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Petersson, Kerstin; Petersson, Christer; Håkansson, Anders

Published in:
Scandinavian Journal of Caring Sciences

DOI:
[10.1111/j.1471-6712.2004.00260.x](https://doi.org/10.1111/j.1471-6712.2004.00260.x)

2004

[Link to publication](#)

Citation for published version (APA):

Petersson, K., Petersson, C., & Håkansson, A. (2004). What is good parental education? *Scandinavian Journal of Caring Sciences*, 18(1), 82-89. <https://doi.org/10.1111/j.1471-6712.2004.00260.x>

Total number of authors:
3

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PO Box 117
221 00 Lund
+46 46-222 00 00

What is good parental education?

Interviews with parents who have attended parental education sessions

Kerstin Petersson^{1,2} RNT, PhD, **Christer Petersson**¹ MD, PhD and **Anders Håkansson**³ MD, PhD

¹Kronoberg Unit for Research and Development, Växjö, ²Department of Nursing, Section of Caring Sciences, Lund University, Lund and

³Department of Community Medicine, Malmö University Hospital, Malmö, Sweden

Scand J Caring Sci; 2004; 18; 82–89

What is good parental education? Interviews with parents who have attended parental education sessions

The aim of the study was to highlight the experiences and expectations of Swedish parents with respect to general parental education within child healthcare. Interviews were carried out with 25 parents who had attended education sessions. With a few exceptions the fathers did not take part, and those mothers who did comprised a relatively highly educated group; their views therefore predominate in this study. Socially vulnerable parents such as the unemployed and immigrants took part more sporadically in the meetings, which is why less material is available from these groups. The arrangement and analysis of the material was done using qualitative content analysis. We identified two main categories of importance: 'parental education content' and 'parental education structure'. The parents were on the whole satisfied with the content with respect to the child's physical and psychosocial develop-

ment. On the other hand, first-time parents expressed a degree of uncertainty with respect to the new parent roles and parent relation and they thought that the education should place more emphasis on the interplay between the parents and between child and parents. The degree of confidence in the nurse as group leader was mainly high. The parents thought that the groups functioned well socially and were satisfied with the organization of the meetings. They did, however, demand clearer structure and framework with respect to the content. Since the aim of legally established parental education is to improve the conditions of childhood growth and to provide support to parents, it must be considered especially important to provide resources so that the socially vulnerable groups in the community may also be reached.

Keywords: parental education, child healthcare, interviews, parental satisfaction.

Submitted 27 January 2003, Accepted 4 December 2003

Introduction

General parental education is a means by which Swedish society meets parents' need for knowledge, contact and fellowship in its broadest sense (1, 2). However, it can be interpreted by some as an authoritarian activity stigmatizing those who deviate in any way from society's norm.

Several studies have shown that the form and content of the general parental education attracts the relatively well-educated middle class, whilst the poorly educated, the single mothers, immigrants and parents with psychological problems or drug abuse are more difficult to engage (3–6).

A number of reports in the 1990s revealed an uneven development and quality in parental education in certain parts of Sweden (7–11). Huge cut-backs and changes in priority for care and service in society threatened the preventative work within child healthcare and the allocation of time for parental education (2, 10).

Social services surveys showed that parental education was mainly offered to first-time parents and that some areas offered none whatsoever (5). Furthermore, it was shown that the content tended to dwell on medical and physical questions whilst the more difficult relation-orientated questions were overlooked.

Traditionally, the nurse has informed and instructed in questions of somatic and medical character, and given advice and directions in her role as expert (12). During recent decades, work in child healthcare has focused more on support and confirmation of the parents' own self-esteem and capacity to cope with parenthood (13).

Previous studies have largely dealt with the nurse's work within the child care system and the parents' satisfaction

Correspondence to:

Kerstin Petersson, Kronoberg Unit for Research and Development, Box 1223, SE-351 12 Växjö, Sweden.
E-mail: kerstin.petersson@omv.lu.se

with child healthcare as a whole (14–17). There are also studies of nurses' house calls and individual support to parents (13, 18, 19).

