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Published in:
Journal of Child Health Care

DOI:
[10.1177/1367493513509421](https://doi.org/10.1177/1367493513509421)

2015

[Link to publication](#)

Citation for published version (APA):

Lefevre, Å., Lundqvist, P., Drevenhorn, E., & Hallström, I. (2015). Managing parental groups during early childhood: New challenges faced by Swedish child health-care nurses. *Journal of Child Health Care*, 19(3), 381-391. <https://doi.org/10.1177/1367493513509421>

Total number of authors:
4

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Managing parental groups during early childhood: Swedish child health care nurses facing new challenges

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Abstract

The purpose of this study was to describe child health centre (CHC) nurses' views of managing parental groups during early childhood. All 311 CHC nurses working within the Swedish CHC system in one county were asked to complete a web-based questionnaire. Findings showed that although the CHC nurses were experienced several found group leadership challenging and difficult. The need for specialized groups for young parents, single parents and parents whose first language was not Swedish was identified by 57% of the nurses. The CHC nurses found the participation of fathers in their parental groups to be low (an estimate of 10 to 20%) and 30% of the nurses made special efforts to make the fathers participate. Education in group dynamics and group leadership can strengthen CHC nurses in managing parental groups. It is recommended that specialized parental groups are organized by a few family centres so CHC nurses can develop their skill in managing such groups.

Background

Parental support is an important part of the Swedish child health service (CHS), including parental groups to provide knowledge and strengthen the parents' social network. However, the support does not always reach the families that need it the most (Lagerberg et al., 2008, Fabian et al., 2006). Countries in Western Europe are struggling with the question whether the CHS should be universal or targeted towards families whose children are at risk (Blair and Hall, 2006, Bellman and Vijeratnam, 2012, Wolfe et al., 2013). The Scandinavian model with a comprehensive universal nurse led CHS programme including both parental support and health surveillance directed to all children and their parents seems to be unique in Europe (Wolfe et al., 2013, Swedish National Board of Health and Welfare, 2012).

The prevalence of mental and behavioural disorders among children and adolescents throughout the world is high and is expected to rise (WHO, 2001, Barlow and Parsons, 2003, Kieling et al., 2011). In Sweden the proportion of young people in care for depression and anxiety is high and increasing (Department of health, 2009). Research had identified that a healthy environment during early childhood promotes both cognitive and social development, as well as mental and physical health (McCrory et al., 2010, Irwin and Hertzman, 2008, Kieling et al., 2011).

Sweden has a long tradition of CHS aiming to reduce disease, mortality and disability but also to support parents in their parental role (Swedish National Board of Health and Welfare, 1991, Swedish children medical association, 2013). The child health centre (CHC) is led by a CHC nurse specialized in health care for children and adolescents (Swedish National Board of Health and Welfare, 1991, Swedish children medical association, 2013). The CHC can be located either at a health centre or a family centre, where CHC nurses, social workers, antenatal care and an open nursery school are situated in the same building. All families in

Sweden are invited to participate in the CHS programme, starting when the child leaves the maternity unit until it reaches the age of six and is transferred to the school health care programme. The programme includes home visits, health examinations, a vaccination programme and parental groups. The CHC nurse organizes parental group meetings eight to ten times during the child's first year (Department of health, 1978, Department of health, 2009, Swedish children medical association, 2013). In accordance with theories about group leadership and group facilitation parental groups are closed groups with 6-8 couples in each group in order to facilitate a trusting climate (Elwyn et al., 2004, Puskar et al., 2008). The groups are meant to serve as a place where parents can meet and share experiences and extend their social network. The agenda should be decided in a cooperative way together with the parents to ensure that themes are addressed according to parents' wishes. This increases the feeling of informality and promotes future independence from the group facilitator (Elwin et al., 2004). The nurse's role is to give information about the themes chosen and serve as a group facilitator. By observing the group dynamics and managing the group processes the nurses should work to obtain the best possible outcome in the group (Elwin et al., 2004, Puskar et al., 2008). There is no structured manual to follow for the meetings, but there are some recommended themes to be included, such as child development, nutrition and interaction between parent and child (Swedish children medical association, 2013).

