Health counselling: parental-oriented health dialogue an innovation for child health nurses
Marie Golsäter, Karin Enskär, Hans Lingfors and Birgitta Sidenvall

J Child Health Care 2009; 13; 75
DOI: 10.1177/1367493508098382

The online version of this article can be found at:
http://chc.sagepub.com/cgi/content/abstract/13/1/75

Published by:
SAGE
http://www.sagepublications.com

On behalf of:
abpn
Association of British Paediatric Nurses

Additional services and information for Journal of Child Health Care can be found at:

Email Alerts: http://chc.sagepub.com/cgi/alerts

Subscriptions: http://chc.sagepub.com/subscriptions

Reprints: http://www.sagepub.com/journalsReprints.nav

Permissions: http://www.sagepub.co.uk/journalsPermissions.nav

Citations http://chc.sagepub.com/cgi/content/refs/13/1/75
Health counselling: parental-oriented health dialogue – an innovation for child health nurses

MARIE GOLSÄTER, BSc, MSc, RN
Phd Candidate, Department of Nursing Science, School of Health Sciences, Jönköping University, Jönköping, Sweden

KARIN ENSKÄR, PhD, RN
Associate Professor, Department of Nursing Science, School of Health Sciences, Jönköping University, Jönköping, Sweden

HANS LINGFORS, MD, PhD
General Practitioner, Unit of Research and Development for Primary Health Care, County Council of Jönköping, Jönköping, Sweden

BIRGITTA SIDENVALL, PhD, RNT
Professor, Department of Nursing Science, School of Health Sciences, Jönköping University, Jönköping, Sweden

Abstract

The Health Curve, used by nurses in community-based health care, is an educational tool for conducting goal-directed dialogues concerning lifestyle and health. The aim of this study was to investigate how child health nurses experienced the Health Curve as a tool for conducting dialogues with parents. Fourteen nurses were interviewed. The data were analysed according to qualitative analysis. The results showed that nurses working in child health care experienced the Health Curve as a useful tool for conducting health dialogues with parents. Through their work with the Health Curve, the nurses gained a greater insight into, and understanding of, the families’ health and life situation. The results indicated that working with the Health Curve could increase the opportunity for nurses to provide parents with support early in the process, helping the family to lead a healthy lifestyle.

Keywords    child health • counselling • health promotion • nurse–family relationships • parenting support
Introduction

Obesity is classified as a global epidemic disease (World Health Organization (WHO), 2000) and it is increasing among children both in Europe and the United States (Ebbeling et al., 2002; Lobstein and Frelut 2003; Wang et al., 2002). Healthy behaviours in early childhood could prevent the child from developing obesity and cardiovascular diseases later in life (Hayman et al., 2007). Health dialogue between nurses and clients can be used as a tool in preventive work in primary health care. In Tveiten and Severinsson (2004), public health nurses describe client supervision as an interventional strategy that should include informing, giving advice and teaching in relation to the client’s individual needs and resources. The dialogue between nurses and clients is described as a relational enabling process with the purpose to strengthen resources (Tveiten, 2004). Färnkvist et al. (2008) showed that individual health dialogues between public health nurses and clients improved the individual’s health according to lower frequency of cardiovascular disease and diabetes mellitus. As children’s primary caregivers, parents can create and control the domestic environment and thus promote healthy behaviours in their children, such as positive eating habits and physical activity. Health dialogues focused on the parents’ health can be used to help a family lead a healthy lifestyle, in turn reducing the risk of their children developing health-related problems such as cardiovascular disease and obesity (Hayman et al., 2007). As an innovation of child health care work for the prevention of overweight and obesity among children and adolescents in the studied county council (Fåhraeus and Lingfors, 2004), parents were invited to a health dialogue based on their own health when the child was aged one year. The objective of this study was to investigate child health nurses’ experiences of this innovation.

