Grete Eide Rønningen (ed.)

Papers and abstracts in the field of health promotion and communitive work

Presented by researchers from the HENÆR Research Center, Vestfold University College.

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Contents:

THE FLOW OF INFORMATION BETWEEN HEALTH PERSONNEL AND CLIENTS  
Abstract presented at the XVIIth World Conference for Health Promotion and Health Education, 15-20 July 2001, Paris France  
By Anett Arntzen, Thor A. Johannsen, Are Branstad, Dorte Østreng

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POPULAR EDUCATION AND PREVENTIVE CHILD CARE IN THE PERSPECTIVE OF POWER
IMPLEMENTATION OF A HEALTH PROMOTION POLICY FOR CHILDREN AND TEENAGERS: AN EVALUATION STUDY

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TRANSLATION OF HEALTH EDUCATION POLICY INTO CLASSROOM PRACTISE: WHAT ARE THE TEACHERS BEING TAUGHT?

Paper presented at the XVIIth World Conference for Health Promotion and Health Education, 15-20 July 2001, Paris France

By Eyvin Bjørnstad

ORGANISATIONAL DEVELOPMENT METHODS TO CREATE HEALTHIER WORKING ENVIRONMENTS

Paper presented at the XVIIth World Conference for Health Promotion and Health Education, 15-20 July 2001, Paris France

By Liv Hanson Ausland

USING THE INTERNET FOR TRAINING PROFESSIONALS IN SUBSTANCE ABUSE PREVENTION

Paper presented at the XVIIth World Conference for Health Promotion and Health Education, 15-20 July 2001, Paris France

By Rita Bergersen
EXPERIENCE FROM A PROJECT ON HEALTH, ENVIRONMENTAL CONDITIONS AND WELL BEING AT A HIGH SCHOOL IN EASTERN NORWAY


and

  By Annett Arntzen

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and

  By Annett Arntzen

EMPOWERMENT THROUGH EDUCATIONAL PROGRAMS IN ORGANISATIONS

  By Ellen Andvig

POPULAR EDUCATION AS DIALOGUE – UTOPIA OR POSSIBILITY?

  By Jorun Ulvestad

THE INTERNATIONAL DISCUSSION OF THE OPERATIONALISATION OF CLASS: THEORETICAL AND EMPIRICAL CONSIDERATIONS

THE OPERATIONALISATION OF CLASS: THEORETICAL AND EMPIRICAL CONSIDERATIONS

THE FLOW OF INFORMATION BETWEEN HEALTH PERSONNEL AND CLIENTS

Abstract presented at the XVIIth World Conference for Health Promotion and Health Education, 15-20 July 2001, Paris France

By Anett Arntzen, Thor A. Johannsen, Are Branstad, Dorte Østreng

Introduction
The parents of children with serious health problems have many complex, and often confusing interactions with the health care system. This study evaluated a patient diary designed to assist parents and the sick child keep track of, and better comprehend, interactions with health care providers and diverse aspects of care (i.e., diagnoses, treatments). The diary is intended to be used on a continuous and long term basis, with new entries made after every contact with the health care system, thereby building a comprehensive, understandable history of the patient's care. The intention is to strengthen the parents and patients understanding of the care given. Another aim is to provide a means to improve the quality of communication between health personnel and patients. The diary also serves the practical purpose of providing a central collection point for information from all the different health institutions that the parents and patients interact with (family physician, community clinics, pharmacies, hospital, etc).

Methods
We conducted qualitative group interviews with patients, their parents and health personnel, and developed a questionnaire to be completed by parents who used the dairy in connection with their children’s health problems. The data generated focused on the respondents' experience using the diary, and the degree to which the aims of the project were realised.
Results
The data indicated a mix of findings. Positively, parents mentioned that it was practical to have a place to collect diverse medical information, and that it was easier to remember what the doctor had said if a summary was also recorded in the diary so that the information could be reviewed. Many patients reported experiencing increased insight into their illness and treatments, thus enabling them to be more active, ask questions and contribute with their own assessments. Parents and patients were happy to be spared telling different health personnel about their earlier treatments. Health personnel thought it was valuable to have access to a diary containing a comprehensive clinical picture. All the respondents thought it was the health personnel’s responsibility to prepare the information in a way that made treatment clear and easy to understand. Negatively, some doctors who were not familiar with the diary refused to provide written information about treatment.

Discussion
The overall evaluation of the project revealed good potential for a patient diary to improve parents and patients understanding of, and active participation in, medical treatment. The study also revealed some barriers that need to be addressed. Some doctors behaved so as to protect their monopoly of knowledge and refused to contribute information to the diary. Others contributed less than optimally, not taking time to make entries in a readable way. Yet others may have been reluctant to participate, fearing the diary could subject them to surveillance. For such a diary to function as intended, all the users have to experience the diary concept as helpful and non-threatening.
THE FLOW OF INFORMATION BETWEEN HEALTH PERSONNEL AND CLIENTS

PAPER PRESENTED XVIIth World Conference for Health Promotion and Health Education, 15-20 July 2001, Paris France

By Annett Arntzen

Introduction
The parents of children with serious health problems have many complex, and often confusing, interactions with the health care system. The study - I will present here - evaluated a patient diary designed to assist parents and the sick child keep track of, and better comprehend, interactions with health care providers and diverse aspects of care - for example diagnoses, treatments, information about medicines, prescriptions and so on. The diary is intended to be used on a continuous and long term basis, with new entries made after every contact with the health care system, thereby building a comprehensive, understandable history of the patient's care.

- The intention is to strengthen the parents and patients understanding of the care given.
- Another aim is to provide a means to improve the quality of communication between health personnel and patients.
- The diary also serves the practical purpose of providing a central collection point for information from all the different health institutions that the parents and patients interact with (family physicians, community clinics, pharmacies, hospitals, etc).

Methods
In the first phase we conducted qualitative group interviews with patients, their parents and health personnel. The information we received from the qualitative group interviews helped
us in compiling relevant questions for the questionnaire and we had the opportunity to go further in asking about their experiences with the diary and the reasons why something was good or bad. We received many suggestions that can be taken into consideration in further work with the diary.

In the second phase we developed a questionnaire to be completed by parents who used the dairy in connection with their children’s health problems. 101 respondents answered the questionnaire.

First – we asked about the parent’s practical use of the diary – questions such as - design, practical shape, in what situations they used the diary, both at home and outside the home.

Second – we asked about the parents’ experiences using the diary – questions such as consequences for them dealing with the public health sector, if they were taken more seriously by other doctors, if they had gained increased insight into their child’s illness and treatment and if it was easier to follow the doctor’s advice, if they got the feeling that health personnel thought it was valuable to have access to a diary containing a comprehensive clinical picture, and so on.

Results
The data indicated a mix of findings.
- Positively, parents mentioned that it was practical to have a place to collect diverse medical information. It was easier also for them to remember what the doctor had said if a summary also was recorded in the diary so that the information could be reviewed.

A typical statement was:
"You don’t have to remember everything the doctor says, you can relax at the consultation and read about the important things at home afterwards – or before the next consultation”.

A parent said:
“After we started to use the diary - It’s so much easier to talk about the consultation with the other parent who was not there”.

11
Nearly 50% of the respondents used the diary actively at home before a consultation to prepare themselves, or to remember what the doctor had said last time they were there. 43% used it to collect all the different papers they received from different health instances.

- Many patients reported experiencing increased insight into their illness and treatments, thus enabling them to be more active, ask questions, and contribute with their own assessments.

A father said:
“There are so many difficult medical terms and words in the information we received; now I can go back to the doctor and ask about their meaning, or point out to the doctor what I don’t understand”.

45% used the diary when they were visiting doctors or child health centres, places that are traditionally connected to treatment or illness, but only 6% used it in other places such as in schools or kindergartens, where they also discussed their children's health.

- Parents and patients were happy to be spared telling different health personnel about their earlier treatments.

A woman said:
“You don’t have to tell different people the same story over and over again. It’s also thoughtful of my doctor to write about things that can be too private to talk about to health personnel you don’t know very well, but that’s information it’s good for them to know about”.

Other respondents said: It’s so much quicker and more effective just to show all the written information the doctor has given me, instead of explaining everything by myself to all the different health personnel I meet.

All the respondents thought it was the health personnel’s responsibility to prepare the information in a way that made treatment clear and easy to understand.
One third of the respondents thought the diary had lead to a positive change in their relationship with the health services. They reported that they were taken more seriously by other doctors, they thought they had received increased insight into their child’s illness and treatment and they thought it was easier to follow the doctors’ advice. In particular the parents with children who have chronic diseases reported this. Those who have children with chronic diseases were very motivated to use the diary. Otherwise, there were no associations between the patient's age or educational background in the effects in using the diary.

Negatively, some doctors who were not familiar with the diary refused to provide written information about treatment.

- Health personnel we talked to thought it was very valuable to have access to a diary containing a comprehensive clinical picture.

But some of the patients we interviewed had an impression that health personnel had different objections to the diary - either to the increased control the diary gave the patients – or that it took to much time to give written information. One doctor had said to a patient who had asked for written information after the consultation that his (the doctors) knowledge was not common (or public) property.

Discussion
The overall evaluation of the project revealed good potential for a patient diary to improve parents’ and patients’ understanding of, and active participation in, medical treatment. The study also revealed some barriers that need to be addressed. Some doctors behaved so as to protect their monopoly of knowledge and refused to contribute information to the diary.

Others contributed less than optimally, not taking time to make entries in a readable way.

Yet others may have been reluctant to participate, fearing the diary could subject them to surveillance.

For such a diary to function as intended, all the users have to experience the diary concept as helpful and non-threatening. As the patients put it, they were frustrated about how health institutions have received the diary.
An important target in further work for improving the flow of written information in the relationship between health personnel and clients is to inform the different health institutions about the diary, its purpose, the value of having access to a diary containing a comprehensive clinical picture, and therefore to encourage (promote) this institutions to use it more actively than today.
The flow of information between health personnel and clients

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Aims for the diary

- **The intention is to strengthen** the patients understanding **of the** care given.
- **To improve the** quality of communication **between health** personnel and patients.
- **To provide a central** collection point for information **from all the different health institutions that patients interact with** (family physician, community clinics, pharmacies, hospital, etc).

Method

- **Qualitative group interviews** with patients, their parents and health personnel.
- **Questionnaire** to be completed by parents who used the dairy in connection with their children’s health problems.
Results

- Parents mentioned that it was **practical** to have a place to collect diverse medical information, and that it was easier to remember what the doctor had said if a summary was also recorded in the diary so that the information could be reviewed.

- Many patients reported experiencing **increased insight** into their illness and treatments, thus enabling them to be more active, ask questions and contribute with their own assessments.