Although parental support is important within CHS few evidence-based methods are used (Sundelin et al., 2005, Swedish National Board of Health and Welfare, 2008, Swedish National Board of Health and Welfare, 2012, Sundelin and Hakansson, 2000). The International Child Development Programme (ICDP), aimed at improving communication and interaction between parents and children (Hundheide, 1996) and Motivational Interviewing (MI), a communication methodology (Rollnick et al., 2008), are evidence-based methods recently introduced within the CHS but they are not yet frequently used.

The CHS program is appreciated by the parents and reaches about 99% of the families (Department of health, 2009), but only about 40% of the parents participate in parental group activity (Wallby, 2008, Center of Excellence for Child Health Service, 2012) and the accessibility and participation varies greatly in different regions of Sweden (Petersson et al., 2003, Wallby, 2008). Young parents, single or unemployed parents, parents with a low education level and/or with a non-Swedish background are significantly underrepresented in the parental groups (Lagerberg et al., 2008, Fabian et al., 2006). Parental groups directed exclusively to e.g. parents of twins, young parents, parents with adopted children, or single parents, so called specialized parental groups, only occur sporadically in the country (Wallby, 2008).

In a national survey previously conducted in Sweden, CHC nurses pointed out that they found it difficult to manage parental groups (Wallby, 2008) and as a result a booklet about group leadership was developed by the Swedish National Institute of Public Health (Heimer, 2009). In addition, a regional manual, designed as a detailed checklist containing suggestions for themes to be addressed and suggestions of problems to be highlighted and discussed was developed and implemented in a county in the south of Sweden (Development Units for Child Health Care, 2009), aimed at supporting CHC nurses in their work with parental groups.

Even though there are regional guidelines used at some CHCs, there are no national guidelines on how to manage parental groups in Sweden. This might imply that the individual nurses' views of managing parental groups influence how the parental groups are held. Therefore the aim of this study was to describe CHC nurses views of managing parental groups during early childhood in a county in Sweden.

Method

Settings

The study was conducted in Skåne, a county in the southern part of Sweden with 1.2 million inhabitants and 16,000 children born every year (Statistics Sweden, 2011). Skåne consists of both urban and rural areas and has 138 CHCs with about 300 nurses employed. More than 95,000 children between 0-6 years of age are registered at the CHCs (Kunskapscentrum för barnhälsovård, 2012). During the year 2011, 86% of the parents in Skåne were invited to participate in parental groups and the average participation among all was 45%, but the spread was large (17-80%) between the different CHCs (Center of Excellence for Child Health Service, 2012).

Study population/data collection

The addresses of all 377 CHC nurses working in the county of Skåne were requested from the Centre of Excellence for CHS in Skåne, 66 of these were no longer in use. The remaining 311 CHC nurses were asked to complete a web-based questionnaire previously used in 2008 (Wallby, 2008). The questionnaire contained 30 questions concerning the structure, content and extent of the nurses' parental groups and how they define parental support, as well as what they find important to address in the groups. Furthermore, background characteristics such as organization, education, years of working and how many children the nurses are responsible for are included. Eight questions concerning the nurses' views of their own personal group leadership and the manual implemented in 2010 were added to further illuminate these subjects. Most questions were of a multiple-choice character with the possibility of adding comments. A pilot study including eight CHC nurses was conducted in early 2011 in four CHC centres in order to test the questionnaire and the technical procedures. Minor corrections were made concerning technical issues.

The study was performed between December 2011 and April 2012. Study information, a unique study participation number and the link to enter the survey were provided by e-mail. Two reminders were sent by e-mail to those who did not answer. As a last reminder a telephone call was made to the nurses that still had not answered.

Statistics

Descriptive statistical analyses were conducted using IBM, SPSS version 20.0. Fishers' exact test was carried out to explore whether CHC organization, educational background or experience (e.g. number of years working within CHC) were of any importance for the nurses' experiences of managing parental groups. The significance level was set to $p < 0.05$. Comments expressed in open questions were summarised in a structured way.

