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# HEALTH PROMOTION INTERVENTION IN MENTAL HEALTH SERVICES

**PETRA SVEDBERG**

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Department of Health Sciences, Faculty of Medicine,  
Lund University, Sweden 2007



# HEALTH PROMOTION INTERVENTION IN MENTAL HEALTH SERVICES

PETRA SVEDBERG

Akademisk avhandling

som med tillstånd av Medicinska fakulteten vid Lunds Universitet för avläggande av doktorsexamen i medicinsk vetenskap kommer offentligen försvaras i Hörsal 01, Vårdvetenskapens hus, Baravägen 3, Lund, onsdagen den 23 maj 2007, kl 13.00

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Abstract  <p>The aim of this thesis was to define and develop the concept of health promotion in mental health services as well as to develop a questionnaire to measure patients' subjective experiences of health promotion intervention in mental health services. The samples consisted of 12 patients in study I and 12 nurses in study II as well as 135 patients in mental health services in study III and IV. Data were collected in open-ended interviews as well as from questionnaires such as the Health Promotion Intervention Questionnaire (HPIQ), the Helping Alliance (HAS), the Client satisfaction Questionnaire (CSQ), the Making Decisions Scale and the HSCL-25. Qualitative analysis and statistical methods were used when analysing the data. The thesis started with two qualitative studies that focused on how health processes are promoted in mental health nursing. The first study showed that the patients' health is promoted through interaction, attention, development and dignity. The second study showed that nurses promote health through their presence, and the balance of power and health focus in their nursing activities. Based on these findings the third and fourth study focused on the development of a reliable and valid instrument, the Health Promotion Intervention Questionnaire (HPIQ). The analyses in study III resulted in a scale containing 19 items derived from 4 factors: alliance, empowerment, educational support and practical support. The findings from study IV showed that overall perceived health promoting interventions were positively correlated to helping alliance, client satisfaction with care and empowerment. The strongest relationship was found between perceived health promotion intervention and helping alliance. The results of this thesis contribute a new understanding of health promotion in mental health services.</p>		
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*Coming  
together  
is a beginning;*

*Keeping  
together  
is progress;*

*Working  
together  
is success.*

*Anonymous*





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## LIST OF PUBLICATIONS

This thesis is based on the following studies:

- I. Svedberg P, Jormfeldt H & Arvidsson B. Patients' conceptions of how health processes are promoted in mental health nursing. *Journal of Psychiatric and Mental Health Nursing* 2003; 10: 448 - 456.
  
- II. Jormfeldt H, Svedberg P & Arvidsson B. Nurses' conceptions of how health processes are promoted in mental health nursing. *Journal of Psychiatric and Mental Health Nursing* 2003; 10: 608 - 615.
  
- III. Svedberg P, Arvidsson B, Svensson B & Hansson L. The development of a self report questionnaire focusing on health promotion interventions in mental health services (submitted).
  
- IV. Svedberg P, Svensson B, Arvidsson B & Hansson L. The construct validity of a self report questionnaire focusing on health promotion interventions in mental health services (submitted).

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## **INTRODUCTION**

The concept of health promotion has received greater attention in the last decade both in terms of health care policy making as well as health care practice and research. It has been suggested that health promoting activities should be improved and incorporated into all health care services as an integral part of all forms of treatment (SOU 2000, WHO Europe 2005). No consensus has, however, been reached regarding the concept (Medin & Alexandersson 2000, Whitehead 2001, 2006). The World Health Organization defines health promotion as processes that facilitate people to enhance and improve control over their health (WHO 1986) and describes the basic elements of health promotion interventions as empowerment, participation in society, self-determination and shared responsibility (WHO 1984). Powerlessness and lack of social support are known as key risk factors for ill health, and a health promotion perspective must therefore include an empowerment approach (Fitzsimons & Fuller 2002). It is important to notice that the focus for health promotion has usually been the general population and not specifically included or aimed at people with mental health problems and their families. Health promotion practice has often been subject to question thus making it important to find evidence that health promotion in the health care services actually works (Whitehead 2003b). Research in the area of health promoting nursing usually focuses on disease prevention or health issues at the group or community level, there is thus a need for more research on the health promotion perspective at the individual level (Berg & Sarvimäki 2003).

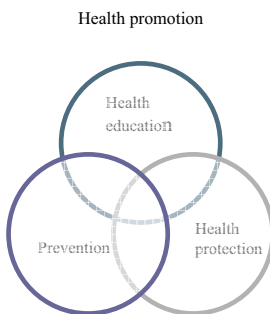
### **The concept of health promotion**

Health Promotion is a relatively new and unexplored field. The concept of health promotion has been interpreted in many ways and is still viewed and used differently. There is no consensus on what health promotion is or what health promoters do when they try to promote health, nor what a successful outcome might be (Nadiou & Wills 2000). The problem is accentuated by the fact that the definition and term tends to be characterised by a lack of clarification of the underlying meanings (Downie *et al.* 1996). Some researchers have described the concept of health promotion as representing a uniform construct which should only include salutogenetic promoting interventions, while others have regarded it as consisting of several dimensions where disease prevention and disease protection should also be included. The interpretation has often been implicit rather than explicit and there has been a tendency to define health promotion and disease prevention as being inseparably linked

without clarifying the distinctions between the two terms. It can thus be concluded that there are divergent views of the precise meaning of the concept and as yet no universally accepted definition. A number of different approaches and models of health promotion have been developed and the following is an overview of the major models and theories that have emerged.

### **Different approaches**

All of the approaches to health promotion reflect different perspectives and different ways of working. A large part of the literature on the concept of health promotion describes health promotion as including disease prevention and to be consistent with the disease perspective. Tannahill (in Downie *et al.* 1996) developed a model of health promotion where health promotion comprises three overlapping spheres of activity: health education, prevention and health protection, see figure 1.



*Figure 1. A model of health promotion  
Source: Downie et al 1996, p 59*

Prevention aims at influencing lifestyles in the interest of preventing ill-health and disease. Health protection focuses on community actions to protect the people from illness, for example, policy-making about smoking. Health education aims at influencing behaviour on positive health grounds and seeks to help individuals, groups or communities to develop positive health attributes central to the enhancement of true wellbeing (Downie *et al.* 1996). Health education has in many ways been described as the main concept in health promotion and traditionally it has been associated with behaviourally focused medical/preventative approaches to practice (Whitehead 2006). Health education is any planned activity that promotes health or prevents illness by changing behaviour and is usually dependent on

experts to inform the public, and is most often focused on preventing illness (Dennil *et al.* 1999). Health education is often based on an expert authority model where one of the paradoxes is the degree of voluntarism or free choice. We might then believe that health education is the giving of information and success in promoting health when the client follows the advice (Naidoo & Wills 2000, Whitehead 2003a). Seedhouse (1997) makes a distinction between ‘medical health promotion’, ‘good life promotion’ and ‘social health promotion’. A medical health promotion focuses on prevention of disease and defines health as absence of disease. In social health promotion the focus of interest is justice and equality. Good life promotion has a different approach being as it defines health not only as the absence of disease but also as something more that concerns a good life and well-being. These categories are not exclusive, but the boundary is often blurred.

Some authors have made an explicit distinction between health promotion and health prevention (WHO 1984, Nutbeam 1998, Pender 1996). Pender (1996) argues that it is important to clarify the differences between health promotion and prevention since there is no clear distinction between these concepts in health care. Health promotion is not limited to prevention or education. In contrast, Pender (1996) and Dennil *et al.* (1999) are of the opinion that health promotion intervention includes advocating health needs and aims to increase positive potential for health. This is underlined by the World Health Organization, WHO (1986), who define health promotion as ”processes to enabling people to increase control over and to improve their health” (WHO 1986, s. 1). WHO describe the fundamental factors in health promotion intervention as empowerment, equality, partnership, collaboration, participation in the community, self-determination, and mutual responsibility (WHO 1984). Health promotion focuses on positive health and its main aim is to build up strengths, competencies and resources (Leddy 2006). Hansson (2004) also describes that it is important that health promotion has a focus on a health promotion salutogenetic perspective and should consist of both the individual and the social context. Health promotion has four criteria, where promoting health, arena perspective, collaboration and process are important factors.

By viewing health promotion from an empowerment approach we obtain a structure and a holistic perspective to guide the interventions in practice (Hansson 2004). It is common for a practitioner to think that theory has no place in health promotion and that action is determined by work roles and organizational objectives rather than values and ideology (Naidoo & Wills 2000). It is essential for practitioners to be aware of the implicit values in the approach they adopt. This will clarify their view of the purpose of health promotion and give an idea about

which strategies to use in order to achieve different goals. It is the aims of the actions that decide if they can be labeled health promotive or not (Liss 2001). In order to have a health promotion perspective it is of importance that a clear and mutual understanding of the concept of health is formulated, and that this understanding is guiding health promotion interventions in a direction towards a better individual health. It is also of great importance how health care staff define and interpret the concept of health promotion and its relation to health. The practitioners' understanding of health promotion will have consequences for their interventions.

### Health promotion in health services

Liss (2001) developed a model using the comprehensive concept health enhancement, which is divided into two categories; health promotion and health care, see figure 2.

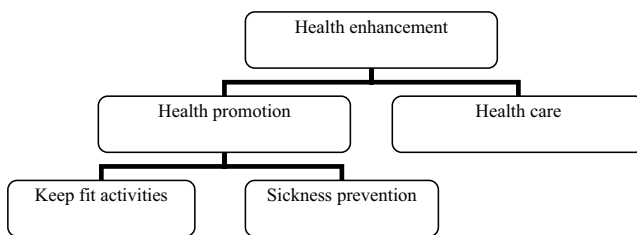


Figure 2. A model of health enhancement  
Source: Liss 2001, p.101

Health promotion is then subdivided in two types of actions; keep fit activities and sickness prevention. Keep fit activities focus on enhancing the health of people who already have a relatively good health. Konarski (1992) describe three levels in public health care: promotion, prevention and health care interventions. In this description prevention and health care interventions are derived from a problem-based perspective and health promotion interventions from a salutogenetic perspective. These models implicitly state that people who already have a diagnosis or are ill, do not have the right to have health care and health promotion interventions. From this perspective health promotive interventions are directed towards people who are healthy and therefore they do not apply to people who already have got a diagnosis. In addition, from a holistic perspective both a disease-oriented perspective and a health-oriented perspective are prevalent in health services. Health promotion is a multidisciplinary field of knowledge and this view moves the emphasis to a health orientation



in health services that represent a widening focus and a shift in perspectives. In order to expand health promotion interventions in hospital, the World Health Organization (1991) created a platform “Health Promotion Hospital” in 1988. The health promotion hospital movement represents one of the main motivators for a more holistic partnership approach to health services delivery (Whitehead 2005). A health promotion perspective in health services can contribute to the treatment of illness with an intervention that strengthens the health processes for the person who already has a diagnosis. A person with an acute or chronic illness, as well as at the end of his/her life, can experience health and have the same right to health promotive interventions as people who are healthy do, and not just the relief of illness. Most health professionals in a hospital setting do, however, not readily associate health promotion as a valid part of their role or function (Casey 2007a, WHO 2003).

### Strategies of health promotion

In practice, health promotion encompasses different political orientations which may be characterized as individual versus structural approaches (Nadiou & Wills 2000). In a conference in Ottawa 1986 WHO outlined a number of action levels: (1) building public health policy, (2) creating supportive environments, (3) strengthening community actions, (4) developing personal skills including information and coping strategies, and (5) reorienting the health system (WHO 1986). Beattie (1991) describes the four strategies for health promotion as health persuasion, legislative actions, personal counselling and community development, see figure 3.