- Parents and patients were happy to be **spared telling** different health personnel about their **earlier treatments**.

- Health personnel thought it was valuable to have access to a diary containing a **comprehensive clinical picture**.

- All the respondents thought it was the health personnel’s responsibility to prepare the information in a way that made treatment clear and easy to understand.

- Some doctors who were not familiar with the diary refused to provide written information about treatment.
Discussion

- The overall evaluation of the project revealed good potential for a patient diary to **improve parents and patients understanding of, and active participation in, medical treatment.**

- The study also revealed barriers. Some doctors behaved so as to protect their **monopoly of knowledge** and refused to contribute information to the diary.

- Others contributed less than optimally, **not taking time** to make entries in a readable way.

- Yet others may have been reluctant to participate, fearing the diary could subject them to **surveillance.**

- For such a diary to function as intended, **all the users have to experience the diary concept as helpful and non-threatening.**
EMPOWERING PARENTS OF LONG TERM PSYCHIATRIC PATIENTS

Paper presented at the XVIIth World Conference for Health Promotion and Health Education, 15-20 July 2001, Paris France

By Ingun Stang and Ellen Andvig

Norwegian parents of adult children suffering from severe mental illness often experience a sense of powerlessness. One important reason is the recent reorganisation of the Norwegian mental health care services, which has led to heavy burdens of care for parents, without being followed by the power, influence and resources that a heavy care-giving role requires. Still, there is reason to believe that these parents, to some degree, have empowered themselves through the struggle to gain the necessary care and treatment for their child. The parents participating in this study described their experienced-based knowledge and competence related to their adult child’s illness, developed through years of fulfilling a care-giving role. This can be considered as the intrapersonal aspect of empowerment. Gibson (1995) found in her study of the empowerment process in mothers of chronically ill children that the process of empowerment was influenced by both positive and negative support. In our study, it is obvious that the parents’ frustration caused by lack of support, power and influence, functioned as a catalyst for the process of empowerment. Yet since they felt alone and isolated in the care-giving role, the importance of taking action to further empower the parents has become a salient issue in the field of mental health.

Data collection consisted of semi-structured interviews, conducted with six parents of long-term psychiatric patients. The interviews and analysis were tied to a theoretical framework of empowerment that considers explicitly two related concepts, power and powerlessness. In this...
Empowerment has been associated with a sense of control. In order to increase their control, the parents in this study expressed the desire for additional information, education and counselling concerning their child’s illness, its prognosis and relevant treatment. They also expressed a desire for increased competence concerning practical techniques in dealing with aberrant, and sometimes threatening behaviour. Likewise, they wanted counselling on how to cope with their own feelings and reactions accompanying the child’s illness.

Thus, the aim of this paper is to illuminate the interpersonal aspect of empowerment and how health care personnel can contribute to the empowerment of parents of mentally ill adult children. The study data revealed numerous meaningful opportunities for health care personnel to increase power among parents caring for disabled adult children. By taking a more supportive, proactive and coordinating role in the interaction with parents, health care personnel can significantly stimulate parental empowerment. In this paper the findings will be presented as:

1. the informative and counselling role
2. the supportive and advocacy role
3. the coordinating role

The informative and counselling role

Parents interviewed in this study expected the health care personnel, and especially the district psychiatric nurse, to arrange for regular meetings together with them, preferably in the parents’ home. The parents articulated the importance of health care personnel taking initiative to such meetings, citing one reason for their exhaustion caused by care-giving duties being the never-ending efforts to acquire necessary support and help from the health care system or other public services. By arranging meetings for information and counselling, health care personnel can contribute to stress reduction and energy mobilization, which, according to Gibson (1991) and Meleis (1997), are two central aspects of empowerment.
The parents also expressed a desire for health care personnel to be accessible by phone on weekdays, as well as weekends and holidays. In order to meet this wish, the health care system should be able to organize some type of 24-hour phone service.

Even though various health care services, like the district psychiatric nurse, were available, many parents were not informed or aware of this. Thus, they requested additional information, either given to them as folders or by the district psychiatric nurse, the doctors or the hospital staff. In other cases, when parents were informed of these services, they did not receive necessary support, as their adult child refused to accept help from other than their parents. Due to professional confidentiality and principles of patient autonomy, health care personnel on such occasions found it difficult to interact with the parents. In such situations where professionals were prevented from giving specific information about their adult child’s condition, parents expressed a desire for more general information and education. At least they expected guidance and counselling on how to deal with their own feelings and reactions accompanying the care-giving role and the adult child’s behaviour.

The supportive and advocacy role

Often parents experienced a lack of influence and participation in their child’s treatment program. The parents pointed out the importance of being treated with respect by health care personnel, and as equals and collaborators with them. The parents often experienced that their competence was not asked for or acknowledged by the professionals. Yet through years of caring for their child, parents had gained an experienced-based knowledge and competence that made them expect a reciprocal sharing of expertise. To empower these parents, the insights they have about their own child need to be valued as complementary to the professionals’ generalized skills. Otherwise, parents’ attempts to influence the decision-making regarding their child’s treatment and care can increase their frustration and sense of powerlessness. One example of such frustrating events is when an adult child is discharged to the parents’ home, yet without informing or involving the parents.

According to Benner (1984), the advocating role is a salient issue for empowerment. Advocating implies the courage to stand up for someone and to risk the sanctions of persons in power. In this study the parents primarily expected the district psychiatric nurse to be their advocate towards the health care system. Benner (1984) claims that nurses do have power.
Yet some parents expressed concerns about, and had even experienced, the nurses’ lack of power and/or willingness to influence the health care system.

**The co-ordinating role**

Parents in the study emphasised the importance of not being blamed for causing their child’s illness. Such “accusations” at times added extra weight to the already heavy burden of care. This has also been a barrier for successful professional and parental co-operation. Parents clearly expressed their desire to have the responsibility of caring for their adult child, but they expected health care personnel to take a more coordinative and collaborative role in care giving.

Due to the sometimes seeming inability of health care personnel to cooperate amongst themselves within the health care system, parents expressed a desire for someone who could help them get on in an unpredictable and sometimes incomprehensible world of health care. The parents often experienced a lack of accessibility of psychiatrists and other doctors. On some occasions they also experienced general medical practitioners with an insufficient competence in treating and dealing with mental diseases. These aspects, and the fact that the nurses’ position and authority were interpreted as less discouraging than the doctors’, reveal that parents more often regarded nurses as an equal partner than the psychiatrist or other doctors. Therefore, parents expressed a desire for the district psychiatric nurse to take on the coordinating role within the health care system. By becoming a coordinator of the mental health services, a district psychiatric nurse could considerably relieve parents of some of the heavy burden of care. The parents’ experience of running from one office to another represents a considerable consumption of energy, which as mentioned earlier, counteracts the process of empowerment.

Finally, to empower the parents of long-term psychiatric patients, this study reveals that health care personnel must respect parents’ autonomy, resources, competence and desire for participation in the decision-making concerning their adult child’s treatment and care. This is not only a task for the district psychiatric nurse, but includes the psychiatrists, general medical practitioners and the whole health and social care system.
Literatures


Abstract presented at the XVII\textsuperscript{th} World Conference for Health Promotion and Health Education, 15-20 July 2001, Paris France

By Ellen Andvig and Ingun Stang

Introduction
In accordance with Norwegian national health policy, the mental health services have reduced substantially the number of psychiatric hospital beds over the past years. The municipalities have been given the responsibility for the care of the mentally ill. Because the services of the municipality are poorly developed to meet these patients’ needs, a large burden of care falls to the families. The purpose of this paper is to illuminate the phenomenon of powerlessness in families of long-term psychiatric patients. The aim is to understand the mechanism of powerlessness in this context, so as to be able contribute to the present dialogue on the need for empowerment of these patients and their families.

Methods
This paper is based on an empirical study of parents of long-term psychiatric patients and their expectations regarding collaboration with health care personnel. The empirical data were obtained from semi-structured interviews with parents, and the data were assessed in the context of a theoretical perspective that has its focus on the construct of powerlessness.

Results
Lack of control, lack of influence in participation and decision-making, periodic lack of energy, and lack of knowledge of the illness, caused both continual and situation-based powerlessness in the parents. In addition unhelpful attitudes and actions on the part of health care personnel contributed to the parents’ experience of powerlessness.

Discussion
Just as empowerment is a process, these results reveal that powerlessness is also a process, not a simple state. This study begins to illuminate how powerlessness in the parents takes form and illustrates the importance of studying the mechanisms that induce powerlessness. Such knowledge is an important foundation for future intervention to prevent powerlessness.
THE EXPERIENCE OF POWERLESSNESS IN FAMILIES OF LONG-TERM PSYCHIATRIC PATIENTS.

Paper presented at the XVIIth World Conference for Health Promotion and Health Education, 15-20 July 2001, Paris France

By Ellen Andvig and Ingun Stang

In accordance with the Norwegian National Health Policy, the Mental Health Services have substantially reduced the number of psychiatric hospital beds over the past years. Thus, the municipalities have been handed over substantial responsibility for the care of the mentally ill. The services offered by the municipality are, as yet, poorly developed to meet the needs of mentally ill patients. Therefore, a large burden of care falls upon their families. This has led to increased distress on the part of family members, as they often feel ill-prepared to meet the demands of the role as primary caregivers.

The purpose of this paper is to elucidate the phenomenon of powerlessness in families of long-term psychiatric patients. The aim is to attempt to better understand the mechanisms of powerlessness in this context, in an effort to contribute to the present dialogue concerning the need for empowerment.

Studies show that a sense of powerlessness is significantly associated with a change in health status. Increased powerlessness have clear negative consequences for health status and longevity (Seeman and Lewis 1995).

According to Miller (1984 p. 118), powerlessness is circumstantial. She defines the term as: “a perceived lack of control over a current situation or immediate happening”.

Seeman and Evans (1962), on the other hand, characterise powerlessness as a continual state. They define the term as “The expectancy or probability held by the individual that his own
behaviour cannot determine the occurrence of the outcomes, or reinforcements, he seeks”.
Continual powerlessness develops through time and is by others called “learned helplessness” (Seligman 1975).

Just as empowerment is a process, the results of this study suggest that powerlessness is also a process, rather than a static state of existence. In this paper I will only focus upon circumstantial powerlessness, yet I will point out that circumstantial powerlessness can develop into a continual, almost chronic state. It is important to recognise this form of powerlessness at early stages, in order to prevent it from developing into a “fixed” state.

Methods
This paper is based on an empirical study of parents of long-term psychiatric patients and their expectations regarding collaboration with health care personnel. The empirical data were obtained from semi-structured interviews with parents, and the data was assessed in the context of a theoretical perspective, with focus upon the construct of powerlessness and empowerment.