Ethical considerations

The study was planned and conducted in accordance with the WMA Declaration of Helsinki 2008 (WMA, 2008). Permission was given by all responsible managers. All the participating nurses gave written informed consent and were given a code number. The study was approved by the Regional Ethical Review Board (2011/3) and possible inconveniences for the participants were considered to be small and compensated by the benefits of the study results.

Result

Of the 311 CHC nurses 156 nurses (55%) from 31 of 33 different municipalities completed the survey. Nurses with different educational background and different experiences (working years) were represented (as set out in Table 1).

In all 66% of the nurses defined parental groups as parental support, which in turn was defined as availability, continuity and personal knowledge. The nurses defined the primary

aim with the parental groups as a place where parents could connect and create a network and secondly as a place for learning. Parental groups were offered by almost all the nurses (98%) during the child's first year. Most nurses held groups for both first time parents and parents with more than one child (86%) but 10% of the nurses primarily had groups for first time parents alone. On average the nurses started four to six new parental groups annually and had six to eight meetings with each group. Mostly the parental groups were organized and started by the nurses and not transferred from the antenatal care. The subjects most commonly addressed were nutrition and sleep (Table 2). In all, just over half of the nurses (55%) led all their group meetings themselves while 24% managed their parental groups together with another nurse. 18% invited other professionals e.g. librarian, dental hygienist or psychologist to some meetings.

Overall, 85% of the nurses expressed that they were content with the overall support they received from their employer in order to facilitate the parental groups. However, 52% of the nurses did not have regular supervision and whilst 45% of the nurses found it difficult to manage their groups 45% found it easy. No relationship between background characteristics of the nurses and their experience of conducting parental groups was found.

In 92 of the 156 answered questionnaires nurses made comments on the question about group leadership and of these 60 CHC nurses mentioned that it was both easy and difficult to lead parental groups due to the dynamics within the groups. For example some nurses stated "It is difficult in quiet groups and with dominant parents" (code number 288), "if the dynamics within the group is good then it is easy, but otherwise it is difficult – I get nowhere and end up giving a lecture, and there will be no cohesion in the group" (code number 112). Several of the nurses expressed a need for education and training in group leadership and group

dynamics. Some nurses expressed that great expectations were put on them as parental group leaders as they had to keep more up to date. For example a nurse commented that “Many different subjects are brought up and I need to be very up to date, the parents have a lot of worries because they surf on the internet and find a lot of different information, I have to sort out and give guidance” (code number 286).

The booklet about group leadership provided by the CHS was read by 28% of the nurses and 84% of them felt that it was useful. Most nurses (87%) attended the training sessions that were held when the regional parental group manual was presented and 93% of them found that they were helped by these sessions. It was found that 83% of the nurses used the parental group manual in their work with parental groups and 88% of them felt that the manual was useful in supporting them. Other structural programmes were used to a minor extent by the nurses in their daily work at the CHC, such as the ICDP (5%) and Marte Meo (Aarts, 2008) (2,4%).

It was estimated that only between 10-20% of fathers participated in the parental groups and 16% of the nurses did not have any fathers in their groups. In all 30% of nurses indicated that they made efforts to increase the participation of the fathers. The most common effort to increase the fathers' participation was to offer parental groups at hours that could suit the father's working hours better and to orally emphasise the importance of both parents participating. Specialized parental groups, e.g. groups of parents of twins, young parents or parents with a foreign background (Table 3) were held by 57% of the nurses and were more common among nurses working at family centres ($p < 0,004$).

Discussion

The result showed that the CHC nurses were experienced in managing parental groups, but in spite of this several nurses found the group leadership challenging and difficult. They expressed a need for education in group leadership and many of them felt that they were in need of more supervision.

The nurses primarily defined parental groups as a place where parents can connect and create a network and secondly as a place for education. This reflects a change in the group leader role, which follows the change of CHS in general, where focus has shifted from surveillance towards health promotion, aiming to strengthen parents' self-esteem (Hallberg et al., 2005, Sundelin et al., 2005, WHO, 2005, Blair and Hall, 2006, Bellman and Vijeratnam, 2012). The parental group leader has extended from being a teacher and expert to a facilitator for processes and communication among the group members, two group facilitating roles that can be difficult to combine (Elwin et al., 2004). This is a result not only of decreased economic resources within health care (Sundelin et al, 2005, Hallberg et al., 2005) but also educational reforms during the 20th century, where expert controlled curricula have been replaced by brief guidelines where teachers and students are responsible for the students educational development (Egidius, 2009). Pedagogics has changed from teaching factual knowledge towards teaching by reflection and understanding (Egidius, 2009).