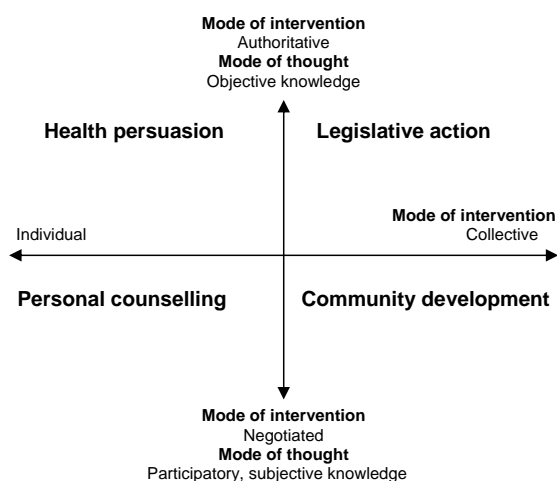


Figure 3. Strategies of health promotion. Source: Beattie 1991

Health persuasion and legislative action are interventions led by professionals' and directed towards individuals and communities and are focusing on protection and prevention. Personal counselling is an intervention that is client-led and focuses on personal development. The health promoter is a facilitator rather than an expert and helps clients to identify their health needs and then works with them on a one-to-one basis or through group work in order to increase their confidence and skills. Community development is an intervention, in the same way as personal counselling, that seeks to empower or enhance the skills of a group or local community. Health promotion involves both lobbying and political advocacy but also involves working with individuals and groups to enhance their knowledge and understanding of factors affecting their health.

The present thesis will focus on health promotion intervention in relation to the individual person with an experience of mental health illness and who is in contact with mental health services. The majority of the literature in the field focuses on the "negative side" i.e. the risks and illnesses, and therefore a positive perspective on health promotion are emphasized in this thesis.

### **Health promotion in relation to the concept of health**

Health promotion interventions are activities aimed to strengthen people's health. The understanding of health determines the direction of the health care which guides the type of interaction that emerges between the staff and the patient (Hwu *et al.* 2001). It is thus important to discuss how the concept of health is defined since this has an influence on the content of health promotion interventions. WHO defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (WHO 1947). This definition of health has often been criticized for being too wide and hard to achieve (Simmons 1989, Pender 1996). Downie *et al.* (1996) have refined WHO: s definition clarifying the difference between negative and positive aspects of health. Health from the negative view is seen as the absence of disease or infirmity and health from the positive view is seen as constituting the presence of a positive quality of life and well-being. This categorization is in line with the commonly occurring definition of health in the literature that can be divided into two approaches: the biomedical and the humanistic (Naidoo & Wills 2000). In the biomedical alignment, which has a medical and natural science basis health is viewed as the opposite to disease. In the humanistic alignment health is viewed as being more

and something different from just the absence of disease. It has been emphasized that the humanistic and positive aspects of health in many ways tend to be neglected in practice and that this affects the health promotion interventions (Downie *et al.* 1996).

Some researchers have argued that health promotion interventions should be derived from a health perspective, where health is something different not just the absence of disease (Pender 1996, Dennil 1999). Konarski (1992) and Eriksson and Lindström (2006) have emphasized that health promotion interventions need to emanate from a salutogenetic perspective where factors that contribute to health are to be considered, not just the factors related to illness. Antonovsky (1991) contributed with a salutogenetic perspective on health and maintained that health arises when the individual has a sense of coherence and the ability to master stress in his/her life situation. Eriksson (1984) suggests that love, belief in the future and trust in one's own ability is essential for health. Jones and Meiles (1993) have described that an important dimension in positive health is a process of empowerment, where people's resources, strengths and possibilities are seen as essential. Individuals can thus from this perspective perceive health in spite of acute or chronic illness. Illness or disease is a component in the holistic concept of health, which means that people with physical and mental limitations can perceive health in terms of psychosocial and spiritual aspects. Disease can be seen as a possibility to be strengthened, and through this gain enhanced awareness of what is important to one's individual existence (Moch 1998).

People with chronic illness have described health as independence, physical functioning, being satisfied with one's social situation, zest for life, harmony and meaning (Hwu *et al.* 2002) as well as honouring the self, connection with others, creating opportunities, celebrating life, transcending the self and acquiring a state of grace (Lindsey 1996). In a similar way the road to recovery and positive mental health has been described as an enlarged consciousness and feeling of connectedness with oneself and the environment (Long 1998). Older women with mental illness describe that the essence of mental health is the experience of confirmation, trust and confidence in the future, as well as a zest for life, development, and involvement in one's relationship to oneself and others (Hedelin & Strandmark 2001). Older hospitalized patients with different diagnoses describe health as being able to be the person you are, being able to do what you want to do and being able to feel well and have strength (Berg *et al.* 2006). Patients in mental health services have described health as autonomy, community with others and meaningfulness in life, even though they perceive ambiguity

about their possibilities in influencing their health (Svedberg *et al.* 2004). Nurses in mental health services have also described health as related to autonomy, processes of personal growth and participation in social contexts (Jormfeldt *et al.* 2007).

### **Health promotion and mental health services**

Little research has been carried out on health promoting interventions in the mental health field and a literature review revealed difficulties in finding any studies investigating the relationships between health promoting interventions and other concepts in the mental health field. The very few empirical studies that have investigated this field have shown that elderly women described the essence in health promotion as being when the nurse confirms their individual human existence and dignity (Hedelin & Strandmark 2001). Older hospitalized patients describe health promotion interventions as something they get through the sense of being seen as an active person, through information and knowledge and through hope and motivation (Berg *et al.* 2006). Health promoting interventions including an individual health enhancement plan, health education, co-ordination of the community health care services and empowerment strategies to enhance independence among older frail patients resulted in an improved quality of life, a better mental health functioning, reduction in depression as well as enhanced perceptions of social support (Markle-Reid *et al.* 2006).

The alliance between the staff and the patient is essential in the delivery of mental health services (McGuire *et al.* 2001) and therefore it is of interest to investigate its relation to health promotion interventions. The alliance in a health promotion perspective may be viewed as a partnership between two or more persons that follow a set of common goals in health promotion (Nutbeam 1998). Participation, collaboration and empowerment are essential components in the good alliance (Kim *et al.* 2001). Studies investigating alliance has shown that the patients' satisfaction with their relationship to the staff is strongly related to improved health outcome (McCabe & Priebe 2004) and also to their satisfaction with the mental health care they receive (Björkman *et al.* 1995, Johansson & Eklund 2003, Schröder *et al.* 2006). The patients' experience of satisfaction with mental health care depends on the staff's empathic qualities as well as their ability to listen, to show interest, to be understanding and to respect the patients. These qualities of the staff – patient relationship are of the greatest importance in reaching a good quality of mental health care (Björkman *et al.* 1995). Dissatisfaction with mental health care has been related to a higher prevalence of unmet

patient needs for care and to a negative self-esteem (Sörgaard *et al.* 2002), as well as to worse overall subjective quality of life (Hansson *et al.* 2003). Hansson *et al.* (1999) found that self-esteem, mastery and sense of autonomy play a role in the appraisal of subjective quality of life, which implies that these factors are important to consider in practical mental health services.

Powerlessness and lack of social support are known to be key risk factors for ill health, and any health promotion perspective should therefore include an empowerment approach (Fitzsimons & Fuller 2002, Wallerstein 1992). Empowering, defined as freedom of choice and self-determination, is acknowledged as an important goal in the treatment and care of persons with mental illness (Lecomte *et al.* 1999). Empowerment emphasizes recovery processes and is a positive concept pointing to the development of resources and abilities in the individual, it should therefore be a major focus in health promotion interventions in mental health services. The concept of empowerment can be used to describe an ideology, a process or an outcome of treatment (Hansson 2005). Empowerment as a process includes the support people assert control over, factors that affect their health and changes where people strengthen the involvement and control over their life. This is a way to enhance people's abilities to meet their own needs, solve their own problems and mobilize necessary resources to take control over their own lives (Hansson 2004). The concept of empowerment as an outcome involves self-esteem and optimism, having control, real power and the ability to be active in one's private life and in the community (Rogers *et al.* 1997). The individual's self-esteem and empowerment are strengthened and developed through close relationships, the experience of social support and feelings of having a social role in the community (Medin *et al.* 2003). A care situation that emphasizes empowerment impacts mainly through supporting the patient's needs and own priorities, thus contributing to an increased self-esteem and less stigma (Lecomte *et al.* 1999, Link *et al.* 2001). People with mental illness have experiences of stigma, such as being treated as less competent, sensing that other people distance themselves from them as well as being given advice that decreases their ambitions in life (Wahl 1999). Stigmatizing attitudes are also common among staff in mental health services (Corrigan *et al.* 2001, Angermyer & Schulze 2001). Stigmatizing experiences seriously harm self-esteem and affect a person's whole life situation, and are major obstacles to recovery from severe mental illness (Link *et al.* 2001, Link & Phelan 2001).

## **Health promotion and nursing in mental health services**

The main issue in the discipline of nursing is the concept of health from an individual perspective (Anthony *et al.* 1996, Halldórsdóttir 2000) and nurses play an important role in health promotion interventions (Berg & Sarvimäki 2003, Casey 2007b, World Health Organisation 2000). A literature review suggests that there is a degree of ambiguity in the way health promotion in nursing is described and existing research on health promotion in nursing has focused primarily on prevention and risk-oriented health education associated with lifestyle-related health behaviour (Whitehead 2006). Attempts to integrate health promotion in nursing practice are often limited to a health prevention approach and to traditional information-giving health education techniques (Casey 2007b, Irvine 2007, Whitehead 2003a, Whitehead 2006). Health education is one important component in health promotion (Maben & Macleod Clark 1995, Naidoo & Wills 2000) and all health promoting activities that include health education needs to be characterized by empowerment, partnership, patient centeredness and collaboration (Benson & Latter 1998). Nurses that adopting this latter approach may therefore be termed health promoters (Casey 2007b). Uys *et al.* (2004) have emphasized that nurses know that they should be incorporating health promotion into their practice, but that they do not know how to tackle this task. Berg *et al.* (2005) found out that nurses in clinical health practice balanced between the biomedical and the holistic approach of health promotion. This study showed that the essence in practical nursing is focused on alleviating and reducing disease and not on actively strengthening the patients' positive aspects of health. Other researchers have maintained that nurses need to improve their awareness of what focus they use as a foundation for health promotion interventions in mental health services (Lindsey 1996).

Health promotion seems to be implicit in many nursing theories, but the theoretical basis of health promotion in nursing is not always explicitly stated. The interpretation of health promotion, which affects the interaction and dialogue between the individual and the nurse is closely related to the interpretation of human beings, health, illness and nursing as key concepts in nursing theories (Berg & Sarvimäki 2003). Parse (1990) considers that health is a process of development in accordance with personal values, in the interaction between the individual and other people and his/her environment. In this interaction the personal meaning is created. During the ongoing health process, nursing care should guide patients in their choice of options and help them focus on their personal definition of quality of life. Health

promotive nursing should be built on trust and respect, in order to support and impact the individual's sense of self-respect and self-worth. The patient is not seen as a passive recipient of care but as an active participant and expert in the promotion of his/her own health (Parse 1990). Berg & Sarvimäki (2003) proposed a definition of health promotion in nursing based on a holistic-existential approach. The definition is based on a humanistic view of a human being and seeks to understand the individual's life-world in relation to health, illness and suffering, instead of primarily focusing on problems and disease. The health promotion nursing focuses on the individual's autonomy, identity, integrity, self-care and self-esteem as important attributes and therefore the concept of empowerment should be added to the definition (Berg & Sarvimäki 2003). Uys *et al.* (2004) developed a model of health promotion for nurses where the major assumption is that health is dependent not only on health behaviour or health care, but also on the socioeconomic and cultural context within which people live. This health promotion model is an empowerment model, based on five elements: a) empowering people through a systematic, planned, need-driven curriculum, b) empowering people through comprehensive content, c) empowering people through interactive teaching, d) promoting behavioural change through small group support, and e) empowering people through linking with external resources (Uys *et al.* 2004). Health promotion includes effective and real participation, where patients are active agents and decision makers and not passive consumers of care (Lindsey & Hatrick 1996). Smith *et al.* (1999) argue that nursing health promotion should be based on community equity, empowerment and participation. With an empowerment approach, the client's own priorities for improving their health are the most important and the nurse's actions can facilitate the mobilization of the individual resources and is therefore a self-evident intervention in the health promotion nursing (Wallerstein 1992).