However, there are few studies that highlight the effect of parental education and the parents' incentive to participate. Exceptions to this are a few Swedish studies from the 1980s and 1990s (3, 6, 11, 20).

International comparisons of nurse's child healthcare work especially with parental education are more difficult to make due to differences in job description, legal and finance systems. Parental education as a legal requirement, organized as in Sweden, does not exist in the neighbouring countries of Norway and Denmark. In Norway, there are courses in the form of 'parent preparation' but these are not available nation-wide (12).

We have previously studied parental education from the nurses' perspective and found that it was difficult to achieve the goal of good parenthood training for all parents (6). To gain a more complete image we wanted to focus on the parents' perspective and in this article we show the results of interviews with those parents who participated in the parental training sessions. The aim of our study was to highlight parents' experiences of and expectations in the child healthcare parental education programme.

Material and methods

Setting and participants

Our study was carried out at two of the three health centres featured in two previous studies (6). The two health centres served their own separate geographical areas in the town of Växjö. The nursing staff had responsibility for both healthcare (including child healthcare) and medical care (predominantly the elderly).

In conjunction with the invitation to parental education in the mid-1990s nursing staff informed participants that follow-up interviews would be conducted after completion of the course. The medical officers then sent out a letter of inquiry to all participants. An independent person (first author) would interview them and ascertain their views on the course. The study was approved by the local ethics committee and informed consent was obtained in line with the Medical Ethics Council's guidelines (21). Participation in the interview was optional and the answers obtained would be presented at group level and the material was treated confidentially. The parents were told they could withdraw at any point of the interview (principle of autonomy).

A total of 61 parents of whom 46 were first-time parents agreed to participate in the study and the interviewer was presented with a list of names, address and telephone number, age, civil status (married/cohabiting or single parent) and employment. Information on whether or not

the parents were first-time parents or immigrants was also provided.

Among the first-time parents were 33 born in Sweden. They were married or cohabiting and both parents were in employment. Ten interviewees were chosen consecutively from this group. The remaining 13 first-time parents comprised parents born in other countries, Swedish born young single mothers and unemployed parents. In this group, the aim was to interview all parents. However, there were finally only seven who could be interviewed, in spite of repeated attempts to reach the parents and repeated efforts to book a suitable appointment time.

The remaining 15 parents already had children and this group was composed of Swedish-born and immigrant parents, married/cohabiting and single mothers, and unemployed parents. Here, the aim was also to interview all parents but only eight agreed.

There were a variety of reasons for the non-response in these two latter groups. Some of the mothers had returned to work and found it difficult to find time for interview. In some cases it was impossible to reach the parents in spite of repeated telephone calls. Some had moved away, and one parent was suddenly taken ill.

The term 'parents' is in this study synonymous with 'mothers' since 23 interviews were carried out in the presence only of the mother. In two interviews both mother and father were present.

The interviews

The interviews were conducted during 8 months in the late 1990s when the children were more than 2 years old. Two of the parents had, at the time of interview, a second child. The parents were contacted by telephone to arrange an appointment for interview. All interviews were, according to the parents' wishes, conducted in their homes, except for two that were held at the health centre.

The taped interviews were between 1 and 2 hours in length and could be regarded as a conversation between interviewer and parent (22). A semi-structured interview guide was used which gave the interviewer the freedom to hold a conversation, but with a focus on that area which concerned parenthood, the content of the group meetings, fellowship within the group, partly between parents and partly towards the nurse.

The interview guide's relevance was put to the test by two pilot interviews with parents who had not taken part.

Analysis

The interviews were written out word for word. The transcript was processed and analysed with the help of qualitative content analysis (23–25). The work was done dialectically from looking at the interview as a whole to

placing its interpretation in relation to parts, and to be able to go from understanding to explanation (22, 26). Repeated interpretations of the transcript from all interviews were done at separate abstraction levels (24, 25).