Findings:

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I will relate my findings to three characteristics of powerlessness, as outlined by Miller (1983): low, moderate and severe powerlessness. In my study I found signs of both low and moderate powerless, but no severe powerlessness. Miller points out that severe powerlessness is characterised by passivity, resignation and alienation. However, in this study, I found a clear tendency towards parents not giving up. They endured considerable adversity and
explained their endurance being due to a commitment towards and feelings of responsibility for their child.

**Low powerlessness**
Some of the parents reported periodic burn-out, lack of energy, depression, feelings of wanting to give up.

**Moderate powerlessness**

Unpredictability / Lack of control
* The parents felt threatened by their child during psychotic episodes, and sometimes experienced threats towards their own lives and security
* A ruination of the family’s economy
* A fear for their son or daughter’s own life, i.e., the threat of suicide.
* Often they worried about the future: “who will care of my child when I die?”
A lack of control seemed to lead to feelings of anxiety, fear and confusion.

**Feeling of guilt**
The parents sometimes felt guilty about not being able to help their child. They blamed themselves for not being able to acquire adequate help from the health services. Some of them felt stigmatised by health personnel. One mother referred to herself as a leper, and after meetings with health personnel left with a sense of her family being considered the “scum of society”.

**Lack of participation and influence in decision-making**
All the parents reported bearing considerable responsibility for the care of their adult child, yet with little power to influence their situation. They cited:
* A lack of influence and participation concerning their child’s treatment.
* Their knowledge and experiences were not solicited by health personnel.
* In their attempt to influence decision-making policies concerning their child they experienced frustration and helplessness.
* Adult children living in their parent’s homes were often sent home after hospitalisation without the parents being informed
Lack of knowledge
*A lack of knowledge concerning the illness made them frustrated and left them feeling helpless in coping with their child’s behaviour.
*Parents did not know whom to contact in the health system. They had to struggle for a long time to know what was expected of them.
*They did not know the right questions to ask in order to obtain the information they needed.
*They lacked information about the child’s rights in the health and social service system.
At this point I will further consider possible causes of the sense of powerlessness experienced by these parents. There seemed to be two varying, yet interdependent, origins.

1) Parents experienced schizophrenic and mood disorders as highly unpredictable.
In situations where symptoms of these illnesses were expressed, parents felt threatened, due to a lack of knowledge about the illness, its treatment and how to cope with varying behaviour. For example, parents could not make long-term plans, not knowing when the next episode of psychosis might occur, and finding themselves forced into action at most inconvenient times. Also, the right of adult patients to make their own decisions about treatment, hospitalisation and personal economy left the families in a terrible quandary when poor decisions were made.

2) Unhelpful attitudes and actions on the part of health care personnel contributed to the parents' experience of powerlessness. Experiences of not being believed when reporting increasing symptoms to the health care system, and being denied assistance when asking for help to have their child admitted, reinforced this sense of powerlessness. Parents had a strong sense of carrying responsibility alone, viewing the system as neglectful of their needs and concerns.

Do we possibly encounter a traditional view of the family as the aetiology of mental illness here? This “family is the cause” perspective may still influence the attitudes of many health personnel and can at least partially explain why families were not allowed to participate in decisions about their child’s treatment and discharge from the hospital. Another cause may be health personnels’ paternalistic attitudes of not sharing their “professional knowledge” with patients and family.
Conclusion
In this study I have attempted to illuminate how powerlessness in parents of adult psychiatric patients takes form and to illustrate the importance of studying the mechanisms that induce powerlessness. Such knowledge is an important foundation for future interventions in preventing powerlessness and encouraging empowerment.
Literature


POPULAR EDUCATION AND PREVENTIVE CHILD CARE
IN THE PERSPECTIVE OF POWER
Close relation between politics and science

Paper presented at the XVIIth World Conference for Health Promotion and Health Education, 15-20 July 2001, Paris France

By Jorun Ulvestad

This paper focuses on The National Program for Parental Guidance, established in Norway in 1995. Attention is paid to perspectives at the macro-level, based on the work of the German sociologist Niclas Luhmann.

Currently there are many concerns about modern childhood and the conditions for growing up. The media in Norway has been focusing on how the development of society has influenced the everyday life of children, and questioned whether parents are able to manage the demanding parental challenges. Attention has been given to urgent social concerns such as behavioural problems, crime, drug abuse, violence, and other negative phenomena involving children and young people. Demands have been directed to parents such as: “Now parents must take responsibility”, and questions such as “where are the parents?” have been asked. These demands and questions from the media have no doubt contributed to strengthen some myths about parents, children and childhood.

They have also contributed in placing childhood and the parental role on the political agenda. The parental role has been a theme in the political debate, presuming that parents are in need of help when it comes to the upbringing of children – and presuming that this is a political responsibility.
Another issue concerns research in this area. The focus for a while has been directed towards the complexity in the relationships between parents and children, and how parents in modern society are facing quite new and demanding challenges. It is argued that science possesses the true knowledge about these questions, and that parents are in need of this knowledge.

The discourse concerns whether parents might be enabled to become good parents. Many new proposals have been introduced, from parental schools to network groups. One of the latest contributions is The National Programme for Parental Guidance, a cooperative effort between three Norwegian ministries and a range of researchers.

The guidance and co-operation takes place in public health centres, kindergartens and schools. The aim is to support and strengthen the parental role in families with children, to prevent psychological-social problems among children and young people, and to contribute in preventing interaction-problems within the family. The programme is directed towards all classes, groups, and types of families, and is defined as a programme for preventive childcare. Participation for parents is intended to be voluntary. Comprehensive material such as videos and books for professionals and parents have been developed, containing contributions from different professionals of high competence in the field of child research. The content is mainly built on eight themes for good interaction based on scientific epistemology of knowledge.

Legitimation through originality

The National Programme for Parental Guidance represents a strong co-operative effort between politics and science. From the perspective of Niclas Luhmanns I understand this communication between “the system of politics” and “the system of science” as representing a communication between two different systems with different values.

Through this, at least during the last decade, the systems have established a more joint discourse. This discourse acts as the new and joint framework – and inside this framework both systems together offer solutions to central problems involved in the parental role.

Some might interpret this unification through joint discourse as a victory for holistic thinking and commonsense. Others will assert that this represents a threat for the legitimacy of the systems themselves.
From the later point of view the challenges for the systems inside a society based on differences, are not to describe and prove their identity through unification. The systems have to legitimate themselves through originality, which means to be irreplaceable. Otherwise they might in fact be replaced. And then we have a dilemma:

The political and scientific systems seem to be in danger of falling apart through their close relationship: *Science might be replaced by politics* – or the other way around – *politics might be replaced by science*.

From the viewpoint of the sociology of knowledge one might conclude that scientific results are under a particular pressure when the political system is adopting these results as well as making use of them within the framework of political communication. The utility of research should in other words also be discussed in this perspective.
Literatures


Fauske, H: Forståelse, forklaring og konstruksjonen av sosiale problemer I: Sosiologi i dag 4 1997


IMPLEMENTATION OF A HEALTH PROMOTION POLICY FOR CHILDREN AND TEENAGERS: AN EVALUATION STUDY

Abstract presented at the XVIIth World Conference for Health Promotion and Health Education, 15-20 July 2001, Paris France

By Grete Eide Rønningen

Introduction
Based on the health promotion principles expressed in the Ottawa Charter, as well as the recommendations from WHO's Adelaide conference, a government action program named “Children & Health” was funded in Norway during the period 1995-1999. The main goal of this programme was to stimulate organisational development and sustainable inter-sector collaboration at the municipal level, in order to create healthy environments for children. While the broad elements of the programme were described in guidance provided by the national government, it was left to the municipalities themselves to determine how the work would be done at the local level.

Methods
An evaluation study was conducted to study the processes through which municipalities in one Norwegian county (Buskerud, population 235,000), attempted to implement the national programme. Data were collected through documentation analyses, and in a survey conducted in 17 out of 21 municipalities in the county. In addition in-depth studies in two of the municipalities were based on interviews with key personnel and group interviews.

Results
16 of the 17 municipalities established teams for inter-sector collaboration to implement the programme. It was observed that an essential condition for inter-sectoral collaboration was that such collaboration was viewed as meaningful for all the co-operating partners and that the
actions had to be of common professional interest. It was observed that positive attitudes towards inter-sector collaboration could be developed through capacity-building exercises. Capacity building in interaction with the local organisational developments appeared to advance sustainable inter-sectoral collaboration in health promotion. Political decisions and administrative anchoring also promoted sustainable results.

**Discussion**

In addition to pinpointing issues that favour sustainable inter-sectoral health promotion collaboration at the municipal level, the results from the evaluation study represent a challenge in seeing the opportunities in the interaction between capacity building in change processes and collaboration, and organisation developments as such in the municipalities. The remaining discussion is how the municipalities and the educational system are able to meet these expectations.
IMPLEMENTATION OF A HEALTH PROMOTION POLICY FOR CHILDREN AND TEENAGERS

An evaluation study.

Paper presented at the XVII\textsuperscript{th} World Conference for Health Promotion and Health Education, 15-20 July 2001, Paris France

By Grete Eide Rønningen

Introduction

Implementation of a national programme into municipal politics, administration and services, has been - and still is - a challenge. Within health promotion politics and action this is perhaps a special challenge, because such activities demand commitment from all sectors of society, and thus, inter-sectoral cooperation.

In this paper I will try to present some experiences collected through an evaluation study. This study focused on how the municipalities in one Norwegian County attempted to implement a national programme of health promotion for children and teenagers. The study was carried out in Buskerud, one of the twenty-two counties in Norway. There are 235,000 inhabitants in this county, and the municipalities vary from cities to small agricultural communities. The study covers 17 out of 21 municipalities.

The HENAER research centre – Research Centre for Health Promotion in Local Communities, situated at Vestfold University College in Norway - carried out the evaluation study.

I’ll first portray the background to this specific implementation of health promotion policy at the local level. Then I’ll explain how the implementation process and the evaluation was
carried out, present some of the results, and finally wrap up this presentation with some discussion issues.

Background
In the Norwegian Parliamentary White Paper no 37 (1992-93) “Challenges in Health Promotion and Preventive Efforts”, challenges in public health in general were thoroughly discussed. The paper was based on health promotion principles expressed in the Ottawa Charter and the recommendations from WHO’s Adelaide conference. The paper, and the subsequent deliberation by the Norwegian Parliament, pointed out four main areas of input for health promotion and disease prevention towards the year 2001:

- Psycho-social problems
- Musculoskeletal disorders/ physical exercises
- Accidents and injuries
- Asthma, allergies and indoor environmental diseases

As a follow-up of the Paper, the Ministry developed several plans of action and one of these, the “Children and Health Action Programme (1995-1999)” was directed towards children and young people and included all four areas of action. The programme also added two more areas of input:

- Nutrition
- Tobacco-free children and young people

The experience that had been gathered in the health promotion field, clearly pointed to the municipal level being the place wherein such work must be anchored.