### **Health promotion and measurement**

A responsive evaluation and assessment of health promoting intervention has been proposed as an essential input, a basis for planning and for implementation of interventions on both a service level and an individual level (Abma 2005, Whitehead 2003b). There are two main types of evaluation in health promotion; outcome assessment and process assessment. Outcome assessment refers to what has been achieved and process assessment focuses more on how the intervention was achieved (Downie *et al.* 1996). The mental health services have traditionally evaluated outcome in the patient in terms of changes in the individual's ability to

function well, his/her well-being, and symptoms of illness, while not focusing on evaluating the processes of health promotion interventions performed by staff working in mental health services (Lindsey & Hartrick 1996). In order to properly evaluate health promotion interventions in relation to health outcomes in the patient, it is of importance to clearly define such interventions (Abma 2005) and investigate the concept of health promotion in relation to other concepts (Ryles 1999). A literature review failed to identify any questionnaires that evaluated health promotion interventions as perceived by patients in mental health services. One of the difficulties has been to identify the relationships between specific health promotion interventions and changes in the individual's health status (Nutbeam 1998). Personal and subjective health experience is an essential component in evaluating health promotion interventions, and the use of a methodology that reduces people to mere objects has been questioned (Abma 2005, Raphael & Bryant 2000). Further knowledge about what patients in mental health services experience as important for enhancing their health may improve the ability of these services to promote health processes (Lindsey & Hartrick 1996, Playle & Keeley 1998). It has been acknowledged that traditional outcome measures are not sufficient for the evaluation of health promotion, and few efforts have been made to investigate health promotion as a process of intervention where participatory styles of evaluation, which include the views of the participants, are far more appropriate (Whitehead 2003b). This shows the need for further research to focus on the health perspective of the individual level (Berg & Sarvimäki 2003). New instruments for the assessment of health promotion interventions could be useful tools for ensuring that mental health services provide improved possibilities for the patients to enhance their health.



## **AIMS**

The overall aim of this thesis was to define and develop the concept of health promotion in mental health services as well as to develop a questionnaire to measure patients' subjective experiences of health promotion intervention in mental health services.

The specific aims were:

- I. To describe patients' conceptions of how health processes are promoted in mental health nursing.
- II. To describe nurses' conceptions of how health processes are promoted in mental health nursing.
- III. To develop an instrument designed to measure patients' subjective experiences of health promotion interventions in mental health services, The Health Promotion Intervention Questionnaire (HPIQ), and investigate psychometric properties of this instrument in terms of factor structure, internal consistency and test-retest reliability.
- IV. To investigate construct validity of the Health Promotion Intervention Questionnaire (HPIQ). The hypothesis was that perceived health promoting intervention would be positively related to client satisfaction with care, perceptions of the helping alliance and empowerment, and negatively related to psychiatric symptoms as rated by the patients.

## **METHODS**

### **Design**

Both qualitative and quantitative methods have been used in this thesis to gain understanding of health promotion. Study I and II have a descriptive qualitative design with a phenomenographic approach. The phenomenographic approach was chosen to determine qualitative variations in the participants' conceptions of the phenomenon. Study III and IV used a cross-sectional design and interviews were performed in order to investigate perceived health promotion interventions among patients in contact with outpatient mental health services. The studied patient populations were selected from outpatient settings and different

diagnostic groups among the patients were included in the studies. The methods used in this thesis is summarized in table 1.

**Table 1.** Overview of the methodological framework of the thesis

Study	Design	Subjects	Instruments	Analysis
I	Descriptive qualitative design	12 patients in contact with the outpatient mental health services in the south of Sweden. The informants were strategically chosen	Open and semi structured interview	Qualitative analysis based on a phenomenographic approach
II	Descriptive qualitative design	12 nurses working in mental health services in the south of Sweden. The informants were strategically chosen	Open and semi structured interview	Qualitative analysis based on a phenomenographic approach
III	Cross sectional study	Consisted of a 20% random selection of outpatients in contact with the mental health services in Halland from January 2005 to February 2006. The final sample consisted of 135 patients and test-retest sample consisted of 17 patients.	Health promotion intervention questionnaire	Principal component analysis with varimax rotation Bartlett's sphericity test The Kaiser-Meyer-Olkin measure Cronbach's Alpha Cohen's Kappa Student's t-test and one way ANOVA
IV	Cross sectional study	Consisted of a 20% random selection of outpatients in contact with the mental health services in Halland from January 2005 to February 2006. The final sample consisted of 135 patients	Health promotion intervention questionnaire, Empowerment, Client satisfaction with care, Helping alliance, Psychiatric symptoms	Pearson's correlation test Stepwise multiple regression

### **The qualitative studies (study I & II)**

Phenomenography is an area of qualitative research which focuses on identifying and describing the qualitatively different ways in which people understand the phenomena in the world around them (Wenestam 2000). Phenomenography has its roots in cognitive psychology and was developed by a research group in the Department of Education at the University of Göteborg in Sweden in the early 1970s. Phenomenography has gained widespread acceptance in the fields of health care and nursing research (Fridlund & Hildingh 2000, Wenestam 2000) and is favoured when the intention is to determine qualitative variations in the participants' conceptions of a phenomenon. The fundamental essence in phenomenography concerns how something is conceived to be. In phenomenography a distinction is made between the first order perspective, which has to do with facts, and the second order perspective, which has to do with the individual's conception of something. In phenomenography conceptions are described from the second order perspective. Conceptions are central in phenomenography and they often represent something implicit, something that does not need to be verbalized or that cannot be verbalized since it has not been reflected upon (Marton & Booth 1997). Knowledge about how people perceive phenomenon is important because people plan their actions based on their conceptions (Svensson 1997).

In study I, the first author (PS) informed the managers of the units at the psychiatric clinic about the study, both orally and in writing, and then the managers informed the nurses at their units. The nurses informed the patients who met the criteria about the study orally and in writing. The first author conducted the interviews at a place chosen by the informants; eleven were interviewed in their homes and one at the clinic. The interviews lasted 30–90 minutes effective time. One pilot interview was conducted, which was not included in the analysis. In study II, the first author (HJ) informed all the nurses and their managers at the psychiatric clinic about the study, both orally and in writing, and then the first author invited the nurses who met the inclusion criteria and wanted to participate in the study to an interview. Before the interviews started one pilot interview was conducted, this was not included in the analysis. Each interview lasted for approximately one hour at a place chosen by the participant. The interviews in both study I and II were open and semi-structured and audiotape was used, which is a common method of data collection when a qualitative analysis method is used (Fridlund & Hildingh 2000).

### **The quantitative studies (study III & IV)**

Studies III & IV used a cross-sectional design in order to develop a questionnaire intended to investigate the subjective experience of health promotion interventions among patients in mental health services. Study III was an investigation of factor structure and reliability in terms internal consistency and test-retest reliability and study IV investigated the construct validity of the questionnaire using client satisfaction with care, helping alliance, empowerment and psychiatric symptoms as validation measures. The staffs at the eight units included in the studies were given information both orally and in writing. A key person among the staff at each unit was appointed to perform the selection of patients. Participants were chosen by random from the case register at the unit. This procedure was chosen in order to guarantee anonymity of the participants until they had accepted participation in the study. The key person also ensured that each participant received identical information and invitation to participate in the study, based on a detailed written short manual. The patients were first given information that they were randomly selected for the study by their key-worker and then the key person on the unit gave further information. All participants were provided with oral and written information about the purpose and structure of the study, after which they gave their informed consent in writing.

### **Ethical considerations**

The principle of informed consent and voluntary participation were carefully considered. The participants were informed that their participation was voluntary and that they could withdraw from the study at any time. All participants who decided to take part in the studies signed a written consent. For reasons of confidentiality, the interviews in study I and II were tape-recorded, transcribed verbatim and coded to protect the individuals' identity and in study III and IV the questionnaires were coded so as to protect the confidentiality of the informants. All studies were reviewed by the Regional Research Ethics Committee Lund, Sweden. Permission for all studies was obtained from the head of psychiatric primary care in the county where the units included in the studies were situated.

### **Subjects**

The patients (study I) and nurses (study II) were chosen strategically in accordance with the phenomenographic tradition in order to guarantee variation and enhance plausibility (Fridlund 1998). In study I 12 patients, who were in contact with the outpatient mental health services in

a county in the south of Sweden, were invited to participate. The background variables used were age, diagnosis, experience as patient of psychiatric nursing, sex, civil status and education, see Table 2. The participants in study II comprised 12 nurses working at a psychiatric clinic in the south of Sweden. Background characteristics are presented in Table 3. The mean age for the 12 participating nurses was 37 years with a range between 20 and 59; three of them were male and nine were female. All twelve were registered nurses and eight of them had a Postgraduate Diploma in Psychiatric Nursing and their mean length of time as nurses in the profession was 11 years with a range between 12 months and 20 years. Three nurses worked with inpatient care and nine with outpatient care, and their nursing interventions ranged from short acute encounters to rehabilitation programmes lasting more than one year.

Studies III and IV included outpatients in contact with the mental health services in Halland, Sweden. The total number of patients in this population was 1,195, of whom 20% were randomly selected and invited to take part in the study by their key workers. Patients were selected during a period from January 2005 to February 2006. Inclusion criteria were experience of outpatient care, understanding of and ability to read the Swedish language and over eighteen years of age. In total, 239 patients were randomly selected to participate, of whom 37 declined, resulting in an external drop-out rate of 15.5 %. Sixty-one patients who had agreed to participate did not complete the interviews, thus the internal dropout was 30.2 %. The final sample consisted of 141 patients, representing 59 % of those initially approached, of whom six failed to complete the health promotion intervention questionnaire. The analyses were thus performed on 135 patients; constituting 56.5 % of the original sample. The test-retest reliability study of the Health promotion intervention questionnaire was intended to be performed on a random sub-sample of 24 patients willing to participate in this part of the study. However only 17 patients were finally interviewed twice with an interval of four weeks. Background characteristics of the total sample and the test-retest sample are presented in Table 2. Of the total number most subjects were women, living alone in their own apartments. The diagnostic profile of the subjects showed that 52.8 % had an affective disorder, 19.4 % had a diagnosis of schizophrenia, 11.1 % had eating disorder and 16.7 % other diagnoses. With regard to work, 40.0 % were engaged in some form of competitive employment while 34.0 % were on sick leave or in receipt of an old age pension. No significant differences were detected between the test-retest sub-sample and the other with

regard to sociodemographic and clinical background characteristics, or with regard to any measures used at the interview.

**Table 2.** Background characteristics of the sample in Study I, III & IV and the test-retest sample.

		Study I (n=12)	Study III & IV (n = 135)	Test-retest (n= 17)
<b>Sex</b>	Male	6	48	6
	Female	6	87	11
<b>Age</b>	Mean ( range)	44 (20-62)	41 (17-72)	25 (19-62)
<b>Education *</b> (n= 134) (test-retest n =16)	Primary school	5	52	9
	Secondary school	5	45	5
	University	2	37	2
<b>Civil status</b>	Single	8	71	11
	Married/co-habiting	4	42	3
	Divorced/separated	-	20	3
	Widow/widower	-	2	-
<b>Housing situation</b>	Own apartment	-	122	15
	Rented accommodation	-	7	1
	Supported housing	-	2	1
	Other	-	4	-
<b>Work Situation *</b> (n= 100) (test-retest n =11)	Competitive employment	-	36	8
	Sheltered employment	-	4	1
	Unemployed	-	16	-
	Student	-	10	-
	Pension	-	34	2
<b>Diagnosis *</b> (n= 108) (test-retest n =14)	Schizophrenia	2	21	3
	Affective disorder	5	57	5
	Eating disorder	2	12	2
	Other diagnosis	3	18	4
<b>Psychiatric care treatment history *</b> (n= 124) (test-retest n =15)	Years since first contact (mean, range)	-	14 (1-39)	14 (2-40)
<b>Experience as patient of mental health nursing</b>	< 1–5 years	2	-	-
	6–10 years	2	-	-
	> 10 years	8	-	-

\* Missing data on 1 – 35 persons in study III & IV and test-retest sample.