First, the transcripts from all interviews were read in their entirety, to obtain a sense of the whole and to suggest ideas for continued analysis.

Major or substantial statements were underlined, and similarities and dissimilarities noted. Second, the transcript was split into essential units and those with similar content were collected and coded. The coded units were sorted and grouped thereafter into subcategories, which on reinterpretation were reduced to fewer higher-order categories.

Third, each of the authors, independently of each other, critically reviewed all categories set in relation to the transcript material. The fourth stage in the analysis process involved reflection and discussion between the authors until a consensus was reached with regard to the categorization. Finally, there remained two main categories with four and two subcategories, respectively.

Results

The results of the study may be summarized in the two main categories: *Parental education content* with the following subcategories: knowledge of child development, interplay within the family, contact with other parents, knowledge of community support, and *Parental education structure* with the following subcategories: organization of group meetings, the nurse as group leader. The categories are exemplified with a number of quotations.

It was apparent that parental education during the child's first year was considered to be a valuable complement to the routine child healthcare programme. The parents, predominantly mothers, who participated in the group meetings, were well motivated. They considered that the sessions had given them important support for continued parenthood. Several appreciated the social aspect and exchange of experience with each other, and many continued to meet even after the eight to ten sessions were concluded.

Parental education content

Knowledge of child development. The parents were mainly satisfied with the nurse's teaching of the child's physical and psychosocial development. They were also satisfied with the nurse's advice on breastfeeding and child safety. They also appreciated medically orientated lectures by doctors and others, on childhood diseases, vaccinations and dental health.

From time to time the new mothers were encouraged to relate for others in the group their experiences and knowledge of special areas such as baby massage, breastfeeding or books for children.

It became apparent there was a need to discuss sleep problems of the baby and the child's emotional development at different ages. Some parents revealed a lack of self-confidence by putting anxious questions to the interviewer on what is normal or abnormal in the child's development and what is to be expected of the child at different ages:

I think on the whole that the information we were given was good. We heard about accidents and hazards, both in the home and elsewhere when the child is a bit older.

What was good was that we had a pharmacist who came and lectured for us. She talked about family life and protection against unwanted pregnancy.

Interplay within the family. The training placed most emphasis on interplay between mother and child. The effect of the birth on the parents' sex lives was raised by several mothers who pointed out that the problem was not discussed at the group meetings.

The father's role and participation in the care of the child was not discussed much. Several mothers were concerned that the fathers' sharing of the child's upbringing could be made more difficult if this was not taken up and discussed.

The parental role was felt to be unique and involved great responsibility, a change of lifestyle. This also involved a complicated interplay in the relationship between the two new parents. The joint parental responsibility could be cause of stress, which in turn could influence the relationship to the grandparents.

Two mothers had undergone a separation from the babies' fathers during the first year. Both mothers had lived alone with their babies and had from time to time felt depressed and unable to cope. They had received support from the fathers in one way or another but, as one of the mothers put it that it was just sporadic support.

A number of first-time parents were unsure of how they could meet the child's need for contact and stimulation:

After childbirth my genital area was throbbing and aching and then there was that with breast milk, and I could not face any sexual activity. I felt like a second-hand person and not at all attractive to him.

Women who have recently become mothers have completely different demands made on them compared to those made when my mother had me. It may also be difficult to deal with remarks from one's own mother and others of the same generation.

Contact with other parents. The social contact made between parents was felt to be particularly rewarding. In those instances where the parent groups had functioned well, they had continued to meet, in spite of the fact that the formal sessions had ended.

The group meetings provided an ideal occasion to discuss common experiences, for example, childbirth or the day-to-day care of the baby. It was an exchange of knowledge

and exchange of experience, lending support to, and confirming the role of, the parent. The mothers found themselves in a similar situation whereas the midwife and nurse were regarded as professional experts.