The main goal for The Children and Health Action Programme was therefore to stimulate organisational development and sustainable inter-sector collaboration at the municipal level – in order to create healthy environments for the children. This formulation indicates the necessity to cover children and young people’s needs and perspectives in municipal plans and
actions, and also that this work has to be anchored in the political and administrative leadership in the municipalities.

While the broad elements of the program were described in guidance provided by the national government, it was left to the municipalities themselves to determine how the work would be done at the local level.

How the action program was carried out in Buskerud

Because the municipalities themselves should organise the work at the local level, the co-ordination group at the county level concentrated on capacity-building in health promotion and inter-sector collaboration as a strategy for reaching the programme objectives. The six target areas were used as a point of departure to focus on the importance of an overall view. Though co-ordination groups were established in each county, there was constantly room for local solutions and models based on local conditions. In addition to information, courses, conferences and guidance, the co-ordination group also took the initiative to organise a course in inter-sector collaboration for children and young people. This course was developed in interaction between the University College, the government at the county level and the municipalities. The study equals 10 points at the University level (EU- terms “30 ECTS credits”), which means that the course equals 6 months of fulltime studying. The course was directed towards both administrative personnel and the employees in the collaboration teams in the municipalities. Five municipalities in Buskerud attended this course.

Methods

The evaluation study was conducted to investigate the processes through which the municipalities in Buskerud attempted to implement the national programme.

Data was collected through qualitative methods, first by documentation analyses, second by a survey with open-ended items conducted in 17 out of 21 municipalities in the county, and third by in-depth studies in two of the municipalities, including personal and group interviews with key personnel.

Results
16 of the 17 municipalities established teams of inter-sectoral co-operation to implement the action-programme. There were, however, some variations between the municipalities. This could be explained in part by the different composition of the co-operative groups in each municipality, but especially by differences in the degree of formalisation of such cooperation. Seven municipalities reported that the form of organisation was formalised and anchored through political resolutions – that the working-method had become sustainable in the municipality. Three municipalities reported plans for such anchoring, while the others reported their approach as a temporary form of project organisation.

This evaluation study points out some elements that seem to advance sustainable inter-sectoral co-operation in health promotion policy and action. All the respondents stress that local organisational developments in this field must be grounded in local capacity, resources, and priorities.

The study also indicates that one of the main factors in establishing inter-sector co-operation at the municipal level is capacity building. Seeing capacity building in interaction with local organisational development appeared to advance formalised and sustainable collaboration, and is perhaps the most striking finding in this evaluation study.

The six input areas in the action programme did not achieve equal attention from the co-operating partners. The respondents state as reasons for this that there were too many target areas, and that some of the target areas were not given preference in the municipalities. Some of the target areas also seemed to be more relevant for the municipal health service sector, and could be handled within this sector. Asthma, allergies and indoor environment together with nutrition, were the two target areas with least common interest.

Another essential condition for inter-sectoral co-operation was that it has to be viewed as meaningful for all the co-operating partners, and the actions had to be of common professional interest.

Discussion
For summary, I will to point out some principles from this study that would appear to advance local organisational developments and sustainable inter-sectoral collaboration at the municipal level in Buskerud County.

- Focus on one or only a few target areas at the same time.
- The co-operations and target areas have to be relevant and meaningful for all the co-operating partners and the actions have to be of common professional interest.
- Political decisions and administrational anchoring advance sustainable results.
- Attitudes towards inter-sectoral co-operation in this field can develop through educational and capacity-building exercises.
- Capacity-building in interaction with local organisational developments seems to further advance sustainable collaboration in this field.

In addition to pinpointing issues that favour sustainable inter-sectoral health promotion co-operation at the municipal level, this study represents both a challenge and an opportunity for the municipalities and the educational system to further interaction. The question from my point of view is how the municipalities and the educational system can interact and meet such expectations.

Appendix
In the light of this and other similar studies, The HENAER Research Centre and Vestfold University College have developed methods in capacity building to meet local expectations. Through adjusted educational programmes and studies, the capacity building may interact with local organisational development. As a supplement and a motivating factor for the individual professional who participates in such educational programmes in the municipality, this education may equal points at University level and be converted into a Bachelor’s or a Master’s degree in Health Promotion and Action.
Literatures

Barne- og familiedepartementet; Rundskriv Q-5/95, Oppsummering av utviklingen av foreldreveiledningsprogrammet i 1995 og 1996.

Barn og unge i Buskerud, Informasjonsskriv fra statens fylkesledd, nr. 1: april 1996.

Drammen kommune, Foreldrevedeling, rapport februar 1999.

Hareide, Berger, Tverretatlig samarbeid barn og unge, HENÆR – rapport nr.10/98

Høgskolen i Vestfold, Tverretatlig samarbeid - barn og unge”, Fagplan

Jacobsen, Dag Ivar: Hvorfor er samarbeid så vanskelig? s.70-112, i Repstad, Pål (red) Dugnadsånd og forsvarsverker. TANO, Oslo 1993


Ogden, Terje: Prosjektevaluering- Problemer og muligheter ved valg av strategi og metoder. I Tidsskrift for Norsk Psykologforening, nr. 21/89, 626-635

Olaussen, Leif Petter, Om organisering av nyttefokuset evaluering, Norges barnevern 1:90.


Rønningen, Grete Eide; HENÆR – rapport nr. 2b/99, Høgskolen I Vestfold.


Sosial og helsedepartementet: Rundskriv I - 25/95, Aksjonsprogrammet Barn og helse

Ulvestad/Aanderaa; *Foreldrevedeling - En utfordring for høgskolene?* HENÆR – rapport 16/98

Wold, Bente; *Kvalitativ evaluering* i Hemil-rapport 2/90.

TRANSLATION OF HEALTH EDUCATION POLICY INTO CLASSROOM PRACTISE: What are the teachers being taught?

Paper presented at the XVIIth World Conference for Health Promotion and Health Education, 15-20 July 2001, Paris France

By Eyvin Bjørnstad

Introduction
In Norway, home economics (HE) is an obligatory topic in the school curriculum. The objective of HE is to strengthen pupils' competence to cope with the challenges of daily living. As such HE is a health promotion course, seeking as it does to strengthen students' capacity for happy, healthful and productive living. The HE teachers have the responsibility to translate into concrete terms the national guidelines for HE. Thus, high fidelity translation of policy into practice requires a high degree of correspondence between national policy objectives and training objectives in the teacher's colleges. If these two elements are not in tune, teachers may fail to prioritise the topics that are prioritised by national policy. This study was conducted to examine the correspondence between national policy and training objectives in 16 teacher colleges in Norway.

The public school is an important arena for health promotion – and what is going on in the schools depends on the way we educate teachers. This presentation will focus upon what the teacher-students in Home Economics (HE) are being taught at colleges around the country. Norway is a well-organized country – we believe that teachers in the public schools do what the curriculum instructs them to do!
This presentation focuses on translating health education policy into classroom practice: What are teachers-to-be being taught?

Using Healthy Public Policy as my point of departure, I will argue that virtuous political intentions have a long road to travel before reaching the needs of the target group. This study in Home Economics is used to illustrate challenges in implementing Healthy Public Policy.

Below is a table showing the number of hours Home Economics is taught in the elementary and middle schools in Norway:

- 1-4 grade (6-9 yr.): 38 hours/3 years
- 5-7 grade (10-12 yr.): 114 hours/1 year (3 hours/week)
- 8-10 grade (13-15 yr.): 114 hours/1 year (3 hours/week)

As one can see, HE is granted considerable time during the elementary and middle school years - a total of almost 300 hours. Most of the time pupils are organized in groups of 15 pupils in classrooms formed as private kitchens, and with a primary focus on practical activities.

HE is the key subject in health promotion in Norway, being taught to both girls and boys throughout the first ten (obligatory) years of school.

HE topics are organized in four equally important groups of subject areas, the first of these being Food and Culture. Food and Culture was the initial area of study when HE became a school subject in Norway more than 50 years ago. Below are some examples of topics now taught in Food and Culture:

- Basic techniques in food preparation
- Hygiene standards when preparing food
- Basic meals according to Norwegian nutritional recommendations
- Cultural and social functions of eating

The second area is Lifestyle and Health. Typical topics that we find in the curriculum are as follows:
• An extended concept of health to include lifestyle and health promotion
• Indoor environment, cleaning house and textiles
• Methods in health promotion and health prevention
• Psychosocial health problems in society

The third subject area is Consumer Science and Economy, illustrated by the following points:

• Budget in personal economy
• Consumption, maintenance, reuse, recycling and composting’s affect on the environment
• Labeling of products and the difference between information and advertisements
• Price and quality when buying goods and services

The final area is Child and Family Knowledge in which we find

• The various roles of children and adults in the family
• Manners, courtesy and caring
• Preparing for school-home cooperation
• Equality within the family attained through spending time together, cooperation, and sharing household tasks

Home Economics was originally called “School kitchen”, but during the last few decades the curriculum of HE has been expanded upon. Today the main goal of HE is to help pupils / youngsters cope with the challenges of daily living and to strengthen their capacity for happy, healthy and productive lives.

The purpose of this paper, then, is to compare the intentions of the National Curriculum with the observed practice of HE in today’s teacher training. It is my belief that a critical time in the formation of teachers' professional attitudes and beliefs is during their formal training at college.

At each of the 20 university colleges in Norway, the national curriculum is spelt out in concrete terms, i.e., a local plan of objectives is written by each university college’s
department of education. Thereafter, a curriculum is developed for that particular academic year, and this again is divided into 2 semester schedules. Each teacher prepares lectures, presumably based upon these objectives. At the end of the line is what each individual student perceives concerning that which is taught. Thus, high fidelity translation of policy into practice requires an equally high degree of correspondence between national policy objectives and the training objectives of the university colleges. If these two elements are not attuned, teachers may fail to prioritize the same topics prioritized by national policy.

The study upon which this paper is based was conducted to examine the correspondence between policy and training objectives.

Methods

• The curriculum plans for the academic year of 15 university colleges were analyzed according to the content and time allotment of each lecture.

• The results from a questionnaire survey among students (470 students from 13 colleges, 78% participation). The questionnaires were distributed during one of the final lectures scheduled in the spring, and returned directly to me, without the lecturer reading the results.