**Table 3.** Background characteristics of the sample in Study II.

		Study II (n=12)
		n
<b>Sex</b>	Male	3
	Female	9
<b>Age</b>	Mean (range)	37 (20 - 59)
<b>Education</b>	Registered nurse (RN)	4
	RN and Postgraduate Diploma in Psychiatric Nursing	8
<b>Type of care</b>	Inpatient	3
	Outpatient	9
<b>Length of relationship</b>	Short acute encounters	4
	Weeks to a few month	3
	Several years	5
<b>Years in profession</b>	Average length	11
	1-5	3
	6-10	4
	11-15	2
	16-20	1
	>20 years	2

### Data collection

An open and semi-structured interview was utilized in study I and II. Five different quantitative instruments were used in study III and IV. Socio-demographic data and psychiatric diagnoses were included in all papers.

### Interview (study I & II)

In phenomenographic studies the most dominating method for data collection is the individual semi-structured interviews based on a few entry questions, which is carried in a dialogical manner (Marton & Booth 1997, Dahlgren & Fallsberg 1991). In the interviews in study I and II the entry questions were chosen in order to cover relevant aspects of the informants' conceptions of the phenomenon. The informant was encouraged to reflect on previously unthematized aspects of the phenomenon in question. The aim of the interview was to achieve an open communication in order to increase the understanding of the participants' conception of the phenomena.

The interviews were based on the following entry questions:

1. What does health and nursing care mean to you?
2. How do you consider that nursing care contributes to health and, in your opinion, what qualities should the nurse possess in order to create a positive nursing relationship?
3. How do you think nursing care is affected when the nurse focuses on health instead of illness?
4. How would you describe the connection between health and personal development?
5. How would you describe the connection between health, the individual's inherent strength and the freedom to make choices?
6. How would you describe the connection between health and the meaning of life?
7. In your view, how can the nursing relationship promote inner resources?

### **Questionnaires (study III & IV)**

In study III and IV all participants were interviewed using the health promotion intervention questionnaire, and the interviews also included assessments of client satisfaction with care, helping alliance, empowerment, as well as psychiatric symptoms.

*Health Promotion Intervention Questionnaire (HPIQ)* measured subjectively perceived health promotion interventions and was developed on the basis of the qualitative research concerning patients and nurses conceptions about how health processes are promoted, that constituted the first and second studies in this thesis. The Health Promotion Intervention Questionnaire (HPIQ) was constructed using the conceptions, categories and results from two qualitative studies (study I & II). The categories were transformed into a number of items. In order to make sure that the meaning and wording of the items was comprehensible and clear, the items were discussed in the group of co-authors. The questionnaire measures subjective experiences of health promotion interventions using a five-point response scale ranging from 1 = never to 5 = always and was intended for application on patients. The questionnaire was pilot tested using a sample of 15 outpatients in contact with the mental health services during autumn 2004. The purpose of the pilot study was to test whether or not the items communicated the intended meaning as well as the feasibility and usefulness of the questionnaire. Based on the feedback from the pilot study, some of the items were eliminated or changed because subjects found them vague or confusing. The pilot study resulted in a reduction of items from 52 to 30. Further development is the subject of study III and IV in this thesis.



**Client satisfaction with care** was appraised by the Client Satisfaction Questionnaire (CSQ) (Larsen *et al.* 1979). This questionnaire includes 8 statements where the respondents rate their satisfaction with their care on a four-point scale. The CSQ has earlier shown good psychometric characteristics (Attkisson & Zwick 1982, De Brey 1983).

**Helping Alliance** was measured by a self-report questionnaire, the Helping Alliance Scale (HAS), developed by Priebe and Gruyters (1995). The questionnaire include six items with a ten-point response scale. Earlier studies using the HAS questionnaire have shown good reliability and validity (Priebe & Gruyters 1995).

**Empowerment** was measured by a self-report questionnaire, Making Decisions, developed by Rogers *et al.* (1997). This scale is a 28-item questionnaire and has five subscales; self-efficacy-self-esteem, power-powerlessness, community activism, righteous anger and optimism towards and control over the future. Statements are responded to on a four-point agreement scale. The Swedish version has been tested for reliability and validity (Hansson & Björkman 2005).

**Psychiatric symptoms** were rated with Hopkins symptom checklist-25, HSCL-25, (Derogatis *et al.* 1974, Nettelblatt *et al.* 1993). This self-report scale contains 25 items, mainly focusing on symptoms of depression and anxiety, rated on a four-point scale of severity. Earlier studies using the HSCL-25 questionnaire have shown good reliability and validity (Nettelblatt *et al.* 1993).

## **Data analysis**

### **Qualitative analyses**

The first author (PS in study I and HJ in study II) conducted the analysis. The second and third authors served as a co-evaluator in the process of categorizing the data. All of the authors are nurses and have knowledge of the phenomenographic method, and have specialist knowledge in mental health nursing. The data analysis followed the guidelines of Dahlgren and Fallsberg (1991) and was conducted in accordance with the following stages:

1. *Familiarization* The interviews were first transcribed verbatim with assistance from a secretary and then read repeatedly in order to gain an overall impression before beginning the analytical work.

2. *Condensation* The second step was to search for statements related to how health processes are promoted in nursing. In study I the material contained 298 statements and in study II the material consisted of 267 statements.
3. *Comparison* The next step was to search for similarities and differences in the statements, which had a low level of abstraction and which were formulated so as to match the material as closely as possible.
4. *Grouping* From these emerged preliminary conceptions, this could be lifted out of the context. The analysis continued with a reciprocal interplay between describing the contents of the separate statements and distinguishing more abstract conceptions.
5. *Articulating* The preliminary conceptions were revised so as to be as qualitatively separate as possible. Saturation was reached after six interviews in study I and after the third interview in study II, after which no new conceptions emerged.
6. *Labelling* The next step was to include the conceptions that showed qualitative similarities in one descriptive category
7. *Contrasting* The categories that emerged were formulated in such a way that they described the new context. This resulted in 13 conceptions that were grouped into four descriptive categories (study I) and 11 conceptions constituted three descriptive categories (study II).

### **Statistical analyses**

*Principal component analysis with varimax rotation* was used to analyze the factor structure of the HPIQ. Bartlett's sphericity test was employed to ascertain whether the correlation matrix was an identity matrix, which would indicate an inappropriate factor model. In accordance with the Kaiser criterion an eigenvalue of  $>1$  was used as a cut-off point for inclusion of factors, and only items that loaded on a single factor (Burns & Grove 2001) with a factor loading of  $>.45$  (Altman 1991) were analysed further. Internal missing data were in general low in the items of the HPIQ (range 0.7 % - 3.0 %) but in order to retain all participants in the analyses missing data were replaced by group means. (Study III).

*Cronbach's Alpha* was used to calculate the internal consistency of relevant measures and subscales in the final questionnaire, and was considered acceptable if  $\alpha \geq .70$  (Burns & Grove 2001). (Study III).

*Cohen's Kappa* was used to investigate test-retest reliability of the HPIQ. Kappa coefficients of  $\leq .20$  were considered poor, between .21-.40 fair, .41-.60 moderate, .61-.80 good and between .81-1.00 very good (Altman 1991). (Study III).

*Student's t-test* and *one way ANOVA* were conducted to identify the influence of sociodemographic and clinical characteristics (sex, age, education, civil status, living situation, work, duration of illness and diagnosis) on perceived health promotion interventions. (Study III).

*Pearson's correlation* test was used to investigate bivariate associations between variables. (Study IV).

*Stepwise multiple regression* was used for validation measures having a significant correlation to health promotion intervention ( $p < .05$ ), where overall health promotion scores and the different subscale scores were used as dependent variables. (Study IV).

## **RESULTS**

The most important findings from the four studies are presented in the following section, and the overall results are presented in Studies I - IV respectively.

### **Patients' and nurses' conceptions of how health processes are promoted in mental health nursing (Study I & II)**

Four descriptive categories were created from the interviews with patients who had experience of mental health nursing. The categories were *Interaction*, *Attention*, *Development* and *Dignity*, see table 4. The *Interaction* category describes the importance of a good alliance between the nurse and the patient and that interactions in the form of mutuality in the relationship between patient and nurse are a necessity for the promotion of health processes. The *Attention* category describes the importance of nurses being engaged in and paying attention to the patient as an important individual. The *Development* category describes the patients need for hope and knowledge in order to promote their health. The nurses contribute to hope when they recognize and confirm the patients' positive qualities and support the patients to see new possibilities. The patients report that they need information, suggestions, and support to make their own decisions in order to gain knowledge and understanding. In the *Dignity* category the patients describe that the nurses had to respect and have trust in their potential as well as in their ability to make decisions to promote health processes. When the nurse showed respect for the patients' right to self-determination, the patients' motivation to

succeed in managing their lives was strengthened. The patients felt respected when they were listened to, when their feelings were taken seriously, and when their self-determination was respected. The patients felt violated when nurses lectured too much and considered themselves as experts. It was concluded that the nurse's attitude is of importance for the patient's ability to feel confident in the relationship and that is a prerequisite for promoting health processes. Patients in mental health care need to be treated with dignity and respect. If they are being violated or not seen as individuals, their ability to develop health processes will be negatively affected. The nurses promote health processes in the patient through believing in the patient's potential and being aware that it is important to respect the individual and to focus on the patient's opportunities. This will lead the patient to gain hope and develop a new outlook on life.

**Table 4.** Description categories and conceptions related to how health processes are promoted in mental health services, as analyzed in study I and II.

Description categories	Patients				Nurses		
	Interaction	Attention	Development	Dignity	Presence	Balance of power	Focusing on health
Conceptions	To trust To feel mutuality To enter into a personal relationship	To feel noticed To feel the nurse's commitment To feel that the nurse is accessible	To gain hope To see new possibilities To have one's good qualities recognized To obtain knowledge To be confirmed	To have the right of self-determination To feel respected	To be understanding and see the patient To be committed to the patient To be personal in the relationship To provide security To maintain a professional distance	To influence the patient in accordance with current societal norms and regulations To collaborate with the patient To respect the patients integrity	To trust the human potential To focus on resources To be aware of the healthy and sound

Three descriptive categories, *Presence*, *Balance of power* and *Focusing on health*, were created from the interviews with nurses who worked in mental health services (see table 4). The *Presence* category dealt with how the nurse behaved in the encounter with the patient in

order to promote health processes and describes the nurse's awareness of the importance to be understanding and see the patient as an individual as well as to be personal in the relationship. The nurses also describe the necessity of maintaining a professional distance in relation to the patient as well as to their own feelings in order not to lose sight of the overall picture and to minimize their own emotional strain. The *Balance of power* category, was related to power sharing in the relationship between the nurse and the patient in order to promote health. The nurses describe a dilemma in their conceptions from on the one hand to influence the patient in accordance with current societal norms and regulations, and on the other to collaborate, to respect the patient's own decision even if this could sometimes conflict with their treatment. The conception influencing the patient in accordance with current societal norms and regulations is based on the attitude that, because of their mental condition, patient lack the capacity to judge for themselves what is best. The nurses describe that the best way to encourage the patients' motivation was to collaborate with them. The *Focusing on health* category was related to the nurses' attitudes towards their health promotion work and towards an individual's possibility for changing and influencing life circumstances. The nurses describe that it was important to put trust in human potential as well as to focus on resources in order to contribute to the patients' possibilities for change and to reduce the effects of the illness. The nurses also describe the importance of being aware of what can be healthy and sound, which includes attempting to see deviant behaviours as a logical reaction to painful experience. It was concluded that the nurse's health promoting activities focus on being present and being committed to the patient as well as collaborating with him/her and to focus on health. The findings also showed that the nurses expressed equivocal attitudes about the best way to approach a patient in the mental health services.

