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Walk the talk: Leader behavior in Swedish parental education groups

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Abstract

Expectant and new parents are offered parental education groups as a way to support their transition to parenthood. Group leadership in these groups has been found challenging. By a qualitative and summative design, this study aimed to investigate how health professionals describe their role in parental education groups compared to their actual behavior. Thirteen health professional leaders in antenatal and child health services were interviewed. These descriptions were compared with the leaders' actual behavior in video and audio recordings of 16 different group sessions. Results reveal that no matter how the leaders described their role they acted as experts and left little time to parents for discussions and active participation. Especially leaders describing themselves as discussion leaders did not walk the talk, that is, they did not do what they said they do when leading groups. That could be explained by lack of professional awareness, group leadership, and pedagogical skills. In order to provide high quality parental support, leaders need training in group leadership and pedagogy combined with supervision and support on a regular basis.

Keywords

Group leadership, parental education groups, Sweden

Introduction

Worldwide, expectant and new parents are offered early parenting support in Parental Education groups (PE groups), which is a health promoting effort focusing on preparing parents for childbirth and a healthy transition to parenthood (Barlow, Smailagic, Huband, Roloff, & Bennett, 2012; Berlin, Törnkvist, & Barimani, 2016; Bryanton, Beck, & Montelpare, 2013).

The task and role as group leadership in PE groups was found challenging to health professionals (Baldwin & Phillips, 2011; Forslund Frykedal, Rosander, Berlin, & Barimani, 2016; Lefèvre, Lundqvist, Drevenholm, & Hallström, 2015). This study aims to understand health professionals' role by investigating if they do what they say they will do when leading PE groups for expectant and new parents. Consequently, do they "walk the talk" (Walk the talk, n.d.)?

Background

The transition to parenthood has been described as overwhelmingly stressful with feelings of insecurity, insufficiency, and unpreparedness for the new role (Asenhed, Kilstan, Alehag, & Baggens, 2014; Barimani, Forslund Frykedal, Rosander, & Berlin, in press; Taylor & Johnson, 2013). Therefore, one important goal of PE groups is to promote a healthy transition to parenthood, thereby promoting children's health and psychosocial development (Berlin et al., 2016; Bryanton et al., 2013; Lefèvre, Lundqvist, Drevenholm, & Hallström, 2016).

Parents attending PE groups emphasize the importance of these groups and are relatively satisfied with the content (Berlin et al., 2016), find it meaningful to socialize with other parents (Berlin et al., 2016; Hjälmhult, Glavin, Okland, & Tveitenl, 2014; Lefèvre et al., 2016), and have a preference for an interactive learning approach discussing with other participants (Berlin et al., 2016; Forslund Frykedal & Rosander, 2015). On the other hand, parents report a lack of ability of health professionals to lead the groups (Berlin et al., 2016; Forslund Frykedal et al., 2016; Lefèvre et al., 2016).

Studies on health professionals' perceptions of PE groups have shown that they strongly believe in PE groups as a support method, but stressed their need for competence and training in pedagogy and leadership (Lefèvre et al., 2015). Apparently, health professionals experience a lack of competence in leading PE groups (Forslund Frykedal et al., 2016; Lefèvre et al., 2015), which might result in difficulties in performing their task and role. In several studies, pedagogical and leadership competence have been recommended as a way to improve PE groups and thereby create an optimal health promoting activity for both parents and their children (Lefèvre et al., 2015). The above described circumstances indicate the need to investigate and gain an understanding of what health professionals say they do and what they actually do when leading PE groups for expectant and new parents. Therefore, the aim of the study was to investigate how health professionals describe their role in PE groups compared to their actual behavior.

Specific research questions:

1. How do health professionals describe their role when performing PE groups?
2. What leader behaviors can be identified?
 - a) What duration do the different behaviors have?
 - b) How frequently do the different behaviors appear?
3. What is the proportion of leader activity in relation to the time allowed for parent participation?