The analyses of the plans for the academic year (figure 1) showed the same pattern in all the 15 University colleges: Food and Culture dominated, with a mean value of 46 percent of the total time spent lecturing. Lifestyle and Health received 36 percent of the lecture time, while Consumer Science and Economy scored 9 percent and Child and Family Knowledge 9 percent. When analyzing L&H, it became evident that the few food-related topics that are a part of this subject area dominated here as well.

The questionnaire survey among students reported almost identical use of lecturing time as the plans for the academic year proposed. The students were aware of what they were being taught – a good thing in and of itself. HE is defined as a practical subject, indicating that pupils are to be taught practical skills by doing these by themselves. Figure 2 indicates, however, that the students reported practical work being predominant only in the subject of Food and Culture, while in the other three areas theory was twice as common as “hands-on” experience.
When students were asked what they considered to be relevant for pupils’ the skills of daily living, Hygiene and Lifestyle received the highest score (see figure 3). Yet the most significant finding is that although H & L scored slightly higher than the other 3 areas, all 4 areas were considered relatively equal with regards to necessary skills of daily living. Females reported all topics in HE to be much more important for the skills of daily living than the male students did.

The conclusion, then, seems to be that when planning lectures, college staff choose to emphasize one of the 4 subject areas over the others, and department heads in the university college system – advertantly or inadvertently - exercise their “professional freedom” in the same way to alter their program curriculum, resulting in a distorted focus of the national curriculum.

The study also shows that students report a need for equal emphasis of all four subject areas in HE, corresponding with the objectives of the national curriculum, i.e., the intentions of the policy makers. The results indicate as well a lack of practical tasks, e.g., preparing food, connected to “newer” subject areas introduced to HE the last few decades.

Historically, HE has dealt with how a housewife should take care of the home. This may be one reason why female students feel more comfortable about these topics being taught than do male students, especially when it pertains to the relevance for daily living skills.

In Norway, it is a central goal to permit students and pupils to influence what is going on in the classroom. In some subjects, for example mathematics, teachers may argue against this principle, stating that pupils cannot understand the true meaning of the subject until perhaps later in life. But for HE, the primary objective is to give youth competence in managing their daily lives. Perhaps college students around the age of 20-25 know something about relevant daily living skills for young people?

A total of 77 percent of the students (note: 77% of those students following the 15 ECUs course) reported having little impact on the curriculum plan for the academic year.

Conclusions
Data from this study show that national HE policy on the national level may become altered because university college staff choose to emphasize topics with greater importance 40 years ago (and for females), while neglecting topics that have high priority in today's national health policy. On the other hand, students preparing to teach HE share attitudes and beliefs more in line with national policy. The consequences of this situation on HE in the future are uncertain. Will tomorrow's HE teachers practice according to the values they hold today, or will their teaching mirror their own training? The uncertainty could be reduced if there was a better correspondence between the national HE policies and the educational policies of university colleges.

Perhaps a debate is necessary concerning "the hidden teaching agenda". A debate based on research and documentation, and which can possibly predict tomorrow’s challenges tied to the necessary skills of daily living.

The results of this study also seem to indicate that students are able to contribute to the development of this subject, and that students’ understanding concerning which topics are necessary for mastering the tasks of daily living, coincide well with the intentions of the national policies.
Figur 1: Analyses of the plans of the academic year. Hours planed for the four main areas plus didactics. The area “Hygiene and lifestyle” is divided into “food” and “not food” related topics. Mean value for 13 university colleges.

Figure 2: The extent to which the four central aims plus didactics have been taught. Percent above “covered”. Black is theoretical teaching and stripes are practical exercises.

Figure 3: The response of the Students when asked about the importance of central aims in HE related to daily living skills for their pupils. Percent giving score equal/above “important”.
By the year 2015 over 50% of the Norwegian work force will be more than 50 years old. Today, many older workers are forced into early retirement, either because of health problems, company policies that do not value and nurture older workers, or inability to adapt to the rapidly changing work and technology environments. The competitive labour market will only tighten in the future and older workers will be needed on the job and working productively. Knowledge about diversity of the workforce in terms of age and acquisition of knowledge, skills, experience and attitudes can contribute to the development of organisational learning in the work context and, more generally, to the creation of community capacity for health promotion. In addition, knowledge about human resource development practice and educational interventions involving older workers can facilitate lifelong learning and productivity and, thus contribute to the policies and practices that can prevent the exclusion of senior workers from working life. The challenge for health promotion is to assist employers to arrange for workers' individual learning and development through the whole of working life, and to learn how to arrange work so that it is suitable to the different phases of life, especially the later stages of a career.

Responding to this need, a pilot study has been undertaken by Vestfold University College in Norway, called “healthy working policy”, or more directly translated: “a working policy for different phases of life.” The pilot study was initiated and was supported by the main working organisations in Norway: the Labour Union and the Confederation of Norwegian Employers.
in manufacturing industries, services and crafts. Special education on this topic is offered to business and local government leaders, along with union leaders. The main idea concerns how these personal can influence work policy positively, so that workers stay in jobs and continue to thrive as they age. The intention of the pilot education programme was to increase the participants’ own capacity for creating healthier working environments.

The pilot study started in October 2000, and terminated in June 2001. There were 22 students on the programme, representing 15 different workplaces. All the students were in positions where they were able to influence working policies at their workplaces.

From the points of view of education, training and learning among older (45+) workers, the programme focused on individual and organisational effects, needs and opportunities emanating from the intersection of two trends in society: the ageing of populations and changes in working life. The development and education of old and young workers were studied within the context of work organisations, with the focus on theories of learning and reflection.

Methods
The methods used in the programme were networking, education, and practising healthy working policies.

Networking
The participants built their own networks inside and outside the educational system, in particular involving other people from their own workplaces. About 50-60 persons were involved in the networkgroups. The networks also functioned as anchors for the students.

It is often seen as a problem in continuing education that the students return to their workplaces with all their new knowledge, but neither colleagues nor managers are interested or willing to listen, often because they were not involved themselves. In this pilot study the students’ working environments were involved by inviting colleagues and managers to participate along with the students on parts of the programme.

Education
The programme used a combination of lecturing, working on the Web, and group discussions. The methods used in the education were similar to those used in action learning: The students were trained in how to evaluate and reflect upon their ways of learning, both individually and in groups. The students were also trained in understanding and practising empowerment. The focus was on how to stimulate critical reflection on the relationships between empowerment of managers and empowerment of the employees.

Practising healthy working policy: During the programme all the participants planned, practised and (partly) evaluated an individual project at their workplaces. There were 15 different health promotion projects emanating from the pilot study. Some of the projects were small and quite limited, others involved a lot of people at different workplaces. But most of the projects described and evaluated the students’ own strategies for practising healthy working policy, describing and reflecting critically on how they started to create a healthier working environment at their workplaces. Focus especially on how to arrange learning environments for older workers. All the projects critically tested (or initiated) ways of better arranging work for different phases of life, focusing on the later stages of a career.

Results

22 students initiated 15 different workplace health promotion projects. More than 60 people, representing both local businesses, local governments, national organisations and colleagues of the students are still networking, spreading knowledge and ideas, and helping each other out.

Discussion

A key question is whether these activities will continue after the pilot study is completed. This remains to be seen, but in November 2001, a new “healthy working policy” study will start, and the new students, with their colleagues and leaders, are invited to join the networks along with the others.
Poster 1: Connections between challenges in society and the pilot study.

- Rapidly changing work and technology
- Demographic Development: The working
- Health or Illness?
- Expelled from
- Teach the managers how to arrange for

Poster 2:

Relations between elements in the pilot study.

- Network including both
- Projects in the students’ workplaces
- Educational Methods
- Students’ individual choices and learning
**Literatures**


Lahn, Leif Chr. m.fl: *Livsløp, yrkeskompetanse og arbeidsmiljøutvikling*. AFI rapportserie 5/99

Langslet, Gro Johnsrud: *LØFT Lønsningsfokusert tilnærmning til organisasjonsutvikling, ledelsesutvikling og konfliktløsing*. Ad Notam Gyldendal 1999


Menckel, Ewa og Østerblom, Lars: *Halsoframjande Processer på arbetsplatsen. Om Ledarskap, resurser og egen kraft*. Arbetslivsinstitutet 2000

NOU 1997:25. *Ny kompetanse*


NOU 2000:14. *Frihet med ansvar. Om høgre utdanning og forskning i Norge*


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Using the Internet for Training Professionals in Substance Abuse Prevention

Paper presented at the XVIIth World Conference for Health Promotion and Health Education, 15-20 July 2001, Paris France

By Rita Bergersen

Background
In Norway, substance abuse prevention at the local level is a municipal responsibility. However, due to the fact that Norwegian municipalities are generally quite small (5000-25000 inhabitants), there are rarely more than 1 or 2 persons in each municipality that have substance abuse prevention as their specific task and responsibility. It is also a problem that even if these people are making invaluable efforts and have a lot of experience gained through local projects, there are no structures established to ensure that they can learn from each other across municipality borders. Nor are there educational possibilities available to make sure that they can learn how to systematically improve the quality of their work.

Objectives
The HENAER Research Centre initiated the development of a formal, credit-earning continuing education training programme for municipality employees working with substance abuse prevention. The programme aimed at giving the employees possibilities to 1) work systematically on quality assurance of their own work, and 2) exchange experiences gained from their respective practices in the different municipalities. The training programme was founded on central health promotion action principles, such as empowerment of the employees through encouraging their participation in the management of the training programme. The central goals, both during the programme itself and afterwards, were to be reached through extensive use of the Internet. Internet-based programmes offer several advantages: the programmes are independent of time and space and they facilitate flexible
communication for administrative, social, and teaching purposes. In Norway, Internet-based courses can potentially reach a very broad range of persons from all parts of the country.

Ideally the Internet is available 24 hours a day, 365 days a year. It gives access to information whenever it is convenient for the user and there is no need to synchronize the operation between communication partners.

Intervention
A total of 18 employees from 14 municipalities participated. The training programme was carried out during spring 2000, and those who passed the final examination received 15 ECTS college level credits. The programme’s website contained practical information for the students, texts, relevant links, a chatroom and a discussion forum. In addition, two sessions of regular lectures and group discussions were arranged during the term. Altogether the students met face-to-face six times. Throughout the course the students were encouraged to apply what they learned to their daily work with substance abuse prevention in the municipalities.

Results
Surprisingly, lack of access to the Internet caused some problems in recruiting students. We had expected that everybody in this field had access to a computer.

For our students the fact that the course was offered on the Net was an important reason for enrolling: few of the students would have enrolled for part-time or full-time study otherwise. All the students had full-time jobs and families to take care of and many expressed a reluctance to participate, expecting that the programme would steal time from family life and job achievements. They needed flexible education: education that allowed them to combine job, family, and education in a manageable way.