Knowledge about group facilitation and group leadership is often overlooked as something that does not have to be taught or trained (Elwyn et al., 2004) but in reality profound knowledge in group dynamics, decision making and process consultation is needed to be an efficient group facilitator (Elwyn et al., 2004, Puskar et al., 2012, Petersson et al., 2003).

Most CHC nurses do not have any formal group leadership training in their education and despite the efforts made in terms of CHS continuing professional education to strengthen nurses in their role as parental group leaders they still report uncertainty regarding managing parental groups. The education given seems to be mostly focused on the content of the

parenting themes while our results imply that CHC nurses need education and training in group dynamics and processes. Supervised groups where the nurses are given the basic elements in group facilitation and are encouraged to try new ideas would be a good way to maintain and obtain skills (Hundeide, 2009).

Another reason for the uncertainty felt by the nurses might be that the CHC nurses meet parents with more needs and other demands than they did before. The exposure to media has increased (Sarkadi, 2005, Plantin and Daneback, 2009) and with the immense amount of parental sites on the Internet it has become part of the daily life for parents to socialize and search for information through the web (Sarkadi, 2005, Plantin and Daneback, 2009). The CHC nurses have to compete with this stream of parental information available around the clock and there is a new need for the nurses to help the parents navigate through the jungle of information and opinions. In this study it was found that nurses did not receive regular supervision, a result that not only confirms the findings showed in the survey by Wallby in 2008 (Wallby, 2008), but also shows that no improvement has been made. Supervision should be provided by the CHS and be a part of the CHC nurses' work (Kunskapscentrum för barnhälsovård, 2012), but there is no definition of the form and frequencies and in practice this seems to vary.

Specialized parental groups were held by 57% of the nurses and were more common among CHC nurses working at CHCs located as family centres. Young parents, single parents and parents with a foreign background are underrepresented in ordinary parental groups and it is suggested that having specialized parental groups could be one way of reaching these parents (Fabian et al., 2006). It is likely that there are too few eligible parents in order for such groups to be run frequently at all of the CHCs (Wallby, 2008, Department of health, 2009), therefore the CHC nurses are less experienced in managing such groups which could create reluctance to start them. One way of addressing this could be to organize specialized parental

groups centrally in the area. However, the importance of being able to identify oneself with others in the same situation in order to create a supportive friendship has to be considered (Nolan et al., 2012) together with the idea of parental groups to facilitate a growing and long lasting network in the neighbourhood which suggests that the areas should not be too wide. Family centres have been found to have more parental groups and higher participation rates than those in CHCs (Wallby, 2008) and could using a greater variety of co-workers serve as a base for more specialised parental groups. Little, however is known about what parents feel they would benefit from within these groups and further research in this area is therefore suggested.

The CHC nurses found the participation of the fathers in their parental groups to be low; despite this only 30% of the nurses made any alterations. The actions taken by the CHC nurses to make the fathers participate in parental groups were all actions to increase the fathers' participation in already existing groups. It is well documented that the father's involvement during the childhood period is of great importance both for the family's wellbeing and the development of the child (Sarkadi et al., 2008, Wilson and Prior, 2011). Parental leave exclusively for fathers and gender equality bonuses are actions taken by the Swedish government to increase the father's involvement in the lives of their young children (The Swedish Social Insurance Agency, 2013, Hallberg et al., 2010). Previous studies show that reasons for fathers not to participate in parental groups are not only that the meetings are being held at inconvenient times but also that the fathers felt that they had no need for this kind of activity (Hallberg et al., 2010). There is a need to further investigate mothers' and fathers' needs in terms of parental support.