Methods

Study design

The study had a qualitative, descriptive design. Semi-structured interviews were undertaken together with video observations and field notes.

Study setting

Sweden has a long tradition of early parenting support in PE groups as a general health promotion offered to all expectant and new parents. The PE groups are free of charge and led by midwives in antenatal care (AC) or nurses in child health (CH) services (midwives and nurses will hereinafter be referred to as leaders) (Government Office of Sweden, 2008). AC and CH services have in addition to health promotion in PE groups two other main focuses: *primary prevention* with information and counselling, *secondary prevention* based on health surveillance for pregnant women (AC services) and children 0-6 years (CH services) (Swedish National Board of Health and Welfare, 2017). The leaders' role and the national goals of PE groups are (a) to prepare parents for childbirth, (b) to increase new parents' knowledge about child development and needs, and strengthen the parent-child relationship, (c) to create opportunities for continuous contact between parents and between parents and nurses, and (d) to give insights into the societal conditions related to child upbringing and the parental role (Government Office of Sweden, 2008; National Handbook of Child Health Services, 2017a). In AC services, PE groups mostly take place in groups of approximately 10-15 expectant parents near the end of pregnancy. In CH services, PE groups consist of 5-15 new parents, the group starts when the child is 6 to 8 weeks old and then meets regularly during the child's first year (National Handbook of Child Health Services, 2017a). Approximately 70% of first-time expecting parents attended PE groups during pregnancy in AC services. After delivery, 93% of new mothers, but only 6% of fathers (or partners), attend PE groups in CH services (National Handbook of Child Health Services, 2017b).

Participants

To recruit participants the administrative offices of two different County Councils were provided with oral and written information regarding the study. In turn, they informed all heads responsible for AC and CH services in the various healthcare regions. Meetings with healthcare developers at the Department of AC and Department of CH Services were arranged where oral and written information regarding the study was provided. Healthcare developers contributed with names, email addresses, and phone numbers of potential participants who were starting PE groups on a regular basis. All four authors contacted potential participants by email and/or phone in the two different healthcare regions.

Ethical Considerations

The four ethical principles of the British Psychology Society (2017) based on: (a) respect, (b) competence, (c) responsibility, and (d) integrity, have been practiced throughout the study. We have sought and received oral and written informed consent from all participants: health professionals, and expectant and new parents. In addition, parents received information that they could refuse video-recording and if so, they were asked if they accepted audio-recording instead. Further, the research project was approved by the Regional Research and Ethics Committee at Linköping University, Sweden (Dnr 2013/401-31).

Data collection

Video observations were chosen as the main method for data collection. Observational methods in qualitative research are considered to give a thorough description of both participants and their activities. Furthermore, the method is suitable to capture the natural

setting in clinical nursing practices (Salmon 2015; Patton 2002). In total three different methods for data collection were used: a) *video- and audio recording*, b) *field notes*, and c) *interviews*. *Video and audio* recorded material and *field notes* were collected by all four authors from May 2014 to November 2015. These recordings were made with a single or two video cameras and in some cases also an audio recorder, set up and positioned prior to the commencement of the sessions. Recorded material varied in length (19-158 minutes/session) and comprised in total 21 hours (16 hours video- and 5 hours audio recording). For ethical reasons audio recording was used if participants did not want a video camera to be used. Two researchers attended each PE group session, and sat at the back of the room with the intention to cause as little disturbance as possible. One researcher was responsible for the video and/or audio recorders and one concentrated on field noting. *Field notes* were taken throughout the sessions as a complement to the recorded material. These notes focused on number of participants, activities in the room, topics presented, and questions asked.