The students were not as active in initiating discussions and common reflection on the website as they were at the regular lecture sessions. They were not used to having the control over the learning process, they expected “right” answers from the teachers. However, evaluation revealed that the students considered the contents of the course interesting and useful, as well as inspiring for their daily work.
Discussion
In computer-mediated communication (CMC), one must distinguish between synchronous and asynchronous communication. In asynchronous communication, the message is stored in the communication medium until the receivers find it convenient to retrieve it. Synchronous communication, on the Internet achieved by using tools such as chat-rooms, on the other hand, is inflexible, but allows people to communicate in real time, as they do face-to-face or on the telephone.

Cooperation and dialogue can be hard to achieve in Internet-based education. Our programme was designed so that the students could do all their communication online, but it turned out that the students clearly preferred using the asynchronous elements of the Internet-based part of the programme in their communication and that the possibilities for online synchronous communication were little used. Asynchronous communication allowed the students to communicate whenever it was convenient for them: they could study during the weekends, after their children had gone to bed, during regular work hours, or whenever they had time available.

Still, many students considered the loneliness that resulted from limited access to their student peers as a major problem. From our point of view the Internet served well as an information channel for staff to communicate with the students, but it did not promote dialogue and interaction to the desired extent.

In this study we were using computer conferencing as a supplement to on-campus teaching. Not only for the students but also for the teachers, it seemed necessary to combine use of the web with traditional classroom teaching. It appears that there is a barrier to overcome in using the Internet for interactive purposes. Seemingly trivial details for those used to working with software can form real barriers for the less experienced.

Our experiences seem to harmonise with results shown by Forrester Research (2000). They found that the greatest obstacles to online training were static, uninteresting content and lack of interactivion (56%), and cultural resistance from employees who prefer traditional training methods such as instructor-led classroom courses (41%).
Further work is needed in order to overcome the pedagogical and technological challenges of Internet-based learning in this field, especially given the importance of dialogue in health promotion work.
EXPERIENCE FROM A PROJECT ON HEALTH, ENVIRONMENTAL CONDITIONS AND WELL BEING AT A HIGH SCHOOL IN EASTERN NORWAY


and


By Annett Arntzen

Background
Environmental conditions and sense of well being are important determinants of health and illness. Pupils spend a large part of their day at school. Improvements of the school environment, therefore provides an important opportunity for health promotion.

Objective
The aim of this study was to develop understanding of students’ perceptions of their school environment and ways that the environment could be altered to support better mental and physical health. It was intended that this information would be used subsequently in intervention programmes.

Materials and methods
We conducted qualitative interviews and group sessions with pupils, and developed a questionnaire that was administrated to all 1,700 pupils at the school in Eastern Norway.
Discussion sessions including students, teachers and school administrators were also conducted. The data generated included information on the pupils’ self-perceived health, well being and how they perceived the social environment at school.

**Results**

By using method triangulation, we gained insights and improved our main understanding to a degree that would have been impossible with just a quantitative survey. Among some of the teachers and the pupils the tone was rather negative. There are group gatherings and arguments among the pupils. The negative atmosphere reduced well being and gave rise to psychic stress. By participation in discussion about health issues and environmental conditions the pupils become more conscious and reflexive about their own and others’ opinions and behaviours.

**Discussion**

Seen as a project to prevent psychosocial problems the project has many weaknesses and flaws. The project primarily serves as an example of the importance of the understanding and acceptance of how a specific way to work need to be understood in the organisation to be at its most effective. The project sustains the notion that health promotion is a time consuming process.
EXPERIENCE FROM A PROJECT ON HEALTH,
ENVIRONMENTAL CONDITIONS AND WELL BEING AT A
HIGH SCHOOL IN EASTERN NORWAY

Paper presented at the 3rd Nordic Health Promotion Research Conference.
Outcomes in Health Promotion. Key questions for research and policy. Tampere,
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and

III European Conference on Community Psychology. Community action, empowerment

By Annett Arntzen

Introduction

Our starting point in health promotion deals with organisations in the welfare state – the
challenge is how they can support the people and the community to obtain real empowerment.
First – employers in these organisations have to work in a direction that gives people more
control over their situation and in relation to things that are related to their own health.
Secondly – they have to understand the concept of empowerment: in other words they have to
have competence to employ this notion. Therefore, our interpretation of community
empowerment not only deals with making the community capable to work with
empowerment, but we also have to strengthen the organisations in a way that makes them
more capable of encouraging their clients to meet their own needs.

This paper deals with experiences with health promotion efforts in a school. The project was a
co-operative between a high school in Eastern Norway, health authorities in Sandefjord
municipality and the HENÆR-center at Vestfold University College.
We know that environmental conditions and sense of well being are important determinants of health and illness. Pupils spend a large part of their day at school. Improvement of the school environment, therefore, provides an important opportunity for health promotion.

The aim of this school project was to develop understanding of pupils’ perceptions of their school environment and ways that the environment could be altered to support better mental and physical health. It was intended that this information would be used subsequently in intervention programs.

We will focus on strategies and methods with respect to the pupils' own recourses which promote empowerment and which hope it is to be help for the school as an organisation to make it a better place to be over time. This depends on what teachers, school leaders and the pupils do together, and how we as researchers and health authorities can assist the school in the contribution of health promotion efforts.

To make effective health prevention efforts different types of information are needed. *Problem information* tells us about the extent and distribution of health problems in the population - it is important when you intend to define target populations. A questionnaire is suited to obtain such information.

But, if you are going to obtain knowledge about why some people have bad health or why behaviour varies you need information about causes. Then you have to have theories about what cause an undesirable condition or why people act differently. What’s right for one group in one situation is not necessarily right for other groups in other situations. Qualitative interviews, group sessions and dialogue conferences (in this project discussion sessions including pupils, teachers and school administrators) are some methods suited to obtaining information about causes.

The final type of information needed concerns how to take action. It is important to sort out the information that is relevant to influence interventions.

In addition to the need for different types of information in health prevention work, we know that problems are perceived differently by pupils, parents, teachers or health authorities. Hence, we wanted the school and especially the pupils to define their own problem areas, in
order more easily to deal with them and solve them. In the light of this we used method triangulation in the first stage of the project.

All 1700 pupils attending the high school received a questionnaire. The data generated background information on the pupils’ self-perceived health, well being and how they perceived the social environment at school.

We conducted qualitative interviews and group sessions with pupils from different classes. The information we obtained helped us to compile relevant questions for the questionnaire and we had the opportunity to go further to ask pupils about their experience with the school environment and the reasons of why things being good or bad.

Discussion sessions or dialogue conferences - including pupils, teachers and school leaders - were also conducted. The participants’ own experiences and subjective understanding of the daily life at school, contributed in verifying (the fact) that different groups understand, appreciate and interpret the environment and well being in school in different ways. This information gave knowledge about conditions that can influence interventions and their outcomes.

One of the experiences was that we had a breakthrough for the emphasis that the project should be anchored at the school. This contributed to the fortification of competence at the school, and it's continuation.

Perhaps the most important experience from the initial phase was that the discussions towards a common understanding about a project with open aims take time. There are three important comments here. First, the use of a lot of time increases the probability of developing an ownership in the project since each single contributor may adjust the project to his/her own aims and interests. Second, on hectic working days it is not always possible to give priority to such development work since other duties demand attention. During a longer time-period it is, however, easier to find time for development work. Third, there is always a possible danger of a fall in enthusiasm for the project due to minimal progress.

Results
From the qualitative interviews we received many suggestions that we took into consideration. To be without friends during the lesson breaks for instance was among the worst things several pupils could imagine. So in the questionnaire we included more questions about friends and social networks than we planned at the outset. Other types of statements showed that some pupils felt that their class-environment was detrimental, and they didn’t like it at school because they were bullied by their teachers. We formulated a few questions about this, but were stopped by the teacher-organisation in connection with the approval of the questionnaire. Such an event gives valuable insight!

The majority of the pupils are content at school. More than 80% of the pupils find their school-time satisfactory, but 28% are occasionally anxious about going to school. Concerning self-perceived health, 90% of the pupils say that they find life good, while 9% often feel lonely and 12% often abscond. Only 12% reported that they took part in deciding the format of the lessons.

Although the majority of pupils are fine, it is a collective responsibility for everyone at school to contribute in triggering health-improving resources. We didn’t want to stigmatise any groups, but to focus on an entire effort at school as an arena.

By working with one’s own school environment, and by reducing the barriers for contacts across the classes, fortifying the methods of teaching that involves the pupils, fortifying the quality of the relations between teachers, leaders and the pupils and by mobilising the pupils to work themselves with environmentally creative initiatives, one can probably achieve an improvement in the daily lives of these who dislike it at school or the ones that find themselves in the danger-zone of developing health-related problems.

The dialogue conference (group session) handled prosperity and well-being aspects. The aim was to change situations not to change people. The feedback was positive and the conference form at is good for equal participation for teachers as well as pupils.

After the group sessions we participated in meetings and gatherings to contribute to the experiences of the dialogue conference and the subjects the pupils and the teachers themselves had raised. It appears that while the pupils at the outset were pointing to the defects in the school buildings, complaints about the school system, mistakes in the teaching-forms or
complains about the teachers themselves, they are now occupied evaluating their own conduct and judgement. The school’s leaders think that the pupils have strengthened their faith in their own influence and judgement. The teaching and the completion of the dialogue-conference have contributed to new efforts in teaching methods to improve the class and school environment.

Another important experience was that the use of method triangulation apparently was a part of ensuring legitimacy and anchorage of the project. We got to know the pupils, teachers and leaders very well through the qualitative interviews and the group talks. The leaders understood the importance of collecting relevant information with different approaches, and contributed constructively by letting the pupils fill in their questionnaires at school, and letting them off school to join the dialogue conference.

**Lessons to learn**

In this project we have acquired experience with developing health promotion strategies usable both in an immediate and long-run perspective. We have used principles from action research and organisational development theories. Not least have we been inspired by health promotion ideology with empowerment as a main principle.

The cooperating participants in the project have developed both knowledge, attitudes, and practical skills related to the use of various methods promoting participation in learning and decisionmaking processes. Around 600 pupils and the teachers, school-administrators and leaders have been trained in relevant methods for development of a positive psychosocial school environment, health gain and problem prevention being the goals. The school’s users have been trained in constructing a structured frame for experience sharing and dealing with tasks they themselves rate as priority issues.