### **The Health Promotion Intervention Questionnaire (Study III)**

A principal component analysis of the health promotion intervention questionnaire resulted in a four factor solution explaining 62 % of the variance. The four factors were labelled 'alliance' ( $\alpha = .88$ ; composed of the items easy to talk to each other, warm relationship, personal approach, mutual appreciation, key worker friendly and smiling, key worker gives his/her best and key worker on the same level), 'empowerment' ( $\alpha = .87$ ; composed of the items key worker respects my right to make decisions, key worker takes me seriously, key worker is willing to cooperate, key worker support my efforts, key worker respects my choices and key worker supports my goals), 'educational support' ( $\alpha = .73$ ; composed of the

items key worker informs me about what I need to feel better, key worker tries to make me see things more realistically, key worker is oriented towards problems not illness, key worker is happy when I make efforts and key worker presents new possibilities), and '*practical support*' ( $\alpha$  = was not calculated since it only contained a single item: we do practical things together).

Test-retest reliability according to Cohen's Kappa was considered very good in 2 items, good in 3 items, moderate in 8 items, fair in 5 items and poor in only 1 item "key worker oriented towards problem and not illness".

The mean score of the patients subjective experiences of health promotion interventions ranged from 2.46 (SD = 1.28) for "do practical things together" to 4.44 (SD = .74) for "key worker takes me seriously". In ten items the mean score was more than 4, indicating that the frequency of subjective experiences of health promotion interventions was high (theoretical range 1-5).

The overall health promotion intervention score showed a significant difference with regard to sex, women having a higher score, and with regard to age (median cut), older patients having a higher score. Women and the older age group scored higher on the sub scale of 'alliance' and 'empowerment'. Alliance was also perceived as higher in cohabiters. Scores of the sub scale 'practical support' was higher among people who had a diagnosis of schizophrenia while the scores of the sub scale 'educational support' was higher among those with other diagnoses.

### **The Health Promotion Intervention Questionnaire in relation to other concepts (Study IV)**

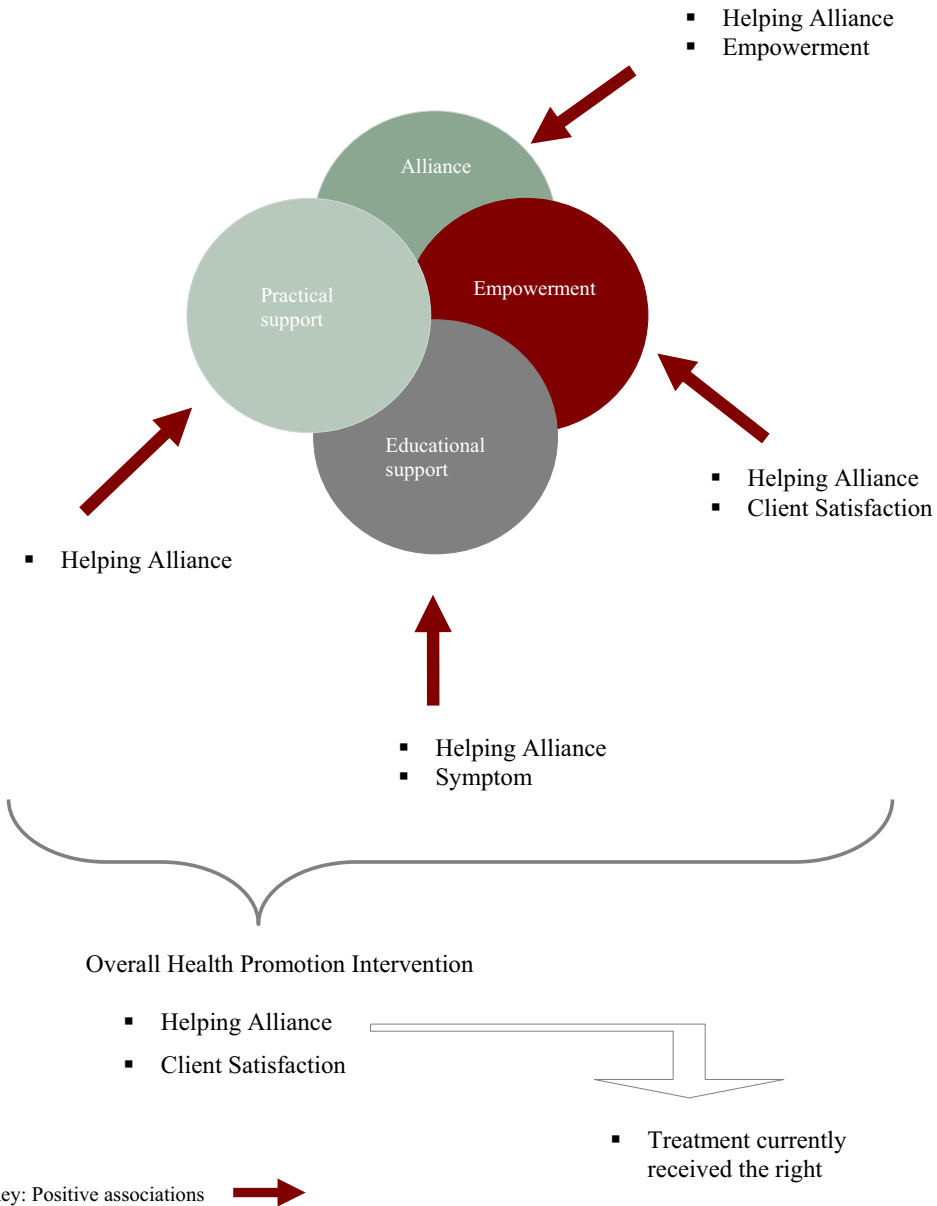
In accordance with our hypothesis overall health promoting intervention was positively correlated to helping alliance, client satisfaction with care and empowerment. No association were found between overall health promoting intervention and psychiatric symptoms. A similar pattern of correlations were found for the subscales alliance, empowerment, educational and practical support. These subscales thus had the strongest correlations with helping alliance and client satisfaction with care.

A stepwise multiple regression analysis was performed and showed that the most important factor related to health promotion was helping alliance which accounted for 57.2 % of the variance, and client satisfaction with care, which accounted for a further 2.1 % of the variance, see figure 4.

In all Health Promotion Intervention subscales, Alliance, Empowerment, Educational and Practical support, the most important factor included in the regression model was helping alliance, which accounted for 6.3 % to 51.2 % of the variance in the subscales. Client satisfaction with care was included in the regression model for the Empowerment subscale (2.3% of the variance), and psychiatric symptoms in the Educational support subscale (12.1% of the variance) as well as empowerment in the Alliance subscale (3.7 % of the variance). These findings are summarized in figure 4.

A regression analysis was performed using the six items in the helping alliance scale as independent variables in order to explore the particular influence of specific aspects of the helping alliance. This resulted in a model including three of the items, which accounted for 59.4 % of the variance in overall health promotion. The most important item related to health promoting intervention was the extent to which the patient perceived that he/she was currently receiving the right treatment, accounting for 48.9 % of the variance (see figure 4).

## Health Promotion Interventions



**Figure 4.** Health promotion in relation to other concepts (Svedberg 2007).



## **DISCUSSION**

### **Methodological considerations**

#### **The qualitative studies (study I & II)**

A qualitative approach, phenomenography, was chosen for study I and II in order to describe how the patient and nurses perceive that health processes are promoted in mental health nursing. In both qualitative studies (studies I and II), the terms applicability, concordance, security and accuracy (Fridlund & Hildingh 2000), were used to ensure safety during the data collection and data analysis.

*Applicability* is concerned with identifying phenomena through selection of informants and through methods of data collection. In these studies a phenomenographic approach was used and this method have showed high applicability for identifying different human conceptions of a phenomenon (Marton & Booth 1997), and the method is often used in health care research (Fridlund & Hildingh 2000). The reason for choosing the interview as data collection method was to gain a deeper understanding of the phenomenon. The interview questions were based on theoretical assumptions of health processes and own experiences to ensure that the questions are relevant to the explored phenomenon. The use of semi-structured interview questions involves a risk that other important aspects of the phenomenon are overlooked, thus the questions were used to increase the understanding of the informant's conceptions of the phenomenon by means of an open conversation. The strategic selection of participants was performed in order to achieve as wide a range of conceptions as possible. A limitation in the spread of variation in the sample can be that most of the participants in study I have had contact with the mental health services over a long period of time and in study II all the nurses came from the same clinic. A limitation in qualitative studies are that the results can not be generalized but in the present studies the purpose of these interviews was instead to gain a deeper understanding of the phenomenon of how health processes are promoted in mental health services.

*Concordance* can be regarded as the validity of the study and in qualitative studies it is concerned with describing the plausibility of the description and interpretation of the data information (Fridlund & Hildingh 2000). This was ensured by a pilot interview with both a patient and a nurse to test the questions understandability and usefulness. The concept of saturation can be questionable when using a phenomenographic approach. In these studies the

use of saturation was used to test that new conceptions do not continue to emerge in the data analysis. If this happens it could be an indication for a need of a larger sample of informants. Saturation in these studies was calculated after all the interviews had been analyzed and saturation in conception was reached before the interview analysis was completed, which increased the plausibility of the result. Furthermore the conceptions have been expressed by several informants, thus also enhancing the plausibility of the result (Svensson 1997).

*Security* can be regarded as reliability (Fridlund & Hildingh 2000) and by the detailed description of the analysis and the fact that the conceptions are illustrated by means of quotations, the security of the data collection can be considered trustworthy. The security was further strengthened by the fact that the first author (PS in study I and HJ in study II) conducted all interviews.

*Accuracy* is concerned with awareness of the researcher's own pre-conceptions throughout the research process. To ensure accuracy, the data have been read repeatedly in order to facilitate reflection on statements, to identify similarities and dissimilarities in the conceptions and in the descriptive categories. The author's pre-conceptions of the phenomenon could be a threat to accuracy in data analysis thus the first author (PS in study I and HJ in study II) analyzed the data before the co- authors examined the analysis.

### **The quantitative studies (study III & IV)**

In the present study III and IV, a fairly large sample was used to test the psychometric properties of a new questionnaire aimed at measuring subjective experiences of health promotion interventions in mental health services. The final scale contained 19 items derived from 4 factors: alliance, empowerment, educational support and practical support. The HPIQ has demonstrated sufficient reliability in terms of internal consistency and test-retest reliability and satisfactory construct validity.

### ***Validity issues***

#### *Sampling and representativeness*

In these studies it was decided to use a 20% random sample of the target population of patients in contact with outpatient mental health services in the county investigated. This was done in order to reduce the risk of a systematic sampling bias due to subject selection procedures (Burns & Grove 2001). This also ensured that all the patients at the units included

in the studies had an equal opportunity to be selected. In total, 239 patients were randomly selected to participate. There was an external drop-out of 37 patients who declined to participate, and an internal drop-out of 61 patients who had agreed to participate but did not complete the interviews. The final sample consisted of 141 patients, of whom six failed to complete the health promotion intervention questionnaire. The analyses were thus performed on 135 patients and the final response rate was 56.5 %, which might jeopardize the validity of the results. The drop-out rate was 43.5 % and it is unknown why some of the informants who had given previous oral consent to participate declined participation at a later date. An essential question is what importance this level of drop-out may have and if so in what way. There might be a risk that the participants who completed the interviews differed in important aspects from those originally randomly selected. They might for example be healthier than those who declined to participate. Many studies have found that there are differences between those who do or do not respond to a questionnaire, non-responders usually being less healthy (Altman 1991). Another suggestion is that the healthier persons had a more sporadic contact with the units and therefore had not been in contact with the unit during the last year, which was the upper limit for inclusion in the random selection of patients. A relevant question is therefore whether the participants in study III and IV are representative of the sample intended for inclusion. Background characteristics of those who did not complete the interviews are not known, since it was found not ethically correct to collect information about subjects who had not given their written informed consent to participate, or consent to collect such information. This consideration is in accordance with the importance of protecting the rights of human research subjects (Burns & Grove 2001). In spite of this, it is a drawback of this part of the study that no calculations of the representativity of the participants with regard to demographic, social and clinical characteristics were possible to perform. On the other hand, participants showed a great variation with regard to a number of sociodemographic, social and clinical characteristics indicating that they represented a wide range of patients in contact with the services.