Nine interview occasions (five one-to-one interviews and four including two leaders/interview) with 13 leaders were conducted during October 2014 up to June 2015. Leaders were interviewed after completion of their PE group sessions and mostly at their workplace. One question in a semi-structured interview guide focused on the nurses' descriptions of their role. Participants were asked: *How would you describe or name your role when working with PE groups?* Their responses were audio recorded and transcribed verbatim. Other collected data from these interviews were used in another study aimed at understanding leaders' experiences of creating conditions for interaction and communication between the parents in the group [reference will be provided after the review process].

Data analysis

Two qualitative content analysis approaches were used as outlined by Hsieh and Shannon (2005): **conventional** (inductive category development) and **summative** (counting/calculating events and activities in video- and audio recordings). The analysis was performed in four steps. First step: a **conventional approach** was used in which coding and categories were constructed directly from the transcribed interview answers regarding how nurses described their role in PE groups (research question 1). This analysis was done inductively in which each code was related to a phrase or statement in empirical data followed by the creation of subcategories and categories. Second step: a **conventional approach** was used to categorize leader behaviors in the video and audio recorded PE groups (research question 2). In order to analyze this data, all the recordings were uploaded to the software program MAXQDA11 (MAXQDA, 2014), designed for computer-assisted mixed methods data analysis.

Descriptions of different behaviors were written down and segments were selected in which leaders took an active role. An inductive analysis was used for these text segments in which codes and categories of different behaviors were created. In this process quotes were also consistently noted in relation to the different behaviors. The first author initially analyzed six videotaped sessions and sent the initial analysis to the co-authors for checking. After confirmation, the remaining data material was analyzed, in which no new leader behaviors were identified. When using the conventional approach (first and second step) tables were used to give structure to the process of inductive analysis (see Tables 1, 2 and 3 for examples). Third step: the **summative approach** was used to count duration and frequency of different roles (research question 2a, 2b), and the proportion of leader activity in relation to the time allowed for parent participation (research question 3). Initially duration and frequencies of different leader behaviors were calculated using the MAXQDA11 (MAXQDA, 2014). However, the summative analysis required further calculations to create values comparable over sessions. This was done by the second author (MR). Duration and frequency of leader behavior are dependent on the length of each observation and the total time each

leader potentially could be active displaying some form of leader behavior. The length of the observations varied between 19 and 158 minutes. Some groups also watched shorter informational films during the sessions. The length for each of these observations was reduced by the minutes the group watched the films, as no leader behavior would be possible during this time. Henceforth the total duration means the total time minus time for films. Duration (time in minutes for each leader behavior during an observation) was transformed into minutes of each hour the behavior was observed (or would have been observed if the total observation time had been an hour).

$$\frac{\text{Minutes of observed leader behavior}}{\text{Total minutes of observation}} \times 60$$

The corresponding calculations were made using frequency of leader behavior resulting in values representing frequency of leader behavior per hour. For two observations, the two leaders present described their individual leader roles differently (in the interviews). To calculate the total time of observation relevant for each leader in these cases the total observation time was reduced by the time the other leader was active. This gave the total time each of the two leaders had the opportunity to be active. Finally, participant time was calculated as the total observation time minus the total duration of leader behaviors. Fourth step: finally, all authors critically analyzed, questioned, read, and compared results.

Results

A total of 13 leaders agreed to participate, running nine PE groups comprising 16 different observed sessions. Five PE groups had a single leader, while four had two leaders per PE group. To these nine PE groups a total of 79 parents were invited to participate, in average of 68 parents showed up (Table 1). Leaders varied in age (35-65 years) and size of city where they worked (56% in large cities; 44% in medium-sized cities).

Table 1. Participants in nine PE groups (A-I) at 16 sessions targeting expectant and new parents.

PE group	A	B	C	D	E	F	G	H	I
Number of observed sessions	3	3	2	1	1	1	1	2	2
Number of group leader at each session	1	1	1	2	2	2	2	1	1
Leaders' profession	Nurse	Nurse	Midwife	Nurses	Nurses	Nurses	Nurses	Midwife	Midwife
Target group	New parents	New parents	Expecting parents	New parents	New parents	New parents	New parents	Expecting parents	Expecting parents
Number of invited parents	20	15	12			12		10	10
Number of participating parents (average)	19	13	11			5		10	10

What leaders say they do and are doing

In the interviews leaders described what they did in PE groups. The analysis resulted in three categories of leader descriptions of their role: (a) using their *professional title*, (b) a *discussion leader*, or (c) a *mediator* (see Table 2).