The project will continue and is now run by the school itself, also financed by the school’s own means. This would not have been possible if we as researchers had just presented the results of the qualitative study or the questionnaire and left the responsibility for follow up or practical use of the results to the school or health department. Integrating the study through participation in it has been essential in securing both ownership and further development into practical outcomes. Simultaneously this has secured that lessons learned remain where they should, with the school and all the participants in the project. This would not have been
possible if the goals had not been negotiated and adapted to the school’s interest by the same participants. The duration of the process has strengthened the participants’ ownership, thus ensuring its endurance.

This project primarily serves as an example of the importance of the understanding and acceptance of how a specific way to work needs to be understood in the organisation to be at its most effective. The project sustains the notion that health promotion efforts are a time-consuming process.
EMPOWERMENT THROUGH EDUCATIONAL PROGRAMS IN ORGANISATIONS

Paper presented at the III European Conference on Community Psychology.

By Ellen Andvig

Background
One of the five areas of strategic importance described in the Ottawa-charter is to stimulate the municipal health services to operate in a more health-enabling manner. This calls for changes in vocational education and training and can lead to changes in professional attitude and in organisations.

In general, there is great interest in competency development within professions, with increased emphasis being placed on the individual employee’s competency as a contributory factor. The idea of the work place as an arena for «life-long learning» has gained support among employers and employees as well as political parties. In Norway, this policy has led to the proposal for a reform within higher education. Universities and state colleges are given a central position in contributing to the execution of this reform. They are challenged by central authorities to develop more flexible education programmes in accordance with the needs of working life.

One strategy for colleges as educational institutions is to research the effects of continuing education aimed at contributing to organisational development. Are there intersecting junctions between employment organisations and colleges? And how can we develop research strategies to ascertain how colleges and places of employment together can meet the interests of both parties?
Intervention
HENÆR arranged an educational program «Cross-departmental Collaboration in Mental Health» in co-operation with the health and social services of a small-town municipality in Norway. Forty employees from various health institutions in the community participated in a one-year programme. Community leaders developed the programme together with HENÆR. The program was based on needs of the municipality and their local plan for psychiatry. (This is a federally determined plan which each municipality is under obligation to develop for the psychiatric needs within the local community.) The municipality exhibited extensive flexibility in contriving solutions which made it possible for their employees to participate in the programme during working hours, e.g. day-time conferences were held in the municipality near participants’ employment places.

The purpose of the programme
The primary purpose of the programme was to improve both the competence level of the individual, as well as the organisation, in relationship to collaboration and health-promotion work. Another aim was to develop plans in both prevention and treatment with regard to psychiatric needs of the community. It was of specific importance to develop the participants’ understanding of and skills in collaborating across professional boundaries, as well as across departmental and sectional borders within the municipality.

Activities of the programme were as follows:
1. Cross-professional groups meeting on a regular basis. During the year, participants with differing work experience and varying professional backgrounds studied together in groups. Each of these groups planned a developmental project within the municipality or between the municipality and psychiatric institution administered on the county level. The groups worked out written project plans for later implementation, the aim being to improve psychiatric services and making those more «user-friendly» with the user in focus. The groups documented their learning process through summaries of their professional discussions as well as summing up the group process. Groups were supervised from college staff four times during the working period and this supervision focused on both the aspects of group process as well as project plans.
2. A two-day conferences seven times during the year. Lectures and class meetings were utilised together with group discussions, so as to «digest» the content of the lectures, and educational exercises were occasionally applied in connection with some of the topics. Topics covered were organisational theory, challenges within the mental health field, health-enabling strategies/methods, project work, theories of supervision, communication, strategies in cross-professional collaboration.

Evaluation

An evaluation study was completed to summarise the experiences of the programme and implementation of the plans. The evaluation study focused on the question of what each party - municipality and college - had learned from the process. Data was collected through focus group interviews with 25 of the participants, as well as interviews with five key persons (i.e., leaders) from both the community and college, as well as through analyses of relevant documents.

Findings and discussion

* Acquisition of a sense of empowerment through participation in the programme.

The participants became more aware of their own capabilities, as well as the competency of the others, both as individuals and as a group. This awareness seemingly empowered them, making them feel more secure in their professional role.

Co-operation across professions and departments was made easier, too, as they felt more confident in their own and each other’s work performance. By becoming better acquainted across professional and departmental boundaries, their self-confidence and trust in one another increased, enabling them to «be themselves» and to interact more informally with one other.

* Development of a feeling of togetherness and bridge-building across professional boundaries.

Through group work the participants gained knowledge and understanding of one others’ professional foundations underlying their assessments, actions, reactions and experiences. They developed a greater feeling of togetherness or «we-ness» as opposed to «us» and «them». Myths concerning each other’s professions dissolved or were reduced. This improved
collaboration led to bridge-building across professional boundaries, which, in turn, benefited the common users of their services.

* Development of a more common language.
The working process within the groups granted members of varying professional and organisational backgrounds the opportunity to communicate in more meaningful ways about the same subjects. They explored core concepts, for example health, client, health promotion, co-operation/collaboration, etc. By sharing their differing frames of interpretation and views of reality, they increased their reciprocity of understanding and tolerance.

The development of a «common language» made it easier to manoeuvre and cope within the framework of the daily working situation, which oftentimes consisted of contradictory expectations from users and authorities. A common language facilitated reflection on what was occurring within the organisation. Pålshagen points out that being able to speak the same language is an important precondition to the creation or recreation of a community (Pålshagen 1998)

* Improved understanding about the organisation and its potential for change.
The evaluation gave the impression that participants had increased their understanding about their own organisation and its potential for change. They understood more about «the limits of the system» and had greater insight into their own position and possibilities of influence in the organisation. It appears that this program has stimulated the participants to develop a more critical approach to leaders and the organisation of the municipality as a whole.

*Lack of commitment.
The evaluation showed that it was not sufficient with simply well meaning leaders. Several leaders participated in the planning stages of the programme. All were well informed concerning the plans and purpose of the programme. Yet the leaders’ involvement was reported by participants as being far too brief and superficial. Leaders granted seemingly insufficient time for discussions between employees and leaders concerning the possible consequences of the interventions instigated by the programme. Lack of commitment from leaders made it difficult to implement plans developed by the groups.
The leaders’ lack of involvement and participation in the students’ work during and after the implementation of project plans demonstrated how the leaders had not viewed the programme as an opportunity to implement organisational development.

From these experiences we have learned the importance of increased co-operation between the different parts as an essential prerequisite for such a programme. Leaders should be involved from the beginning, participating throughout the entire progression of the programme, co-operating with teachers in the planning, implementation and follow-up of the project plans. It is important to utilise strategies which meet the interests of both parties, to be in constant dialogue, and to design curriculum based on local needs.

To summarise my findings: the programme led to self-development and empowerment of the individual participants. A feeling of greater security in their own professional role and an increased knowledge of others’ roles contributed to increased co-operation/collaboration between participants. However, employees frequently move on to other organisations in today’s working world. The effect of this programme on the organisation - the municipality - was seemingly limited, as it has been more difficult to trace any effects of change within the concrete practices of the organisation.

I would like to discuss if the main objective of education in organisations is self-development of the individuals involved, or development of the organisation? Formulated in yet another way: is the main purpose of a study like this to empower the individual student or the organisation as a unit?

We generally consider education to be an individual matter. The educational offers from colleges and universities are mostly directed towards individuals and developed for specific professions. This may exacerbate the entrenchment of already strong professional identities. In addition, educational programmes are mostly aimed at independent individuals. There may be a danger of developing new qualifications that deviate from the general qualifications existing in organisational settings, although it is not certain whether this form for competence will lead to positive or negative deviance. Yet educational programmes can conceivably affect organisations in ways leaders disapprove of. This can again lead to misgivings and agitation, due at least in part to a lack of sufficient grounding – “what is it we will” – being clearly defines prior to the set-up of the educational programme.
During this programme the entire organisation was placed in a school setting. Programmes of this type will necessarily consist of tension between the self-development of the individual student and the development of the organisation. In order to secure organisational development, it has to be made clear to the entire organisation. Leaders and employees must understand the relevance of the programme for the purposes and practices of the organisation. Only in this way will education in organisations promote genuine operational changes.

As a great number of employees from the same organisation participated in this course, it opened for new possibilities to connect work and education. Since employees in daily working relationships studied together in co-operation, their acquired knowledge and skills could more easily be utilised in daily work practices. This might prevent an encapsulating of qualifications. It can also contribute to the development of «process competence». By «process competence» I mean how employees themselves discovered new ways to develop their own practice. Process competence deals with procedures for organisations to authorise their own ways of meeting new challenges. The actual results of their plans and contributions become quickly out-dated and are of minor interest in themselves.
Literatures

Hustad, Willy: Lærande organisasjoner Det Norske Samlaget, Oslo, 1998

Nonaka, Ikujiro: A Dynamic Theory of Organizational Knowledge Creation, Organization Science Vol.5, no 1, febr. 1994

POPULAR EDUCATION AS DIALOGUE – UTOPIA OR POSSIBILITY?

Strategies for enlightenment - some perspectives and dilemmas.

Paper presented at the III European Conference on Community Psychology.

By Jorun Ulvestad

In the following I will discuss The National Programme for Parental Guidance, established in Norway in 1995. Attention will be paid to perspectives at macro- and meso-levels, including issues as: the increasing number of professional helpers, the professialisation of knowledge, and dialogue as the new and very popular concept of building understanding in society. A short presentation like this cannot give a full picture of this programme, so I concentrate on three central dilemmas actualised posed by the programme.

The National Programme for Parental Guidance is a co-operative programme between the three ministries: the Ministry of Children and Family, the Ministry of Social and Health Policy, and the Ministry of Church, Education and Research.

Public health nurses, pre-school teachers, and school teachers are the main target groups for training in supervision and co-operation with parents in public health centres, kindergartens and schools. The aims are to support and strengthen the parental role in families with children, to prevent psychological and social problems among children and young people, and to contribute preventing problems within the family. The programme is directed towards all classes, groups and types of families. It is also a continuation of a programme for preventive childcare.
The programme is resource-orientated, and focuses on the parents’ own needs for co-operation and guidance. Participation is intended to be voluntary.

The programme has developed various objectives:

“The responsibility for children and young people is above all that of their parents. The public responsibility is to create the conditions which make it possible for parents to practise their parental roles as well as possible. The programme for parental guidance will contribute in creating suitable meeting places where parents can exchange experiences and take up questions in raising children. Offers of parental guidance (and groups for fathers) have a preventive objective and will contribute in supporting and strengthening the parental role in families with children”. (Q5/97:4)

Comprehensive materials such as videos and books for professionals and parents have been developed, containing contributions from different professionals of high competence in the field of child research. The content is based mainly on eight themes for good interaction, and these themes are central to the programme. It is also a pre-condition in the programme that the task of the professionals is to contribute with their own professional knowledge.