Strengths and limitations

One limitation of this study was the nurses' low response rate (55%). A new computerized system for medical records was implemented and annual statistics were collected for the first

time during the period for the study, which probably affected the response rate. Nevertheless, nurses from 31 of 33 different municipalities took part in this study with different educational and organisational backgrounds. The questionnaire had been developed by experts and tested previously. Using this approach meant we could not only compare results over time but also compare our results across a large population of nurses. To get deeper insight qualitative interviews with CHC nurses might capture a wider range of nurses' perceptions.

Conclusions

New demands on group leadership increase the importance of education for CHC nurses in group leadership and group dynamics in order to provide a high quality service to parents. Nurses with little experience in managing specialised parental groups might create a reluctance to start such groups. To organize the specialised parental groups centrally in the region, preferably at family centres, would probably increase the opportunities for parents with special needs to participate in parental groups. Further research about what would attract the parents that do not attend to the parental groups is needed in order to increase their involvement.

Funding

This work was supported by the Swedish Research Council (K2010-70X-21420-01-3)

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Figure 1. Flow-chart of participating CHC nurses.

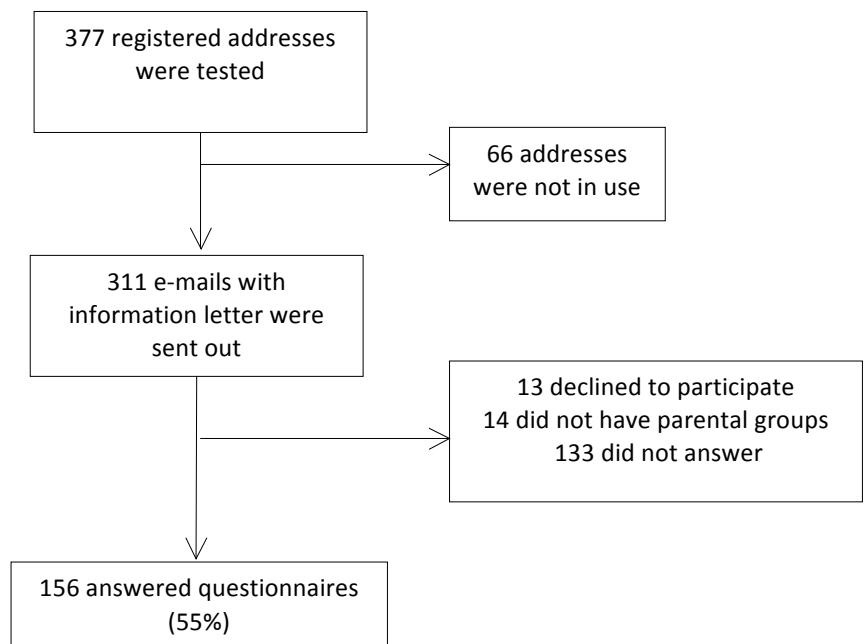


Table 1. Background characteristics of the participating CHC nurses.

Characteristics	
Education (%)	
Public Health Care	70
Pediatric	22
Public Health Care + Pediatric	5
Other specialist education	3
Years working in CHC (%)	
1-5	38
6-10	19
>10	42
Organization (%)	
CHC organized as Family Center	19
CHC-center	81
Nurses working only with children	43
Nurses working with both children and adults	57
Responsible for children under the age of 2 (%)	
20-40 children	47
41-60 children	27
61-80 children	18
81-90 children	6
175-450	2

Table 2. Themes addressed in parental groups.

Themes	N=156
Sleep (%)	93
Child safety (%)	93
Family and relationship (%)	93
Nutrition (%)	92
Self-care (%)	92
Interaction between parent and child (%)	90
Breast feeding (%)	86
Pregnancy and child birth (%)	84
Parental role and parenting (%)	85
Other subjects according to parent's wishes (%)	83
Children with difficult temper (%)	76
Drinking habits (%)	72
Vaccination (%)	70
Languages and speech (%)	60
Smoking habits (%)	58
Dental Health (%)	56
Child related community information (%)	53
Sex and relationships (%)	51

Table 3. Specialized parental groups held in Skåne reported by CHC nurses.

Specialised parental groups	(%)
Parents with twins	25,4
Young parents	14,7
Parents with another mother tongue than Swedish	9,6
Parents with adopted children	4,5
Fathers	3,2
Single parents	3,2