Table 2. Leaders' description of their role in PE groups.

Code Leaders' descriptions of what they do and/or how they name their role	Category	Number
I am a CHC nurse! I am a midwife! I use my professional experiences and knowledge.	Professional title	5
Create a good atmosphere so parents dare to talk Give space so everybody can talk I lead the group! I am a discussion partner! I participate in discussions! Stimulate parents to ask questions Stimulate parents to start talking with each other.	Discussion leader	5
I provide information! By information provide realistic expectations on delivery and parenthood Provide all parents with the same information.	Mediator	3

What leaders do and their behavior

The analysis of video and audio recordings resulted in four leader roles based on the leader behaviors found: the *discussion leader*, the *expert*, the *friend*, and the *organizer*. These four roles were identified among all the 13 participating nurses, although to different degrees. Below follows a description of the different roles supported by quotations.

Table 3. Leader behaviors and leader roles based on what they do working with PE groups.

Code Leader behaviors	Category Leader role
Creates activities Allocates different tasks Creates engagement and involvement Demonstrates or guides during different tasks Gives space to parent participation Asks questions Confirms Investigates expectations	The discussion leader
Gives information, mediates certain knowledge Gives practical advice/suggestions Makes corrections (better to do like this) Makes recommendations (I recommend you mothers meet privately) Makes demands (Consider this!; It would be better to do this!; Do not do it like this/that!)	The expert
Interacts informally – establishes intimacy Contributes with personal experiences and ideas Makes jokes Shows concern, understanding and empathy Is reassuring and sympathetic	The friend
Opens and closes the session Is welcoming Presents the aim of PE groups Presents the theme of the day Creates lists of names and addresses of participants Sets timeframes: total number of sessions, time of the meeting Provides coffee breaks Initiates evaluation	The organizer

The discussion leader: investigates expectations, arranges group activities, such as providing a relaxing massage to each other, engages small group discussions on given topics, and evaluates parents' opinions. In addition, asks reflective questions, stimulates parents to start talking to each other, and encourages them to ask questions.

Do you have any questions? [leader waits for an answer]. You know that there is no such thing as a silly question and you can learn from each other.

The expert: contributes with expert knowledge, information, advice, corrections, recommendations, and demands. The leader behavior could involve corrections, recommendations, or demands.

It might be possible to do it the way you suggest. But, it is better to do it like this.
(correction)

Have any of you felt or touched the cervix, os uteri? Noo? Then I recommend you to start doing that, so that you come to understand where the baby is coming out.
(recommendation)

When the baby is crying, don't shake the baby like this [nurse demonstrates on a doll]. Cool down! You see, I'm afraid that it will be like this [shakes the doll up and down]. That is dangerous. You cannot do it like that! (demand)

The friend: acts informally, shows sympathy and concern, offers refreshments for those who had not had time to eat before coming to the PE group, makes jokes, becomes intimate by sharing personal experiences, ideas, and perceptions.

*Now I'm going to tell you something that I've not told anyone else before. It happened when I had my first child [tells participants a private story]
I acted like that for far too long. It was not good at all to act like that!*

The organizer: deals with practical matters such as timeframes (opens and closes each session, plans for coffee breaks), offers a schedule for upcoming sessions and lists with contact information to participants.

You all will get the schedule today [for the next group sessions]. From now on and up to June, we will meet approximately every second week and a particular subject will be presented each week.

Leader behavior – durations and frequencies

Analysis of video and audio recordings also showed the duration and frequency of different leader behaviors. The results showed that the most common role was *the expert* no matter how they described their role in the interviews (see Tables 4 and 5). The leaders were not doing what they said they do.