The social contact with other mothers over a cup of coffee gave a welcome break from the monotonous and single-handed chores at home, with nappies and crying baby. It was felt to be inspiring to attend the parent groups and one looked forward to meeting in that way. Even the brothers and sisters of the newborn could attend and spend time with other children of similar ages.

The single mothers indicated that they missed the support of other adults and described how difficult it was to find time for themselves.

The parent groups were thus seen as a complement to insufficient adult support.

Parents living at a distance from relatives and friends stressed the importance of fellowship with other parents during and after the group sessions.

It was so instructive to hear how the others coped in their role as parents. It's no good just listening to the experts. You need to know how others solve their problems, tricks of the trade, that's what is useful.

Parent groups are very good for those who don't have family or parents nearby as you have no one to ask when a problem arises.

We have in fact continued to meet since, once every three months; the children are of similar ages and we are able to compare their development.

Knowledge and community support. The matters which concern the family in the community, such as marriage guidance, social security and the nursery school system, were considered to have been given too little time in the group meetings. The economical aspects of having a new member of the family to support had, in the child's first year, become all too important.

Another question which ought to have been dealt with was in which way the parents should divide their entitlement to time off from work. Should they both take an equal share, or does the mother see the baby as being wholly her responsibility? The natural bond between mother and child can be so strong that the father runs the risk of being excluded.

The consequences for the family budget of an extra member of the family to support ought to have been stressed.

Parental insurance and social security should be brought into focus.

Parental education structure

Organization of the group meetings. The parental education comprised eight to ten group meetings in total, and each

meeting lasted just over 2 hours. The group usually contained six to eight parents.

In order to sustain the motivation of the parents to complete the course, a clearer structure and defined limits were seen as a basic requirement. An announcement in advance of the meeting's theme was wanted so that the participants could be prepared.

A number of parents were of the opinion that the groups should be more homogeneous, with first-time parents only, or with parents who already have children. There was also a wish to be a part of the same parent groups, established by the midwife during the pre-birth period.

A Chilean immigrant mother had been able to attend just one parent meeting. She had no car or other means of travelling to the town's child healthcare centre.

We had decided on a theme. The group meetings just finished without following the 8–10 sessions planned.

It would have been more fun to meet the other mothers after the birth since we were all acquainted and could have accompanied each other there also; it would have lent a feeling of security.

The nurse as group leader. The parents were on the whole satisfied with the nurse's contribution, including her leadership of the group meetings. The nurse was seen as coordinating support for the group, which was seen to be well functioning if all were allowed to speak and if parent's wishes were heeded. If the nurse was knowledgeable and furthermore able to create a climate of ease and tolerance, then she was considered a good group leader. Sometimes concrete and unequivocal advice was needed but sometimes just an endorsement of one's role as a parent.

Those nurses who gave a little extra beyond that normally expected, were particularly appreciated. For instance, on a number of occasions evening sessions were organized so that the fathers could also take part. On other occasions, the nurse had organized activities for brothers and sisters.

The nurse led quite well and we chatted amongst ourselves. Each time she had something new to discuss and we each got the chance to speak.

Our nurse has been supportive and she was careful to ensure that we got to know each other.

Some parents, however, did express dissatisfaction with the nurses' management of the parent groups. These mothers had high expectations of parent education and their goal was to complete this. However, the attendance varied and sometimes the number of participating mothers was as low as two or three.

Our questions were not answered. There was no programme and no advance planning for the sessions. It can sometimes be difficult to feel at ease in the group. You feel deserted and wonder if you are making a fool of yourself.

The first nurse we had as group leader had no time to continue with the sessions and it happened now and then that she left us in the middle of a meeting.