Child health care in Sweden

In Sweden, child health care has a long and favourable history of public support, and nearly every family (99.6%) has contact with child health care during the child’s first years (Jansson et al., 1998). Work in the area of child health care is based on a recommended programme consisting of health supervision, immunizations, screening examinations and parental education, the aim being that the child will develop as optimally as possible. During the child’s first year, visits to child health care are relatively frequent, and usually continue at the rate of about one visit a year (National Board of Health and Welfare, 1991). According to the National Council for Medical Research (1999), one of the main principles of child health care work is its focus on parents’ participation, in order to strengthen their ability to take responsibility for the health of their child.
The educational tool

‘The Health Curve’ educational tool (Persson et al., 1998) was developed to guide health dialogues in primary health care and aims to map the needs of lifestyle improvements for individuals. It is a health profile that serves as an educational tool in the health dialogue between nurses and clients, comprising three questionnaires and a health profile. The first questionnaire contains questions about psychosocial strain, mental stress, heredity, use of tobacco and alcohol intake, and is answered by the client before the health dialogue. The second questionnaire, concerning dietary habits, and the third, concerning physical activity, are filled in during the appointment. The Health Curve also includes measurements of four biological risk markers: serum cholesterol concentration; body mass index (BMI); waist-to-hip ratio; and blood pressure.

Then, a personal health profile is constructed based on the answers from the questionnaires and measurements. The health profile includes 13 different risk factors. The first five factors deal with lifestyle: these are presented as modifiable factors which the individuals are exposed to but can change:

- smoking;
- alcohol habits;
- dietary habits;
- physical activity; and
- psychosocial strain.

They are followed by five effect variables (which to a large extent may be regarded as effects of lifestyle in combination with family history), comprising the following biological risk markers:

- serum cholesterol concentration;
- BMI;
- waist-to-hip ratio;
- blood pressure; and
- experiences of mental stress.

The next two factors deal with family history of diabetes and cardiovascular diseases respectively, and the final factor describes the history of disease:

- myocardial infarction;
- angina pectoris;
- arterial hypertension,
- heart failure; and
- diabetes.
Throughout the profile, each risk factor is graded at three or four risk levels (where grade 1 = low risk, and grade 4 = high risk). Different colours representing different ill-health risk levels reinforce the pedagogical message. Red is used for high risk, yellow for intermediate risk and green for low risk. These colours facilitate the understanding of personal risk, thereby the Health Curve helps to evoke an interest in leading a healthy lifestyle. The personal risk factors and their interrelationships are discussed in dialogue with a nurse, and possible changes in lifestyle to improve wellbeing are outlined (further details about the Health Curve have been published previously: Lingfors et al., 2001; Persson et al., 1998). Follow-ups held five years after the original Health Curve-based dialogues conducted with individuals at the age of 30 displayed improved lifestyle changes such as reduced smoking, decreased fat intake and increased physical activity (Lingfors et al., 2003). As the parents of the children in this study belonged to the same age group as the clients in Lingfors et al. (2003), these findings support the use of the Health Curve in child health care. Still, scientific evidence showing that the Health Curve is a useful and feasible method within this context is lacking.

Method

Aim

The aim of this study was to investigate the experiences of child health nurses when using the Health Curve educational tool in order to conduct health dialogues with parents. Qualitative interviews and analysis inspired by Strauss and Corbin (1990) are used in this study.

Sample

The sample consisted of all the 14 nurses who had begun to work with the Health Curve. The nurses had been working in child health care for between two and 34 years (Md = 16.5 years). They had conducted from 22 to more than 200 Health Curve-based dialogues with parents (Md = 72.5). Four of the nurses were working also as public health nurses with adult patients, and had performed several hundred health dialogues based on the Health Curve with that category of patient.