External validity is concerned with the extent to which the findings can be generalized beyond the sample in the study, to other settings or samples (Burn & Grove 2001, Kazdin 2003). The most conservative estimate would be that the findings of these studies can only be said to be representative for the participants of the study. The sample represents adult people with a variation regarding diagnosis, education, living and work situation, in contact with outpatient mental health services. The results may primarily be generalized to outpatient mental health

services in Sweden. Further proof of the validity of the findings of this study with regard to the structure of the HPIQ and its construct validity require further studies.

Another threat to validity concerns the way the information and instructions are given in the interview situation (Kazdin 2003). There might be a risk that the participants' willingness to participate was influenced by the fact that they were in a position of dependence in relation to their key-worker who was the one who requested them to participate, thus bringing into question how autonomous these participants were. This is a question that has ethical and methodological significance. To minimize this threat the patients were first given information that they were randomly selected for the study by their key-worker and then the key person on the unit gave further information. This was done in order to guarantee that every person who was randomly selected was given the same information. Besides the oral information a detailed written description was also given to each patient. This thus ensured that the key-worker would not be able to influence the patient's decision to participate or not, and that participation would not be dependent on differences in information given by the staff.

#### *The Health Promotion Intervention Questionnaire*

The Health Promotion Intervention questionnaire was developed from the results of study I and II. The categories from these studies were transformed into a number of items. To ensure that the meaning and wording of the items was comprehensible and clear, the items were discussed in the group of co-authors. The questionnaire was also pilot-tested using a sample of 15 patients in mental health services during autumn 2004. The purpose of the pilot study was to test whether or not the items communicated the intended meaning as well as the feasibility and usefulness of the questionnaire. The risk for misinterpretations and inclusion of items with a tentative high internal rate of missing responses was in this way reduced, thus the pilot study resulted in a reduction of items from 52 to 30.

Validity also has a relationship to the statistical power of analyses performed. The sample in the study III and IV consisted of 135 patients, which was considered sufficient to examine the psychometric properties of the 19-item scale. Various recommendations defining the ratio between variables used in multivariate analyses and the sample size has been put forth (Altman 1991). Calculation of an adequate sample size for factor analyses is a complicated issue with no simple answer, and methodologists differing in their views. A number of alternative arbitrary "rules of thumb", not mutually exclusive, have been presented. In the

present study we used a combination of two rules in order to decide on the adequacy of the sample size. The subjects-to-variables ratio should not be less than 5 (Bryant & Yarnold 1995) and at least 100 subjects should be included in the analysis (Hatcher 1994). Furthermore, sampling adequacy was ensured by using the Bartlett test of sphericity and the Kaiser-Meyer-Olkin measure of sampling adequacy. These showed that the KMO value was .904 and the significance of Bartlett's sphericity test was .001, indicating that the sample met the criteria for performing a factor analysis.

In order to calculate the adequacy of the sample size with regard to perform multiple regression analyses we used a recommendation put forth by Altman (1991), stating that the number of independent variables used should not exceed the square root of the sample size. The square root of the sample size in the present study is 11.6, which is well above the number of independent variables used in the regression analyses in study IV.

### ***Reliability issues***

The reliability of a measure concerns the stability and consistency of measures obtained in the use of a particular instrument. Reliability testing examines the amount of random error associated with measurement (Burns & Grove 2001). Stability between raters concerns interrater reliability which was not an issue in the present study. Stability over time is concerned with the consistency of repeated measures, and therefore a test-retest reliability study was performed on a sub-sample of 17 patients who were interviewed twice with an interval of four weeks using the Health promotion intervention questionnaire. Cohen's Kappa was used to assess test-retest reliability and considered very good in 2 items, good in 3 items, moderate in 8 items, fair in 5 items and poor in 1 item.

The Health Promotion Intervention Questionnaire showed high internal consistency with an alpha coefficient of .90. Alpha coefficients for three of the subscales ranged from .73 to .88. Cronbach's alpha could not be calculated for the subscale practical support, since it only contained a single item, therefore it seems that further work is needed to explore the role of this factor and whether it is to be kept in the scale.

Examinations of validity and reliability also refer to whether the instruments included in the study actually measure what they are intended to measure. The threats to construct validity are related to the development of measurement techniques as part of a particular study (Burns &

Grove 2001). In order to assess domains of interest such as empowerment, psychiatric symptoms, helping alliance and satisfaction with care, used in the investigation of construct validity of the Health Promotion Intervention Questionnaire in study IV, efforts were made to only include instruments with a record of an acceptable reliability and validity. In each instance internal consistency in terms of Cronbach's alpha was examined for these instruments, based on the ratings of the participants of the present study, and was in all instances found to be satisfactory (CSQ=.93, HAS=.88, HSCL-25=.96, making decisions=.82)

### **Health promotion intervention in mental health services**

Earlier empirical studies of health promotion among patients in mental health services are limited and the foremost concern of this thesis was to increase knowledge regarding health promotion intervention in mental health services. The results from study III showed that health promotion interventions include alliance, empowerment, educational support and practical support. The four-factor solution of the health promotion intervention questionnaire can be seen as a clarification of the results of study I and II, which served as a basis for the development of the questionnaire. The patients' conceptions about how health processes are promoted in mental health services and the health promotion intervention questionnaire are commensurate with Nutbeam's (1998) description of the main aspects of health promotion such as education, alliance and empowerment and to WHO:s (1984) description of the fundamental factors in health promotion intervention as empowerment, equality, collaboration, participation in the community, self-determination, and mutual responsibility. It has been emphasized that health education and health promotion are often used as interchangeable concepts (Whitehead 2006). The findings from study III confirm Casey (2007b) who maintained that health education is more likely to be a part of an overall broad health promotion strategy.

The findings in study III showed that older patients and women experienced more health promotion interventions than men as well as a greater degree of alliance, empowerment and educational support. These results may indicate that the focus of nursing interventions is either dependent on the patient's needs or on the nurse's preconception of those needs related to gender. Another hypothesis is that men and women focus on different aspects of the nursing process. Skärsäter *et al.* (1999) found that men and women have different experiences

of support and that men perceived adequate social support from people within their network and from their families while women received the best support from people outside the family.

The major finding of study IV was the evident association between the perception of receiving health promoting interventions and the patient's perception of helping alliance in their contact with the key worker. Overall health promoting interventions showed positive correlations with helping alliance, client satisfaction with care and empowerment, but no correlation with self reported psychiatric symptoms. These findings confirm the results from study I where patients in mental health services describe that health promotion is based on good interaction between the patient and the key worker. An interaction with focus on the patients' opportunities, trusting the patient's potential and being aware of how important it is to respect the individual as being a resourceful person. This finding is also in accordance with Schröder *et al.* (2006) and Johansson and Eklund (2003) who found that the alliance between the staff and the patient is very important for the patients' experiences of the quality of psychiatric care. The interventions of such services would benefit from playing down the significance of mental illness in order to avoid stigmatizing experiences and to facilitate the process of empowerment through support and supervision (Magnusson *et al.* 2004, Schröder *et al.* 2006).

Furthermore the results from study IV showed that the patients' perceptions of the helping alliance and satisfaction with care, together accounted for 59.2 % of the variance in health promoting intervention, while empowerment was not included in the model. Empowerment and psychiatric symptoms played a less important role than expected. The single aspect of helping alliance most strongly related to health promoting interventions was that the patient perceived that the treatment they currently received was the right one. This might indicate that if the individual experiences treatment as being more adapted to their own needs, the treatment is to a greater extent perceived as being health promoting, which involves power sharing and mutual decision making between the key worker and the patient. This might lead to a situation where the patient becomes more responsible for his or her own care and more involved in making choices. Whitehead (2003b) has described that it is important to produce convincing evidence that health promotion actually does work in health care services, since health promotion practices have often been contested. The present results confirm that health

promotion interventions are linked to a positive experience of the helping alliance and in particular to the current treatment being the correct treatment.

### **Alliance**

The alliance between the nurse and the patient is essential in the delivery of mental health services (McGuire *et al.* 2001) and the alliance in a health promotion perspective could be viewed as a partnership between two or more persons that follow a set of agreed goals in health promotion (Nutbeam 1998). The results from study I and II, where the initial focus was on how health processes are promoted in mental health services, clearly showed that a good alliance that built on trust, mutuality and a personal relationship was important for promoting health. The alliance is developed when the nurse is kind, has a smile on his/her face and when the patient feels that he/she has been seen as an individual as well as when there is continuity in the relationship. The results (study I) showed that collaboration in the reciprocal relationship is a prerequisite for patients be able to feel mutuality. In study II the nurses describe the necessity of maintaining a professional distance in relation to the patient as well as to distance themselves from their own personal feelings, in order not to lose sight of the overall picture and to minimize the emotional strain of being close to a suffering human being. A dichotomy of expectations has previously been found between the close relationship expected by patients and the distant, non-therapeutic relationship provided by nurses (Moyle 2003). Due to the expectancy that professional distance would not have a therapeutic effect in the relationship this conception was not transformed into an item in the HPIQ. Both patients (study I) and nurses (study II) describe that a personal relationship is the foundation of the alliance and embraces expressing individuality as well as encouraging the patient's unique personality. The patients often value the relationship with the nurse more than the nurses' professional competence. It has been put forward that the nursing relationship should be personal, human, warm and empathic in order to promote health processes within the patient (Repper *et al.* 1994). These findings from study I and II were also evident in the results from study III that showed that an alliance is an important factor in health promotion interventions. The subscale alliance in the HPIQ was related to the questionnaires "helping alliance" and "making decisions" (study IV). A reflection regarding the result of study IV is that the patients' perceptions of empowerment is partly dependent on the key workers' ability to show respect for the patient, and build an atmosphere of mutual appreciation. These findings correspond to results from other studies investigating alliance, which have showed that the patients' satisfaction with their relationship to the staff is strongly related to improved health



outcome (McCabe & Priebe 2004) as well as their satisfaction with the mental health care they receive (Björkman *et al.* 1995, Johansson & Eklund 2003, Schröder *et al.* 2006). The greatest importance in the quality of care from a patient perspective was ascribed as the staff's empathetic qualities embracing being interested, understanding, listening and showing respect towards the patient (Björkman *et al.* 1995). Furthermore previous research has found that collaboration, communication and empowerment are essential quality dimensions of the therapeutic alliance (Kim *et al.* 2001, Wilson 1996, Hörberg *et al.* 2004).

In study III it was found that those patients who co-habited experienced more alliance than those who lived alone. These results may indicate that individuals living in a close relationship with another person are more likely to engage in a relationship with their key worker. Having a close relationship with at least one friend is recognized as a key factor for self-esteem and social competence (Sörgaard *et al.* 2002). These findings are not commensurate with earlier research that showed that older age (Draine & Salomon 1996), more service contacts (Klinkenberg *et al.* 1998) and less severe symptoms (Frank & Gunderson 1990, Neale & Rosenbeck 1995) were found to be factors that influence a more positive therapeutic alliance, as well as being not commensurate with the findings of Svensson and Hansson (1999) where a greater ability to work and more frequent social contacts during the years before admission were associated with a better alliance as rated by the therapist, but not by the patient.