Discussion

Main results

The main results from follow-up interviews with the parents indicated that they were on the whole satisfied with the content of parental education with respect to the child's physical and psychosocial development. On the other hand, first-time parents expressed a degree of uncertainty with respect to the new parent roles and parent relation. Furthermore, in our study it was proposed that parental education ought to focus more on problems in relationships between the parents, stress within the family and interplay between child and parents. However, it was those relatively highly educated mothers who participated and it was their requirements that influenced the content. Socially vulnerable parents such as the unemployed and immigrants took part more sporadically in the meetings, which is why less material is available from these groups. We have thus reached an already 'converted' group of parents who also had views on the structure, organization and content of the group meetings. We wonder if the social contact with other parents is more suitable for the group we are trying to reach. The medical element has been given a much too prominent place. Perhaps the psychosocial and care-directed contribution needs to be strengthened. As other researchers have shown, we have seen that the parental education reached an already well-informed and enlightened group of parents (3–6). It was obvious that parents cannot be regarded as a homogeneous group (2, 4, 6, 27).

The few fathers who participated could feel distanced from the discussions. As a result they lacked the motivation to complete the education programme. As in previous studies, it was apparent that men and women have different needs and wishes (2, 28–30), but in view of the small number of participating fathers, we were unable to further investigate their role as parents. This can be seen as a deficiency in the study. The parents demanded that more stress should be placed on the father's need and participation in parenthood and accordingly certain group sessions were held in the evenings. These research findings support earlier research about the importance of family training for supporting mothers and fathers in the transition to parenthood (31–33).

Method

By using the qualitative holistic interpretation method, a heightened awareness of the parents' experiences, seen from their social and cultural situation, could be gained

(24–26). Furthermore, it was important to take into consideration the researchers' familiarity with and knowledge of the subject in relation to the interpretation of the results in terms of plausibility and reliability. Credibility was increased in testing the biases and perceptions through peer debriefing and analysis by the authors. The steps of content analysis created observation of pervasive qualities and atypical characteristics to ensure that characterization was justified through the whole analysis. The skill of the authors in analysing, theoretical knowledge, experience, and professional training has facilitated a thorough, in depth, and intensive examination of the data.

In view of the low participation of single mothers, immigrants and refugee families, and unemployed, care must be taken in drawing more specific conclusions. More research is required here.

Content and participants

Becoming a parent involves a totally new role in the home and in daily life. All parents need knowledge and security in their parental role, and in society, with its rapid changes of role, identity problems, and sometimes poor social networks.

Parental education can be seen as a broad health-promoting effort. The findings are consistent with earlier studies indicating there is a great deal to suggest that parental education should be able to give something to almost everyone rather than a narrow medically orientated activity (12). A Swedish study showed that it required a great deal of time for first-time parents to adopt the roles of parents (34).

The results from this study showed that through the parent groups and encouragement from the nurse, the parents were acknowledged to be 'good enough' and that it was natural to sometimes feel uneasy as to whether or not one would manage as a parent. As in Fägerskiöld's study (35), the nurse was regarded as a resource outside the family; a person one could turn to in times of anxiety. The group activities were seen by the parents in this study as an opportunity to elicit a response to their questions and to exchange experiences with other parents in a similar situation. The requirement for adult contact was apparent and the mothers spoke of a sense of loneliness and feeling of isolation. These research findings support earlier research (36).

In earlier studies, it was also found that the parent groups thus provided an occasion for a break from the daily monotony (16).

A number of the parents continued to organize meetings themselves fairly regularly, even after the completion of the parental education course. It can be said that one of the goals of parent education, namely to establish contact between the parents, had been met.

As far as scope and content of parental education is concerned, there are large local variations (2). This can be due to the local routines and organization of the child welfare system, but it may also be due to the willingness or otherwise of parents to participate in the eight to ten group meetings. In this study, relatively highly educated mothers were over represented. Those parents living under more trying circumstances such as the unemployed and those with an immigrant background took part less often in the group meetings and were more difficult to reach for interview. To be a single mother or unemployed with economic problems could prompt thoughts of stigmatization in a group of socially more able parents. That could be one reason why certain mothers did not want to participate. In this study, it happened that poorly educated mothers who found themselves part of groups with highly educated mothers felt unsure of themselves and afraid to ask questions within those groups. This result is in line with other research (6, 16). In some instances, distance was cited as the reason for non-attendance: lack of transport or other children to take care of.