Table 4. Duration of leader behavior and participant time for the different descriptions of their own role

	Discussion leader		Mediator		Professional title		Total	
	min/h	%	min/h	%	min/h	%	min/h	%
Discussion leader	6.3	10.6 %	4.2	7.0 %	6.7	11.2 %	6.0	9.9 %
Expert	33.7	56.1 %	39.0	65.1 %	40.3	67.1 %	36.3	60.6 %
Friend	4.2	7.0 %	3.4	5.6 %	2.1	3.5 %	3.5	5.9 %
Organizer	4.0	6.6 %	2.1	3.6 %	3.5	5.9 %	3.5	5.8 %
Total leader activity (min/hour)	48.2	80.3 %	48.7	81.2 %	52.6	87.7 %	49.3	82.2 %
Participant time (min/hour)	11.8	19.7 %	11.3	18.8 %	7.4	12.3 %	10.7	17.8 %

Table 5. Frequency of leader behavior for the different descriptions of their own role

	Discussion leader		Mediator		Professional title		Total	
	Freq/h	%	Freq/h	%	Freq/h	%	Freq/h	%
Discussion leader	16.7	19.6 %	17.2	20.9 %	9.9	10.4 %	15.3	17.7 %
Expert	41.0	48.3 %	45.3	55.2 %	46.1	48.3 %	43.1	49.8 %
Friend	6.0	7.1 %	5.0	6.1 %	5.7	6.0 %	5.7	6.6 %
Organizer	21.2	24.9 %	14.6	17.8 %	33.6	35.3 %	22.5	26.0 %
Total leader activity (frequency/hour)	84.9		82.1		95.4		86.6	

Leaders' description of their role compared to what they do

As shown in Figures 1 and 2, the leaders' activities during the PE group sessions dominated, leaving little time for parent participation (12-19% parent participation of the total time). Comparing the different roles described, the discussion leader role gave the most space to parent participation.

Figure 1. Duration of leader behavior and participant time for the different descriptions of their own role.

Figure 2. Frequency of leader behavior for the different descriptions of their own role.

Discussion

Main findings

The aim of the study was to investigate how the leaders' descriptions of their roles in PE groups correspond with their actual behaviors. Video and audio recordings revealed that the majority of leader behavior related to the role of expert, no matter whether they described their role in interviews using their professional title, or as discussion leader or as mediator. For the majority of time all the leaders provided parents with knowledge, information, advice, recommendations, and demands. Consequently, they failed to reach the standards for health education as outlined by WHO (1998): *"not only concerned with the communication of information, but also with fostering the motivation, skills and confidence (self-efficacy) necessary to take action to improve health"* (p. 14). Moreover, they failed to create an interactive learning environment in which parents could actively participate. This is important to note since it is known that through interaction and active participation group members can share ideas and construct new understanding (Boud, Cohan, & Sampson, 2001). It can also stimulate a positive climate in which the parents can share thoughts, difficulties, considerations, and personal histories, which in turn is considered to promote health and wellbeing (Benzein, Hagberg, & Saveman, 2008).

The findings might be explained by earlier studies revealing a lack of training in group leadership for leaders (Forslund Frykedal et al., 2016; Lefèvre et al., 2015), lack of competence in managing groups and teaching methods, as well as difficulties in identifying parents' needs (Forslund Frykedal et al., 2016). The results also support and can provide better understanding to parents' reports of a shortage of group activities (Berlin et al., 2016; Forslund Frykedal & Rosander, 2015), a lack of leadership ability in PE groups (Berlin et al., 2016; Forslund Frykedal et al., 2016), and the most frequent teaching method used in PE groups being lectures (Berlin et al., 2016). This study showed that leaders used their expert role for the majority of the time and mediated information and expert knowledge. This could be explained by findings in previous studies in which health professionals described the role as expert as secure and familiar (Adolfsson Thors, Starrin, Smide, & Wikblad, 2008; Baldwin & Phillips, 2011).