Data collection

The interviews began with an overall question about the nurses’ experience of working with the Health Curve. In order to ensure that all the participants answered the same basic questions, specific questions chosen from an interview guide were used when asking nurses to develop their answers. When the interview was completed, the interviewer presented a summary to the participant in order to prevent misunderstandings. Based on the summary, the next interview
was modified to suit the aim of the study better. The interviews were performed at the nurses’ offices and lasted from 20–45 minutes (median duration approximately 30 minutes).

Data analysis
The interviews were transcribed verbatim and analysed by two researchers. The analysis, inspired by Strauss and Corbin (1990), was carried out in three stages. At the first stage, each sentence was scrutinized to find substantive codes reproduced in the participant’s own words and terms. At the second stage, the substantive codes were compared and grouped into categories describing the content on a more abstract level. At the third stage, the core category ‘overall picture of the family’s health and life situation’ emerged from the pattern of categories. Thus the phenomenon was described, proving the relationship among the substantive codes, the categories and the core category (Strauss and Corbin 1990).

Ethical issues
After receiving written and oral presentations of the aim of the study, as well as a list of interview questions according to the Helsingfors Declaration, the nurses agreed to participate in the study. The study was approved by the appropriate research ethics committee in Linköping, Sweden.

Results
The core emerging category was labelled ‘overall picture of the family’s health and life situation’. Through the health dialogues, the nurses gained an in-depth view, and a greater understanding, of the health and life situations of the families. One nurse expressed this by saying:

This way of living, the fact that it can be covered at all in this conversation … because in our ordinary appointments there is so much we are supposed to inform them about. Here you can cover everything.

The nurses said that in previous contact with the parents, they sometimes got the feeling that there were circumstances affecting the family’s life situation that surfaced in the health dialogue. As one nurse explained:

things have come up that I had no idea about, like someone being unemployed and having a very difficult time financially, and not feeling at all well, but I didn’t know this before. But it can explain a number of things that I have been wondering about.
The results of the nurse’s experiences from using the Health Curve as a method of child health care are presented as separate categories, each containing both obstacles and opportunities.

**The Health Curve provides good structure for dialogue about health**

In the interviews, the nurses found that the Health Curve was useful for this target group, and they described the questionnaires as constituting a good structure for the dialogues. The compilation of the questionnaires and measurements in the health profile made a foreseeable and clear starting point for the conversations. The whole family’s lifestyle, including dietary habits and physical activities, was covered. The extensive questionnaires brought up different aspects of the parents’ health and life situation in a well-structured way and provided opportunities for discussion about different areas of the family’s life. In their previous work, the nurses had not had a structured way of talking about different areas of the family’s life, with certain topics, such as the parent’s intake of alcohol and unemployment, being particularly difficult. A typical response was:

> There were a lot of questions for them to answer concerning the whole family that one could talk about and ‘had to’ talk about because of the Health Curve. Previously [we have] not really had any reason to talk about these things.

The questionnaires presented a clear picture of how the parents experienced their own state of health. By responding to the questions before their visit, the parents had an opportunity to choose what they wanted to talk about with the nurse. This was seen as:

> a great benefit as a nurse at the child health clinic to not have to ask the questions; instead, they have already answered them themselves.

The questionnaires were not designed originally for use in child health care. However, the nurses found certain questions, such as those dealing with the degree to which others controlled the parents’ lives, very relevant for the parents of small children. Such questions resulted in many discussions about the role of a parent, revealing that many parents felt that time and space needed for their own personal development and wellbeing was limited. The questions provided a basis for conversations concerning what it is like to have small children and a long life ahead.

**Opportunity to involve both the mother and father**

Since both parents are given the opportunity to participate in the health dialogue, the nurses have a chance to meet both the mother and father and talk about their individual views on health and their life situation, as well as that of the whole family. Both parents, the whole family, are active participants. In the majority of
the families, the mother still takes care of the children and stays home from work. For that reason, the mother is the parent that the nurse usually meets at the child health care centre. Because of the health dialogue, the nurses had more contact with the fathers, one nurse said: ‘More than anything, it led to more contact with the father.’