### **Empowerment**

The findings from study I showed that dignity and respect for the patients' right to self-determination as well as the belief in the patients' ability was evident in all the categories. The experience of dignity is influenced to a high degree by a respectful attitude and trust in the patients' capacity to make their own decisions which is crucial for their motivation and development. The findings from study I show that patients have experiences of being violated by not being taken seriously and not having the right to express their view. It has been put forth that one's image of oneself and what one is worth is mainly an outcome of social interaction because pride and empowerment tend to mutually enhance each other (Svensson *et al.* 2006). Self-evaluation is crucial to mental and social well-being thus focusing on self-esteem has been considered a core element of mental health promotion (Mann *et al.* 2004). In study II the result showed that one aspect of health promoting interventions is related to a balance of power between the nurse and the patient. To collaborate with the patient was

viewed as the most constructive way to meet the patient even though conceptions expressed varied from letting the patient make all the decisions, to influencing the patient in accordance with current societal norms and regulations based on the patients' ability to make their own decisions. This finding is similar to the results from a study by Valimaki and Helenius (1996) that showed that nurses sometimes think that patients in psychiatric care should not be allowed any self-determination because they do not consider them as capable of making decisions. They maintain that patients should become more motivated to engage in their own decisions when they are allowed to participate in the nursing care process. The power to define health problems devolves on those who experience the problems, and the nurse cannot promote health while considering him/herself to be the expert (Hartrick *et al.* 1994, Lindsey & Hartrick 1996, Hedelin & Strandmark 2001). Lack of knowledge and relevant information about care leads to powerlessness and limits the patient's possibilities for self-determination (Nordgren & Fridlund 2001, Sines 1993), which is known to be key risk factors for ill health (Fitzsimons & Fuller 2002, Wallerstein 1992).

The findings from study III showed that the empowerment factor in health promotion intervention questionnaire embraces cooperation, self-determination, the experience of being taken seriously and supported in choices, goal and efforts. The findings from study IV showed that the questionnaires "helping alliance" and "client satisfaction with care" was correlated to the Empowerment subscale. Consequently, in order for the patients to be able to experience a helping alliance and satisfaction with care, the care may have to have an empowerment approach. Furthermore study III and IV showed that care situations with an empowerment approach support the patient's needs and own priorities, in line with previous research (Lecomte *et al.* 1999, Link *et al.* 2001). The findings of study III and IV contributes to further knowledge about empowerment as an intervention process. This is in accordance with Hansson (2004) when defining empowerment as a process of enhancing people's abilities to meet their own needs, solve their own problems and mobilize necessary resources to take control over their own lives. Crane-Ross *et al.* (2006) used the term "service empowerment" to denote the elements of the collaborative relationship as consumers' involvement in decision making about their services and the respect within the relationship. They found in their study that consumers' perceptions of service empowerment were the most powerful predictor of recovery outcomes. Roth and Crane-Ross (2002) found that consumers who reported high levels of service empowerment were more likely to perceive that their service needs were met and that met needs were related to more positive mental health outcome as decreased

symptoms and increased quality of life. An intervention based on an empowerment approach embracing dialogue, partnership, group educational sessions, facilitating supportive environments have shown significant impact in improving health and quality of life in chronically ill patients (Wallerstein 2006). The establishment of a collaborative relationship based on an empowerment approach between the patient and a mental health service provider has particular relevance to the enhancement of the individual self-esteem and recovery (Mann *et al.* 2004).

Older age and being a woman were related to a feeling of being given more empowerment interventions in the sample in study III. No correlation was found between educational level and empowerment in the present study, in contrast to Kim *et al.* (2001) who found that patients with a higher educational level were more involved in their own care with more collaboration and empowerment.

### **Educational support**

The subscale educational support in the HPIQ is mostly related to the categories “development” and “health focus” in study I and II. The category development was related to hope, new possibilities, recognition of good qualities, knowledge and confirmation. The findings from study I showed that the patients need to get knowledge in an interactive way and to be encouraged through focusing on possibilities that are inherent in every individual instead of solely focusing on the illness, which can lead to feelings of hopelessness. Hope is recognized as a prerequisite for the patients being able to see new possibilities. The nurse’s most important task is to inspire the patient and to give hope (Cutcliffe & Grant 2001, Moore 2005). The category health focus was related to trusting the human potential, focusing on resources, and what is healthy and sound (study II). The findings showed that nurses perceive that they have to give information in order to make the patients more realistic, because they assume that they have greater knowledge about what is best for the patient. The findings showed that the nurses felt more secure if they focused on illness even though a focus on resources is to discover the individual's possibilities to create a meaningful life in spite of the diagnosed illness. Byrne (1999) suggests that in an empowering approach the nurse should focus on strengths and the view of the individual as a disabled person should be in the background. According to Repper *et al.* (1994), it is important that nurses in mental health care find ways to develop a positive attitude, with a focus on the patients’ capacity to be motivated and actively engaged in their own health process.

The findings from study III showed that educational support includes information and a problem solving orientation that presents new possibilities as opposed to solely illness oriented information. These findings are interesting in relation to the review by Whitehead (2006) who found that the foundation for the majority of health promotion activities in nursing practice are based on and has focus on behavioural, lifestyle and risk-orientation health education. The practice of health education can be described with two different focuses, in the first the health educator decides if there is a health problem and gives information and the health promotion is successful if the client follows the advice. In the second focus the health educators are facilitators rather than experts and work together with the patient to identify their needs and for an informed choice (Naidoo & Wills 2000). The choice of approach will thus influence the type of interventions that can be successful in promoting health. Eldh (2006) found that information should be regarded as something shared, not given, to promote knowledge and participation in care. The information provided needs to be accompanied by opportunities for the individual to evaluate the content in relation to his or her situation and context. This thus puts greater demands on the nurse's educational and communicative ability being as it is not sufficient just to pass on facts (Gedda 2003). This supports the findings from studies I and III that showed that the patients need the kind of information and educational support which is given in an interactive manner to support their own decision-making. This is commensurate with the findings of Laugharne and Priebe (2006) who emphasized that patient choice is important to patients and improves their engagement with services and who found that the patients did not want a consumerist system but rather a partnership with their provider where the knowledge of the expert is utilized by the patient. Buchanan (2006) described that the quality of a health educator's work could not be evaluated by its effectiveness in changing people's behaviour but by whether these people find the dialogue valuable in helping them to make crucial value judgments concerning their priorities and helping them think about how they want to live their lives. Furthermore Skärsäter (2002) maintained that there is a need for mental health services to develop and use information methods that can empower the patients to participate and make appropriate decisions and Nutbeam (1998) described that health education should focus on empowerment, communication, information, as well as on fostering the motivation, skills and confidence necessary to encourage patients to take action to improve their own health.

An interesting finding in study IV was that the subscale educational support, besides being linked to the helping alliance, also was linked to the patient's levels of symptoms. A higher level of symptoms was related to a perception of more frequently receiving educational support. Further research needs to replicate this finding and examine the direction of this association. Corrigan *et al.* (1999) found that persons with more severe psychiatric symptoms seem to be less empowered and experience diminished self-confidence. Hansson and Björkman (2005) also found that empowerment was negatively associated with severity of self-reported psychiatric symptoms. Furthermore, this reasoning is in line with previous research where problem-based educational interventions, based on an empowerment approach in patient groups, showed results of enhancement of the participants' personal resources such as hope, self-confidence and autonomy as well as ability to participate in social contexts (Byrne *et al.* 1999, Webster & Austin 1999, Medin *et al.* 2003, Arneson & Ekberg 2005) while symptoms of illness were reduced (Webster & Austin 1999). This is corroborated by Little *et al.* (2001) who found that good communication, partnership and a positive approach in health education was strongly related to the patients' ability to cope with problems and with life, and to reduced burden of symptoms and satisfaction with care.

### **Practical support**

The practical support subscale in study III, covers activities undertaken by staff in order to provide practical support to clients in their actual life context. The subscale practical support was not clearly shown among the qualitative descriptive categories in studies I and II, but was shown as a part of the mutuality category in study I. Individuals diagnosed with schizophrenia experienced more practical support (study III) while individuals in the 'other diagnosis' group experienced a higher level of educational support. This may be in accordance with the patient's needs or as found in study of Edwards (2000) that patients want nurses to understand and provide practical help with social and economic existence and that the mental illness diagnosis sometimes could become a problem in it self with a negative image reflected back on to them through their treatment by others. Fitzsimons and Fuller (2002) described the importance of developing services for individuals with mental health needs that strengthen social connections and participation in the life of the community. Wallerstein (1992) states that there is an interrelatedness between individuals and their social context such as empowerment in terms of community involvement. Hansson and Björkman (2005) found that social function and social network had a significant correlation with the individual experience of empowerment. This may imply that health promotion interventions should include practical

support to enhance the individuals' participation in community life and to reduce stigmatization. This finding requires further research in order to clarify the content of practical support and to verify its importance.

## **IMPLICATIONS**

### **For clinical practice**

- The findings of these thesis adds a new dimension to the understanding of health promotion for this group of subjects, and suggests that interventions focusing on respect, participation and empowerment would be an essential part of mental health care delivery, supporting a good quality of care.
- These findings could assist the development of health promotion intervention among nurses and other professions in mental health services.
- The mental health services have traditionally evaluated outcome in the patient, while not focusing on evaluating the processes of health promotion interventions performed by staff. This questionnaire could enables evaluations of process assessment focuses on how the health promotion intervention was achieved in mental health services
- The questionnaire could be used to justify resources for health promotion intervention in mental health services as a complement to other interventions.

### **For further research**

- To evaluate the utility of the HPIQ in practice, further studies are required to determine the relationship between health promoting intervention and patient satisfaction with care as well as outcome of care.
- The questionnaire should be further tested on samples with different clinical backgrounds and diagnoses in order to determine whether it can be used in branches of the health services other than mental health care.
- A very small part of the variation in the subscale practical support was explained. This subscale only includes one item, and it seems that further work is needed to explore the role of this factor, and whether it is to be kept in the scale. This finding requires more research in order to clarify the content of practical support and to verify its importance.

- An interesting further research issue is whether there are specific considerations concerning health promotion interventions in specific mental illnesses or with regard to functional level.
- Furthermore there is a need for evaluation of intervention programmes that include factors of health promotion intervention. Longitudinal studies are needed in order to investigate the effect of such interventions on the patients' outcome.

## CONCLUSION

- This thesis started with asking patients and nurses about their conceptions of how health processes are promoted in mental health nursing and the answers to these questions led to a focus on the concept of health promotion in mental health services. The studies that followed then investigated the concept and developed a questionnaire of health promotion intervention in mental health services.
- This thesis has provided a health promotion perspective and thereby a new dimension for understanding this in mental health services.
- The questionnaire developed to evaluate patients' experiences of health promoting interventions included 19 items comprising four factors, Alliance, Empowerment, Educational support and Practical support.
- In the development process of HPIQ, good psychometric properties were found. The questionnaire showed satisfactory reliability and validity, indicating that Health Promotion Intervention is measured in a valid way by the scale.
- The present questionnaire is intended to evaluate subjective experiences of health promotion interventions and not merely the health outcome as perceived by the patient, which is more frequently evaluated in the mental health services. This questionnaire does not measure interventions to alleviate illness or symptoms of disease, but covers those aspects of health promotion interventions in the mental health services that have been difficult to define.
- The strong association between health promoting intervention and helping alliance adds a new dimension to the understanding of health promotion among patients in mental health services, and suggests that interventions focusing on respect, participation and empowerment would be an essential part of mental health care delivery, supporting a good quality of care.

- From a holistic perspective, alliance, empowerment, educational support and practical support are essential elements of health promotion intervention in mental health services.
- The foremost concern of this thesis was to increase the knowledge base on health promotion intervention in mental health services. This knowledge is intended to help staff in mental health services to increase their health promotion interventions. However further investigation is needed in order to find out how this kind of knowledge can best be implemented in clinical practice and ought to be included in the education of nurses.