The leaders in this study did not walk the talk. Especially the self-described discussion-leaders who also used the expert role most of the time. The reason for this might be explained by a lack of professional awareness. Nairn, Chambers, Thompson, McGarry, and Chambers (2012) stressed the importance for health professionals to have an awareness of and ability to critically reflect on responsibilities in different roles. Thus, this awareness and ability are considered a quality indicator and "a potentially powerful way of enhancing care" (Nairn et al., 2012, p. 189). As stated by William (1995), a professional awareness can help to identify what limits the potential and efficacy of the health promotion activity. In addition to professional awareness, the findings illustrate that leaders need group leader and pedagogical skills. Group leadership training has been found to provide leaders with important tools and a clarification of the leader role when leading PE groups (Lefèvre et al., 2016).

As concluded by Forslund Frykedal et al., (2016), leaders hold their professional knowledge in AC services and CH services and not in education or group psychology. Parents prefer leaders who can create participative and interactive learning environments instead of a more lecture type style (Berlin et al., 2016). Obviously, it is a challenge to give up the expert role and give opportunities to the parents to set the agenda (Baldwin & Phillips, 2011; Forslund Frykedal & Rosander, 2015). Therefore, providing leaders with opportunities to develop these abilities is important for learning in a PE group environment, thereby being able to provide better parental support.

Methodological considerations

To the best of our knowledge, the real life setting in PE groups has never been investigated with video and/or audio recorded material. The main strength of this method for data collection is the direct access to the phenomena under study in a naturalistic setting, which might be difficult to capture with qualitative interviews and/or quantitative methods (Salmon, 2015). According to van Deventer (2009), data collection using video and audio recordings of PE groups could be considered as an overt (open) approach, and considered a strength since participants are aware of the researchers' role and data are recorded openly, which reduces possible problems of research ethics. A possible weakness is that we cannot know for sure what impact the recordings and presence of researchers had on the leaders' description and performance of their role.

To describe varying trustworthiness factors the concepts credibility, confirmability, dependability, and transferability are used (Graneheim & Lundman, 2004). To achieve credibility the video and audio recorded data along with the analysis were discussed until consensus regarding the coding and categorizing was achieved. To attain confirmability, citations were added to the description of behavior in the different roles, the majority of the participating nurses were quoted. The dependability of the study could have some limitations. Three different persons interviewed the leaders, so even though all authors used the same guide when they asked the question, it is possible that data were not gathered consistently. We tried to facilitate transferability by giving a clear description of the study's context, data collection, and data analyses. Although the goals and performance of PE groups differ between countries, and may thus not be transferable across borders, the results of the current study might be transferable to other contexts on a conceptual level, regarding the ways leaders perform their role and engage parents in interactive learning and the interchange of knowledge.

Conclusion and implications

The leaders did not walk the talk. Their descriptions of their roles did not correspond to their actual behaviors. No matter how they described their role, they acted as *experts* and left little time to parents for active participation. In order to provide high quality PE groups to expectant and new parents, the following recommendations are given:

- Provide leadership and pedagogical skills in order to manage the role as discussion leader.
- Provide opportunities for supervision and support of leaders on a regular basis to develop an awareness of their role in PE groups.
- Increase group activities using an interactive learning approach.

This is important since parenting-focused interventions of high quality can contribute to a healthy transition to parenthood with positive effects on children's health and wellbeing (Pinquart & Teubert, 2010).

Authorship declaration

All authors (AB, MR, KFF and MB) acquired funding and collected the video and audio recorded data. Interviews were conducted by three of the four authors (AB, MB, KFF). AB with help from MR and KFF designed analyzed and categorized data. AB drafted the manuscript. MR, KFF, MB have critically revised the manuscript and approved the final manuscript.

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