**Improved relationship between the parents and nurse**

As the nurses meet the parents continuously throughout the child’s first year of life, they become familiar with them. Through the health dialogues, the nurses experienced becoming even more familiar with the parents than before they had started using the educational tool. One nurse explained this when she said: ‘You got to know the parents in a whole new way; yes, you got another picture of the parents’ situation.’

As part of their work in public nursing, some nurses also conducted preventive health dialogues with other groups of adult patients. Compared to conversations with the patients they only met for health dialogues, the nurses felt that more information about the families came to light when they were working with parents with whom they already had a relationship as described by one of the nurses:

nobody else is supposed to do it. Rather, based on my responsibility as a nurse at the child health clinic, I should do it myself.

The nurses feared one possible obstacle to the dialogues was that because of continuous contact with the parents during the child’s pre-school years, the parents would feel inhibited and unable to speak freely when discussing personal problems, due to their need for privacy. In this study, none of the nurses experienced that this had happened as the following quotation illustrates:

I don’t feel that I have become too close, but we are going to have a continuing relationship, so I can imagine things becoming sensitive.

**Create the opportunity for follow-up meetings**

Since the nurses had continued contact with the parents through regular visits at the child health centre, it was possible to have follow-up discussions on topics that arose during the health dialogues. It became natural to return to the health dialogue in further conversations as it was felt that we: ‘[the nurses] definitely benefit from the conversations we have had when I meet the families for further discussions’.

One obstacle to following up the health dialogues was limited time for regular appointments. The nurses’ available working-hours were limited and time for Health Curve appointments was especially lacking. At the regular appointment,
many other things had to be prioritized in order to follow the recommended programme as one of the nurses explained: ‘I don’t have the time to continue doing follow-ups; I don’t really have time for that.’ The nurses felt that further work was needed with regard to follow-up meetings.

_A stimulating and positive task_

The assignment with the health dialogues was seen as a positive and stimulating task and as: ‘fun and positive; I learned a lot; they are open and talkative’. The health dialogues gave the nurses opportunities to reinforce their preventive health work and to: ‘make a point about health factors’.

Because of reduced resources, two nurses reported that they had been forced to stop running the health dialogues and thus they could not complete the task. They missed the dialogues because for them it was important to be able to offer the dialogues to the parents, and they felt that they were a stimulating and a positive part of their work and it was described as being. ‘Yes, I would say that it’s something I wish we could reinstate.’

During the course of the interviews, it became apparent that it was important for the nurses’ work situation to be able to limit the conversation time because there was a risk that the dialogues would take too long. One of the nurses explained this when she said:

_to be able to limit the dialogues, I told them we had one hour, so we didn’t get hung up on one point._

_NEED FOR SUPPORT_

To be able to work with the health dialogues as part of child health care, the nurses expressed the need for resources in the form of support, education and time. A valuable prerequisite was to have support from their superior that is: ‘support from the head of the department’. For several nurses, the reason that they had begun conducting health dialogues was due to the support and interest shown by their head of the department. The head gave encouragement, displayed interest and approved the time required to carry out the work. In order for health dialogues to function effectively and properly, the nurses deemed it necessary that they be a part of the ordinary child health programme that offered:

_a health dialogue to every parent ought to be part of the ordinary programme and to do this, more time is required._

The nurses felt that it was important to have someone to turn to, to refer the parents to, if the conversations uncovered needs beyond the nurses’ competence. They mentioned needing help with handling issues such as depression, relationship problems, high blood pressure or dietary advice and the importance of having, ‘someone to refer the patient to’. Another important issue the nurses
expressed was their need for education about using the Health Curve as a method. Accompanying another nurse already working with the method was described as a good way to develop knowledge about it; additionally, to be able to talk with someone with more experience when a problem arose was seen as a useful way to learn and it was important, ‘to have someone to ask in the beginning’.