## SVENSK SAMMANFATTNING/SWEDISH SUMMARY

I dagens vård finns ett ökat krav på att hälsofrämjande insatser behöver integreras i hälso- och sjukvården och vara en självklar del i all behandling. Detta har bidragit till att ett ökat fokus på begreppet hälsofrämjande uppstått under det senaste decenniet, både vad gäller riktlinjer inom hälso- och sjukvård, praktisk vård och forskning. Trots detta har begreppet hälsofrämjande än idag ingen entydig definition. Begreppet hälsofrämjande beskrivs både som ett samlingsnamn där sjukdomsförebyggande och hälsofrämjande insatser ingår, men också som ett begrepp med ett renodlat hälsofrämjande salutogent perspektiv.

Världshälsoorganisationen, WHO definierar hälsofrämjande som ”processer för att möjliggöra för människor att förbättra och öka kontrollen över sin hälsa” och beskriver följande grundläggande element i hälsofrämjande arbete: empowerment, jämlikhet, partnerskap, samarbete, delaktighet i samhället, självbestämmande, ömsesidigt hjälpanande och delat ansvar. Maktlöshet och brist på socialt stöd är riskfaktorer för sjukdom och därför beskrivs begreppet empowerment som en självklar och central intervention i det hälsofrämjande arbetet. Det hälsofrämjande perspektivet har vanligtvis fokuserat på befolkningen i stort och inte inkluderat personer med psykiatriska problem eller deras familjer. De hälsofrämjande interventionerna i praktiken har ofta blivit ifrågasatta och tyngdpunkten i det kliniska omvårdnadsarbetet i psykiatrisk vård ligger fortfarande på att lindra och reducera psykisk sjukdom och inte på att aktivt stärka den psykiska hälsan. I detta sammanhang är det betydelsefullt att producera vetenskaplig evidens om de hälsofrämjande interventionernas funktionalitet i hälso- och sjukvården. Forskning inom hälsofrämjande omvårdnad fokuserar övervägande på hantering och förebyggande av sjukdom och hälsoproblem på grupp- och samhällsnivå. Ytterligare forskning bör därför fokusera på ett hälsofrämjande perspektiv på individnivå.

Det övergripande syftet för denna avhandling var att definiera och utveckla begreppet hälsofrämjande i psykiatrisk vård samt att utveckla ett frågeformulär som syftar till att mäta patientens upplevelser av hälsofrämjande interventioner i psykiatrisk vård.

**Delstudie I och II** syftade till att beskriva patienter och sjuksköterskors uppfattning av hur hälsoprocesser främjas i den psykiatriska omvårdnaden. Tolv patienter och tolv sjuksköterskor med erfarenhet av psykiatrisk vård intervjuades och data materialet analyserades med en fenomenografisk ansats i två separata studier. I intervjuerna med

patienterna (studie I) framkom att hälsoprocesser främjas genom *samspel* mellan sjuksköterska och patient som bygger på tillit, ömsesidighet, god personkemi samt att sjuksköterskan vågar vara naturlig och bjuda på sig själv. Samspelet mellan sjuksköterska och patient påverkas av sjuksköterskans *uppmärksamhet* i mötet. Patienterna beskrev betydelsen av att sjuksköterskan var engagerad och närvarande i samtalet, liksom att uppmärksamheten riktas på patienten som individ och inte enbart på symtom och diagnos. Om sjuksköterskan brister i engagemang upplever patienter lätt uppgivenhet och bagatelliserar sina problem. Patienters *utveckling* främjas genom att sjuksköterskan tillvaratar och stödjer patientens egna resurser samt tror på att patienten har förmåga att utvecklas. Detta bidrar till att patienten inges hopp och vågar utveckla nya mönster i livet. Patienter efterfrågar information, förslag, valmöjligheter och stöd för att kunna fatta bra och välgrundade egna beslut. Likaså beskrev betydelsen av att individens *värdighet* respekteras för att hälsa skall främjas. Patienten respekteras när sjuksköterskan lyssnar aktivt, tar patienten på allvar och respekterar rätten till självbestämmande, vilket också ökade motivationen till utveckling. Patienterna beskrev känslan av kränkning när sjuksköterskan använde sig av för mycket tillrättavisande information och när hon såg sig själv som expert. Sjuksköterskans attityd är följaktligen av stor betydelse för patientens möjligheter att känna sig trygg i relationen, vilket är en förutsättning för att främja hälsoprocesser. Sjuksköterskan främjar hälsoprocesser genom att tro på patientens förmåga och potential liksom att respektera patienten som individ, då kan patienten inges hopp och utveckla sin hälsa.

I intervjuerna med sjuksköterskorna (studie II) beskrevs också vikten av *närvaro* i relation till patienten för att främja hälsoprocesser. Sjuksköterskorna beskrev att de var närvarande genom att vara förstående och se patienten som en individ, viktigt för närvaron var också engagemang och personlighet i relationen. Vissa av sjuksköterskorna beskrev också att de ville ha en professionell distans i relation till patienten för att inte förlora överblicken i situationen och för att undvika att bli för emotionellt påverkade. Kategorin *Maktbalans*, handlade om hur makten var fördelad mellan sjuksköterska och patient för att främja hälsa. Sjuksköterskorna beskrev ett spann mellan att påverka patienten enligt gällande regler i samhället, till att samarbeta, till att respektera patientens egna beslut även om de inte överensstämmer med behandlingen. Sjuksköterskans uppfattning att påverka patienten enligt gällande regler i samhället baseras på attityden att patienten inte har förmåga att fatta rätt beslut pga. sin psykiska kondition. Alla sjuksköterskorna i studien beskrev att samarbete och delaktighet var det bästa sättet att uppmuntra patienten till utveckling. Kategorin *hälsofokus*, handlade om sjuksköterskans attityder till hälsofrämjande arbete och till människans

möjligheter att förändra och påverka sitt liv. Sjuksköterskorna beskrev att det var av betydelse att vara medveten om det friska och sunda hos patienten vilket också inkluderar att se avvikande beteende som en logisk reaktion på svåra upplevelser. Sjuksköterskans hälsofrämjande interventioner fokuserar på att vara närvarande och engagerad i patienten, att samarbeta med patienten och att fokusera på hälsa.

**Delstudie III** syftade till att utveckla ett instrument för att mäta patientens subjektiva upplevelse av hälsofrämjande interventioner i psykiatrisk vård. Instrumentet fick namnet *Health Promotion Intervention Questionnaire (HPIQ)* och konstruerades utifrån det resultat som framkommit i studie I och II. *Health Promotion Intervention Questionnaire (HPIQ)* besvarades av sammanlagt 135 öppenvårdspatienter i kontakt med en psykiatrisk klinik i södra Sverige och genom statistiska beräkningar resulterade detta i en fyra faktor lösning, där 19 frågor inkluderades som förklarade 62 % av variansen. De fyra faktorerna i instrumentet kallades *allians*, *empowerment*, *utbildningsstöd* och *praktiskt stöd*. Resultatet visade på signifikanta skillnader vad det gäller kön och ålder i relation till hälsofrämjande interventioner. Kvinnor och äldre patienter skattade högre vad det gäller hälsofrämjande interventioner samt i delskalorna *allians* och *empowerment*. *Allians* upplevdes också högre bland de personer som var samboende än de som var ensamstående. Skattningar av *praktiskt stöd* var högre hos de personer som hade diagnosen schizofreni, medan *utbildningsstöd* skattades högre bland de personerna med andra diagnoser.

**Delstudie IV** syftade till att undersöka begreppsvaliditet för *Health Promotion Intervention Questionnaire (HPIQ)*. Eftersom det vid litteratursökning inför undersökningen inte gick att finna några instrument som mätte hälsofrämjande interventioner jämfördes HPIQ med andra instrument som fokuserade på fenomen med möjliga beröringspunkter med hälsofrämjande insatser i psykiatrisk vård. Instrumenten som användes undersökte hjälpande *allians (HAS)*, patientens tillfredsställelse med vården (*CSQ*), *empowerment* samt psykiatriska symtom (*HSCL*). Resultatet visade att HPIQ hade positivt samband med hjälpande *allians*, patientens tillfredsställelse med vården och med *empowerment*. Inga samband visades mellan hälsofrämjande interventioner och psykiatriska symtom. Det tydligaste sambandet som framkom var mellan HPIQ och hjälpande *allians*, vilket visar att en respektfull relation mellan patient och personal är av stor betydelse för att insatserna ska upplevas som hälsofrämjande. Utöver detta undersöktes relationen mellan de enskilda faktorerna i hjälpande *allians* och HPIQ. Här framkom att det starkaste sambandet fanns mellan patientens upplevelse av att

erhålla rätt behandlingen och hälsofrämjande interventioner. Det fanns också samband mellan utbildningsstöd och psykiatriska symtom, samt mellan patientens upplevelse av empowerment och subskalan allians i HPIQ.

Sammanfattningsvis framkommer i denna avhandling att allians, empowerment, utbildningsstöd samt praktiskt stöd är betydelsefulla faktorer i hälsofrämjande interventioner i psykiatrisk vård. Det starka sambandet mellan hälsofrämjande interventioner och hjälpande allians bidrar till en ny dimension i förståelsen av hälsofrämjande interventioner inom det här området. Resultaten visade på att interventioner som fokuserar på respekt, delaktighet och empowerment är en betydelsefull del i psykiatrisk vård. Denna avhandling bidrar till ökad förståelse för innebörden i begreppet hälsofrämjande, en kunskap som kan användas som grund för att förtydliga och förbättra de hälsofrämjande interventionerna i psykiatrisk vård. Frågeformuläret HPIQ kan användas för att mäta patienters upplevelse av de hälsofrämjande interventionerna som ett led i förbättrad vårdkvalitet.

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## APPENDIX

### The Health Promotion Intervention Questionnaire (HPIQ)

The aim of this instrument is to gain information about your experiences of the care you receive.

#### I experience that ...

1. *My key worker treats me in a friendly way and often smiles*

Never                  Seldom                  Sometimes                  Often                  Always

2. *We do practical things together*

Never                  Seldom                  Sometimes                  Often                  Always

3. *My key worker and I can easily talk to each other*

Never                  Seldom                  Sometimes                  Often                  Always

4. *My key worker gives his/her best in our conversations*

Never                  Seldom                  Sometimes                  Often                  Always

5. *I dare to have a personal approach and share my thoughts*

Never                  Seldom                  Sometimes                  Often                  Always

6. *My key worker and I have a warm relationship*

Never                  Seldom                  Sometimes                  Often                  Always

7. *My key worker and I have a mutual appreciation of each other*

Never                  Seldom                  Sometimes                  Often                  Always

**I experience that ...**

8. *My key worker is on the same level as I am*

Never                  Seldom                  Sometimes                  Often                  Always

9. *My key worker is oriented towards problems, not illness*

Never                  Seldom                  Sometimes                  Often                  Always

10. *My key worker is happy when I make an effort*

Never                  Seldom                  Sometimes                  Often                  Always

11. *My key worker offers and helps me to see new possibilities*

Never                  Seldom                  Sometimes                  Often                  Always

12. *My key worker supports my efforts to gain health*

Never                  Seldom                  Sometimes                  Often                  Always

13. *My key worker respects my right to make my own decisions*

Never                  Seldom                  Sometimes                  Often                  Always

14. *My key worker takes me seriously*

Never                  Seldom                  Sometimes                  Often                  Always

15. *My key worker informs me about what I need in order to feel better*

Never                  Seldom                  Sometimes                  Often                  Always

16. *My key worker tries to make me see things more realistically*

Never                  Seldom                  Sometimes                  Often                  Always

**I experience that ...**

17. *My key worker is willing to cooperate with me*

Never              Seldom              Sometimes              Often              Always

18. *My key worker supports my goals*

Never              Seldom              Sometimes              Often              Always

19. *My key worker respects my choices*

Never              Seldom              Sometimes              Often              Always