The well educated mothers had requested more informative and structured group sessions and less of a 'coffee morning' approach whereas the mothers with lower education stressed the importance of the social contact and simply being with other parents. The majority of the interviewed parents were of the opinion that it had been valuable for them to attend the sessions and that the activity could be developed to provide further sessions from time to time during the entire pre-school period.

The nurse's role

The parental education must be tailored to suit those that attend the parent groups. This demands commitment and interest from the nurse. There was mainly complete confidence in the nurse leading the group. The nursing staff's organization and leadership had produced socially well-functioning groups. However, there were a few negative points of view concerning both the content and the nurse's style of leadership. One reason for not continuing to participate in the group meetings was that a mother experienced a certain lack of interest and ability of the nurse to lead the group.

The nurse's competence and interest in the parent groups is not only an individual issue, it is also an organizational and educational issue. The nurse has traditionally assumed the role of medical informant and adviser. One also expects that the nurse has knowledge of group dynamics and is a progressive leader with respect to psychosocial aspects. During the course of this study, the implementation of the Elderly Care Reform was begun (37) but not yet completely established. This meant that nurses would subsequently have a more specialized responsibility for either child healthcare, reception work at

the health centres or for the council's home-based healthcare with responsibility for the aged. This change meant, amongst other things, that nurses in the future could spend more of their time on child healthcare and parent groups.

Parental education with the ambition to cover whole populations of parents with infants seems to be a phenomenon exclusive to Sweden, but over the past decades the expansion of group-based parenting programmes has taken place in a number of countries (38–41). In almost all of these programmes the attention has been given to providing parental education for families experiencing difficulties with their children such as conduct disorders, behavioural and emotional problems (42, 43) or to families with special needs, i.e. children with physical disabilities, adopted children, etc. (41).

Parental education in the future

The fact that well-educated parents with good access to information of different kinds seemed to inquire after parental education can be due to an uncertainty in their parental role and that they do not have a sufficiently strong social and emotional network to be confident in that role. One must nevertheless ask if this is a good use of resources to design a broad education programme for a parent group that is already knowledgeable and well functioning.

It is well known that the increasing health problems of today's children are within the psychic, psychosomatic and psychosocial areas and because these problems are clearly socially unevenly divided it seems reasonable that broader preventative efforts at least do not miss the most vulnerable groups in the community (44). For parental education to motivate its place in the healthcare of tomorrow we must find ways of reaching socially disfavoured groups such as immigrants, single parents. The service must be suitable for the target group. Good examples of education for immigrant groups, father's groups and single mothers should be disseminated countrywide. Family centres with long running integration of child healthcare, council playgroups and social workers can, above all in certain city districts, provide a good foundation on which to build parental education.

Since the aim of legally established parental education is to improve the conditions of childhood growth and to provide support to parents, it must be considered especially important to provide resources so that the socially vulnerable groups in the community may also be reached.

The changes in the role of the father have, in the recent decades, meant a demand on the fathers to take a more active responsibility for the children. If we want a society with shared parenthood, our parental education must meet the fathers' special requirement for support and

acknowledgement in his role. In conclusion, it may be said that to obtain a more complete picture of the shaping of the parental education scheme it would also be beneficial to design a study focusing on those parents who decline to take part.

Acknowledgements

We thank the parents and personnel who took part in the study. The work was supported by a grant from the Kronoberg County Council in Sweden.

Author contribution

KP's role was that of primary investigator, whilst CP and AH were involved as consultants who, independent of one another, analysed the data and reviewed the article.

Funding

The study was supported by a grant from the Kronoberg County Council in Sweden.

Ethical approval

The study was approved by the local ethics committee (April-1996) and informed consent was obtained in line with the Medical Ethics Council's guidelines.

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