The nurses also brought up the desire to reinforce their knowledge after they had used the method for a while through continuing education. In addition, they requested the possibility to discuss their thoughts on the method with someone and to pose questions that came up during their work and to be able, ‘to review issues concerning food and alcohol, to ask the right questions’.

**Discussion**

The nurses in this study described how the Health Curve provided them with a more exhaustive description of the family’s life situation, which most likely increased their ability to give each family the support necessary to be able to take responsibility for their child’s health. Nurses working in child health care have described the importance of starting health counselling based on the individual family’s needs and wishes (Olander, 2003). Furthermore, child health nurses have pointed out that in order to provide advice that is suited to each family’s needs, knowledge of the family’s specific life situation is essential (Jansson et al., 2001).

This study shows that through using the Health Curve, nurses’ relationships with the families improved, especially their contact with fathers. In turn, the Health Curve provided fathers with the opportunity to be involved in the care of their children, and to take part in individual conversations about their personal life situations. The necessity of taking the father’s situation into account in child health care has been pointed out as an important aspect: fathers who took part in parent education groups at the child health clinic felt neglected in the discussions (Petersson et al., 2004). They also described a need for greater attention from the child health nurse and wanted to have a more trusting relationship with the nurse (Fägerskiöld, 2006).

The nurses in this study felt that parents had a greater opportunity to control the conversation as a result of the Health Curve. Answering the health questionnaires in advance increased parents’ ability to decide what they wanted to focus on in the conversation. An earlier study showed that, to a great degree, the nurses initiated the conversation, bringing up topics that were to be discussed with the parents, and thereby controlled the conversation (Baggens, 2001). Based on the findings from this study, it seems that from a parental perspective, the Health Curve would be a welcome means of having greater control over health dialogues.

Families may need to discuss to a varying extent problems which are more personal. To be able to balance parents’ need for support with their need for
privacy, it is very important that nurses allow parents to guide the conversation and choose to what extent they want to discuss personal problems. The fathers in Fägerskiöld (2006) expressed a desire for nurses to bring up and discuss the entire family’s situation. An earlier study (Hallberg et al., 2001) has shown that some parents, to a lesser extent, did not want the nurse to ask them personal questions about their life situation. With two such contradictory views as to what extent the nurses should deal with a family’s more private situation, it becomes important for nurses to be aware of what parents want to discuss. Using the parents’ health profile (which is constructed based on the questionnaires and measurements) as a starting point for the health dialogue could help nurses to allow parents to control the conversation, in order to satisfy their need for support and secure their privacy.

The Swedish National Board of Health and Welfare (2005), pointed out social differences in health, where children from families with a lower social class showed a higher level of ill-health than those from more socially secure families. As with all preventive work, child health care faces a problem when it comes to reaching families with the greatest needs. In most cases, the mothers who participated in the educational groups in child health care were highly educated, while mothers from more socially vulnerable groups seldom participated (Petersson et al., 2004). Methods based on individual meetings such as health dialogues instead of group meetings, seem to suit better families from groups that are more vulnerable. In a study where health dialogues similar to the Health Curve were used, patients from lower social groups reported greater benefit from health dialogues compared to patients from groups that were more socially secure (Weinehall et al., 2001). Moreover, when mothers ranked clinical strategies for promoting infant health, those with lower incomes and limited education preferred intervention through individual guidance and support (Gaffney and Altieri, 2001). Using these results as a starting point, work with the Health Curve in child health care can be one possible means of reaching parents with the greatest needs from the more vulnerable groups.

To be able to meet parents’ needs in health dialogues and increase their knowledge, the nurses in this study experienced a need for further education in, for example, nutrition and health counselling. The knowledge, skills and further education to strengthen competence were described as prerequisites for inspiring faith in health counselling in child health care (Olander, 2003). Increased knowledge confirms nurses’ experience of competence and gives them energy to do the work, according to the Lindberg and Wilhelmsson (2005) report on public health nurse preventive work. According to these results, having an organization for further education is a necessity if work with the Health Curve is to be carried out in child health care.

