
- Jambroes, M., Lamkaddem, M., Stronks, K., & Essink-Bot, M. L. (2015). Enumerating the preventive youth health care workforce: Size, composition and regional variation in the Netherlands. *Health Policy*, 119(12), 1557–1564. [10.1016/j.healthpol.2015.08.002](https://doi.org/10.1016/j.healthpol.2015.08.002).
- Kelder, S. H., Hoelscher, D., & Perry, C. L. (2015). How individuals, environments, and health behaviors interact. In K. Glanz, B. K. Rimer, & K. Viswanath (Eds.), *Health behavior: Theory, research, and practice* (5th ed., pp. 159–181). Jossey-Bass.
- Kim, J. S. (2008). Examining the effectiveness of solution-focused brief therapy: A meta-analysis. *Research on Social Work Practice*, 18(2), 107–116. <https://doi.org/10.1177/1049731507307807>
- Knijn, T., & Hopman, M. (2015). Parenting Support in the Dutch 'Participation Society'. *Social Policy and Society*, 14(04), 645–656. <https://doi.org/10.1017/S1474746415000329>
- Latham, G. P., & Locke, E. A. (2007). New developments in and directions for goal-setting research. *European Psychologist*, 12(4), 290–300. <https://doi.org/10.1027/1016-9040.12.4.290>
- Marlatt, G. A., & Donovan, D. M. (2005). *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors* (2nd ed.). Guilford press.
- McAllister, M. (2003). Doing practice differently: Solution-focused nursing. *Journal of Advanced Nursing*, 41(6), 528–535. <https://doi.org/10.1046/j.1365-2648.2003.02564.x>
- McKenzie, J. F., Wood, M. L., Kotecki, J. E., Clark, J. K., & Brey, R. A. (1999). Establishing content validity: Using qualitative and quantitative steps. *American Journal of Health Behavior*, 23(4), 311–318. <https://doi.org/10.5993/AJHB.23.4.9>
- Medina, A., & Beyebach, M. (2014). The Impact of Solution-focused Training on Professionals' Beliefs, Practices and Burnout of Child Protection Workers in Tenerife Island. *Child Care in Practice*, 20(1), 7–36. <https://doi.org/10.1080/13575279.2013.847058>
- Mezirow, J. (2003). Transformative Learning as Discourse. *Journal of Transformative Education*, 1(1), 58–63. <https://doi.org/10.1177/1541344603252172>
- Mihelic, M., Morawska, A., & Filus, A. (2017). Effects of Early Parenting Interventions on Parents and Infants: A Meta-Analytic Review. *Journal of Child and Family Studies*, 26(6), 1507–1526. <https://doi.org/10.1007/s10826-017-0675-y>
- Mingebach, T., Kamp-Becker, I., Christiansen, H., & Weber, L. (2018). Meta-meta-analysis on the effectiveness of parent-based interventions for the treatment of child externalizing behavior problems. *PLoS ONE*, 13(9), 1–21. <https://doi.org/10.1371/journal.pone.0202855>
- Moran, P., Ghate, D., & Van der Merwe, A. (2004). What works in parenting support?: A review of the international evidence. *Department for Education and Skills London*. <http://www.prb.org.uk/wwiparenting/RR574.pdf>.
- Neipp, M. C., Beyebach, M., Nuñez, R. M., & Martínez-González, M.-C. (2016). The Effect of Solution-Focused Versus Problem-Focused Questions: A Replication. *Journal Of Marital And Family Therapy*, 42(3), 525–535. <https://doi.org/10.1111/jmft.12140>
- Notani, A. S. (1998). Moderators of Perceived Behavioral Control's Predictiveness in the Theory of Planned Behavior: A Meta-Analysis. *Journal of Consumer Psychology*, 7(3), 247–271. https://doi.org/10.1207/s15327663jcp0703_02
- Novilla, M. L. B., Barnes, M. D., De La Cruz, N. G., Williams, P. N., & Rogers, J. (2006). Public Health Perspectives on the Family: An Ecological Approach to Promoting Health in the Family and Community. *Family & Community Health*, 29(1), 28–42. <https://doi.org/10.1097/00003727-200601000-00005>
- Oudhof, M., de Wolff, S., de Ruijter, M., Kamphuis, M., L'Hoir, M. P., & Prinsen, B. (2013). JGZ-Richtlijn Opvoedingsondersteuning. Voor hulp bij opvoedingsvragen en lichte opvoedingsproblemen. [Youth healthcare-Parenting support guideline. To support in case of parenting questions and mild parenting problems]. <https://www.nji.nl/nl/Download-NJi/Publicatie-NJi/Samenvatting-JGZ-richtlijn-Opvoedingsondersteuning.pdf>.
- Parandeh, A., Khaghanizade, M., Mohammadi, E., & Nouri, J. M. (2015). Factors influencing development of professional values among nursing students and instructors: A systematic review. *Global Journal of Health Science*, 7(2), 284–293. <https://doi.org/10.5539/gjhs.v7n2p284>
- Polaschek, L., & Polaschek, N. (2007). Solution-focused conversations: A new therapeutic strategy in well child health nursing telephone consultations. *Journal of Advanced Nursing*, 59(2), 111–119. <https://doi.org/10.1111/j.1365-2648.2007.04314.x>
- Politi, D. F., & Beck, C. T. (2008). *Nursing research: Generating and assessing evidence for nursing practice* (8th ed.). Lippincott Williams & Wilkins.
- Rayce, S. B., Rasmussen, I. S., Klest, S. K., Patras, J., & Pontoppidan, M. (2017). Effects of parenting interventions for at-risk parents with infants: A systematic review and meta-analyses. *Bmj Open*, 7(12), 1–20. <https://doi.org/10.1136/bmjopen-2016-015707>
- Shek, D. T. L., & Ma, C. M. S. (2011). Longitudinal Data Analyses Using Linear Mixed Models in SPSS: Concepts, Procedures and Illustrations. *The Scientific World Journal*, 11, 42–76. <https://doi.org/10.1100/tsw.2011.2>
- Squires, J. E., Estabrooks, C. A., Gustavsson, P., & Wallin, L. (2011). Individual determinants of research utilization by nurses: A systematic review update. *Implementation Science*, 6(1), 1–20. <https://doi.org/10.1186/1748-5908-6-1>
- Stams, G. J., Deković, M., Buist, K., & de Vries, L. (2006). Effectiviteit van oplossingsgerichte korte therapie: Een meta-analyse. [Efficacy of solution-focused brief therapy: A meta-analysis]. *Gedragstherapie*, 39(2), 81–94. <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2006-09767-001&site=ehost-liveG.J.J.M.Stams@uva.nl>
- Wand, T. (2010). Mental health nursing from a solution focused perspective. *International Journal of Mental Health Nursing*, 19(3), 210–219. <https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1447-0349.2009.00659.x>
- Wells, G., Shields, L., Hauck, Y., Bennett, E., & Johnson, K. (2014). Do we make a difference? Parents' and nurses' experiences of using a strengths-based, solution-focused approach to care. *Australian Journal of Child and Family Health Nursing*, 11(2), 5–10.
- Williams, B., Onsmann, A., & Brown, T. (2010). Exploratory factor analysis: A five-step guide for novices. *Australasian Journal of Paramedicine*, 8(3), 1–13. [10.1.1.475.8594](https://doi.org/10.1.1.475.8594)