Through the interviews, the nurses described how the health dialogues brought up issues concerning the parents’ health, such as psychiatric problems or high blood pressure, which were beyond the nurses’ competence. In order to
handle situations when needs such as these arise, it was important for the nurses to have someone to whom they could refer the parent. This support needs to be properly organized, or the burden on nurses forced to handle things beyond their competence could become too heavy. In addition, as previously mentioned, the nurses in this study pointed out the importance of having their head of department support the project, something which was shown also in Lindberg and Wilhelmsson (2005).

One main principle of child health care is its focus on parent participation, increasing their ability to take responsibility for their child’s health (National Council for Medical Research, 1999). As previously noted, clients in earlier studies developed significantly healthier lifestyles five years after Health Curve-based dialogues (Lingfors et al., 2003). If this is also valid for the parents in the present study, this method could be a way for children to develop a healthy lifestyle and thus reduce the risk of becoming ill or obese as a result of their parents’ lifestyle. As the family constitutes the greatest part of the child’s environment, it is important to focus on the family’s lifestyle in order to support a healthier way of living for the child.

**Limitations of the study**

The nurses interviewed in this study were the first 14 nurses who had begun to work with the Health Curve as a part of health preventive work in child health care. A limitation of this study could be that the nurses are not representative of all nurses working in child health care, because they may have a special interest in preventive work and are more interested in, and positive towards, working with the Health Curve. If a nurse does not have an interest in health preventive work, it is less likely that they will choose to work with it (Lindberg and Wilhelsson, 2005). One strong point of the sample is that all the nurses working with the Health Curve in child health care at that point in time have been interviewed. The analyses of the two final interviews gave no new categories, which can be understood as a sufficient sample interviewed. As noted previously, when each interview was completed, the interviewer made a summary of the contents in order to try to prevent misunderstandings and to ensure the credibility. To increase the objectivity of the analysis and to reduce the risk of the result depending on the researcher, two of the authors made analyses in collaboration. Parents’ experiences of the health dialogues and the effect on the families’ lifestyle ought to be studied further.

**Conclusion**

The Health Curve educational tool is a valid basis for the dialogues and covers most areas that are relevant to a family’s health and life situation. By using the
Health Curve, nurses are provided with a more exhaustive description and understanding of a family’s health and life situation, and it could be one way in which to increase fathers’ participation in child health care. For the nurses, it is a great challenge to be able to balance families’ need for support with their need for privacy. The results indicate that working with the Health Curve would increase nurses’ ability to support a family’s development of a healthy lifestyle at an early stage, positively affecting the health of the child.

Acknowledgements

We would like to express our thanks to the child health nurses who participated in this study. We also thank Assistant Professor Boel Andersson-Gäre for stimulating and encouraging discussions. This study was supported by grants from the County Council of Jönköping (Project 1840).

References


MARIE GOLSÄTER is a PhD candidate at the Department of Nursing Science, Jönköping University. Her research interests are in health promotion among children, youth and families focusing on child and school health care.

KARIN ENSKÄR is Associate Professor at the Department of Nursing Science, School of Health Sciences, Jönköping University. Her research area focuses mostly on paediatric care such as quality of life, quality of care and support of children, parents and siblings.

HANS LINGFORS is a general practitioner at the Unit for Research and Development in Primary Health Care, Futurum, County Council of Jönköping. For more than 20 years he has worked with development of educational instruments concerning lifestyle aimed at primary health care.

BIRGITTA SIDENVALL is a professor in nursing science in the School of Health Sciences, Jönköping University. Her research interests are health promotion among children and youth as well as seniors, with a specific focus on food provision and eating problems.

Correspondence to:
Marie Golsäter, Department of Nursing Science, School of Health Science, Jönköping University, PO Box 1026, S-551 Jönköping, Sweden. [email: marie.golsater@hhj.hj.se]