It would thus appear that an underlying premise of the programme for parental guidance is that professionals are able to support and strengthen parents in their roles, both in respect of the parents’ own behaviour and of their knowledge.

This is an important premise, but the dilemmas are many. The first dilemma to which I will draw attention is based on a macro perspective.

**Many problems seek solutions, and knowledge is often understood as solutions**

The number of professional helpers is increasing in all areas of life. As a society we are using more and more resources on research and development in order to solve the societal and human challenges we are facing. In this situation many groups express their wishes and demands, and other groups offer their knowledge and techniques to meet these needs for help. Such a situation is one of problems seeking solutions.
This is an understandable viewpoint, but the situation is capable of alternatives: The development of society is characterised by division and specialisation, which leads to an explosion of knowledge within different areas. New knowledge about individuals is constantly developed. This knowledge enables the professionals to describe and define the situation of each individual, especially related to what is considered to be normal or not (Foucault 1973). This means that there is increased knowledge of what is not normal – and how professionals can contribute to a treatment in order to achieve a modification or an abolition of deviation. Closely related to this kind of knowledge many methods and techniques have been developed, connected to observation, guidance, therapy, and other forms of treatment. It becomes important to introduce these methods and techniques to new areas, especially for those who possess the new insights.

This alternative understanding opens a new focus. A great deal of the knowledge, methods and techniques adopted through a highly specialised division of society lead to many groups establishing themselves in important positions with respect to other groups – where these other groups can be differentiated, defined and separated through this individual-orientated knowledge. This creates a situation where we can talk about position and power versus help and dependency.

Professionals possessing this knowledge and able to use the techniques are in a central position concerning this development. People with needs are defined from the point of the existing knowledge and available techniques. At the same time there are an increasing number of groups who are considered to be in “need”. In other words: we may state that the solutions seek problems.

The development of monopolies of knowledge creates a basis for dominance socially, economically, and culturally. From this perspective the welfare state appears as a system for the transformation of power and position.

**The Programme of Parental Guidance as idea - a first dilemma**

The Norwegian psychologist Magne Raundalen, who has a central role in the programme, writes in Dagbladet about The Program of Parental Guidance:
“It is going to be a huge challenge to make use of all the knowledge gathered and systematised through modern child psychologist research in recent years, and to do this in a way that will strengthen parental competence, self-confidence and the choice of direction (Raundalen, Dagbladet 30.1096).

This gives us a reason to reflect whether we have the situation of problem seeks solution or the solution seeks problem.

Is the central point that somebody actually possesses new knowledge for use, or is the central point the parents’ needs for help?

**Is dialogue a more strategically correct concept? - A second dilemma**

Parents are different and they have different lives and different understandings of their parental roles. Their aims in raising their children might also be different. What they have in common is a mixture of knowledge dominated by informal knowledge.

In some of the documents in The Parental Guidance Programme it is emphasised that “parents are experts on their own children”. Apparently this means that there is a lot of knowledge about children among parents, and that respect for this knowledge is the new and central point when professionals meet parents. This is meant to secure the basis for mutual and equal dialogue.

But, and this is a crucial point, nowhere in the written materials are there any statements about parental knowledge which may be of interest for the professionals. There is not mention that parents might develop new and important insight into children and childhood, rooted in their knowledge of everyday life. On the contrary, the direction is only the way – from the helper to the user.

Furthermore, it is striking that children’s own knowledge about how it is to be a child here and now, is not mentioned at all in the programme. This underlines the partial perspective of the development of knowledge through dialogue.

The programme gives the appearance of a willingness to develop knowledge through dialogue in mutual and equal meetings between parents and professionals. Nevertheless, from my point
of view, the programme is quite close to the same characteristics we know from the traditional monologue within popular education (Ulvestad 2002).

**Conditions for equal dialogue – a third dilemma**

The third dilemma is connected with the conditions for the dialogue. What are the preconditions for an equal dialogue when the participants have different bases of knowledge?

There are many participants in this discussion. I will briefly mention the dispute between the German sociologist Jürgen Habermas and the French philosopher Jean-Francoir Lyotard.

Habermas and Lyotard are both concerned about equality in dialogues, but on ... different premises. Whilst Habermas focuses on equality through ideal conditions such as unconstrained participation, receptivity and honesty, Lyotard looks elsewhere. He stresses that different types of knowledge have their different characteristics - and this includes formal scientific knowledge as well as informal narrative knowledge. These different types of knowledge are established on different bases, and based on different rules. Even if these rules are not visible to the participants, they are still controlling the dialogue. Being unequal and invisible, the rules are difficult to establish as common rules. Lyotard asserts that a precondition for making common rules in order to make them function must be that the rules are surveyable for both participants in the dialogue, that it is possible for both participants to make use of the rules, and also that it is possible for both participants to abolish the rules.

All parties must have the same rights. It is not enough that only one party understands the rules and is the master of the situation, otherwise we no longer can talk about an equal dialogue.

Lyotard argues that in social reality there will exist a mass of games of languages that are overlapping and heterogeneous. In this programme, based on dialogue in a few meetings, I assume it will be extremely difficult to establish common meta-rules for these games of language as a basis for the development of parental knowledge. Of course, in some connections communication will be successful incidentally because people happen to meet other people with relatively equal basic knowledge. Parents meeting professionals with some of the same background and basic knowledge as their own, might experience successful communication. For other groups this will probably not happen. The parties have no
possibility to reach each other, and there is a great danger that this will cause confusing and hurt. *Good results don’t depend on good intentions.*

**Conclusions**

Different people and different institutions will find different solutions for the three dilemmas I have drawn up connected to The National Programme for Parental Guidance. I will claim that the programme is close to legitimize the traditional authoritarian use of power by dressing it up with concepts such as “dialogue” and “parental expert knowledge”.

83
Literatures

Barne- og familiedepartementet: Rundskriv Q-5/97


Dagsavisen Arbeiderbladet 11.05.2000


Fauske, H: Forståelse, forklaring og konstruksjonen av sosiale problemer I: Sosiologi i dag 4 1997

Foucault, M (1973): Galskapens historie i opplysningens tidsalder. Gyldendal


Raundalen, M (30. oktober 1996): Kronikk i Dagbladet


THE INTERNATIONAL DISCUSSION OF THE OPERATIONALISATION OF CLASS: THEORETICAL AND EMPIRICAL CONSIDERATIONS


By Annett Arntzen

This paper is a contribution to an important on-going discussion on the operationalisation of class. Different inter related choices must be taken into consideration in the operationalisation of class. All the choices have both theoretical and empirical elements. First, researchers must choose which conceptual scheme to employ – conventional occupational class or neo-Marxist social class categories. Second, who is it to be the unit of analysis – the respondent or the household? Third, what is to be the degree of coverage – whether or not to include the economically inactive? Considerations of all three choices is followed by a discussion of their inter relations and consequences.
THE OPERATIONALISATION OF CLASS: THEORETICAL AND EMPIRICAL CONSIDERATIONS


By Annett Arntzen

Introduction
Different inter related choices must be taken into consideration in the operationalisation of class. First, researchers must choose which conceptual scheme to employ – conventional occupational class or neo-Marxist social class categories. Second, who is it to be the unit of analysis – the respondent or the household? Third, what is to be the degree of coverage – whether or not to include the economically inactive? This presentation is about some issues surrounding these choices.

Class is one of the most central concepts in the discipline of sociology. The debate has fragmented the theoretical considerations and empirical appraisal. Neo-Marxists have revived the issue of social versus occupational class and feminists have stimulated discussion of the unit of class analysis. Contributions to both these and related issues have tended to ignore each other at the empirical level.

1. The conceptual scheme: occupational class versus social class
There is a tendency in the presentation of empirical research to use the label “social class” when the data employed are based on occupational class categories. In sociology the term social class often refers to the neo-Marxist categories that are based on divisions within the social relations of production. Occupational class categories are based primarily on positions within the technical relationship in production (for example occupations) and comprise a
smaller number of classes. The term *occupational status* is reserved for occupational prestige scales usually comprising several hundred categories.

The conceptual scheme decision is a fundamental theoretical choice between opposed schools with different views as to the nature of class in advanced capitalist society. Generally occupational class schemes give primacy to the manual/non-manual boundary and are further sub divided according to varying skill levels within each category. By contrast, social class schemes emphasize the owner/non-owner distinction and are then further sub divided on the basis of control over labor.

*Which particular operational scheme?*

The choice whether occupational class or social class is most consistent with the researchers’ theoretical position is not the end of the decision making. Each of the two conceptual schemes has given rise in practice to many alternative operational schemes. Some researchers have even advocated a combination of the two.

The basis for *occupational class* schemes most commonly used by Norwegian scientists is the Nordic Classification of Occupations. In addition the official statistics use this classification. The occupations can be divided into occupation-groups or occupation-fields.

Most of the *social class schemes* also use occupation, but the criteria are different. Primarily they use the conditions of appointment, but also education, income or information about participation in decision making are used. These schemes are often inspired of Marxist theory.

In spite of the theoretical differences between the two models, a lot of studies have shown that they are similar in their empirical explanations.

2. The unit of analysis: respondent or household

Is the appropriate unit of class analysis the respondent or the household? The case for a *respondent* based indicator is a simple one. It is argued that respondent attitudes and behaviour should logically be analysed in terms of the direct experience of the respondent.
For example the direct occupational experience of working wives is more relevant to their class action than the occupational experience of their husbands.

On the other hand, several prominent theorists on social stratification are insistent that the *household* rather than the individual is the appropriate unit of class analysis (Giddens, Goldthorpe, Parkin). The main argument is that the family acts as the basic unit of economic strategy both in terms of production (whether or not the spouse works) and consumption. In this sense some analysis asserts that lines of class division run *between* rather than *through* families.

An instructive contribution to the respondent versus household debate has been the suggestion that both measures are appropriate - but in different circumstances. Two class concepts can be used, one work-related with individuals as the unit of classification, and one marked-related with families as the unit of classification. Empirical evidence also corroborates that taking occupation of both spouses into account explains more of the variation in family class position than merely taking one of the spouses.

*Which method of measuring household class?*

Applying only the *respondent* is the most straightforward procedure. But it is often more complex to use the same occupational categories for women and men. Selection of the *household* option involves the further decision of which indicator is most appropriate, whether to utilize head of household (usually male), a joint classification of household members, or the dominant member of the household.

Where there is only one adult in a household the procedure is identical to a respondent based indicator. However, where there is more than one adult in the household, and if the two adults are in different class locations, the question arises as to which should determine the household class measure.

Household class location has been based on the male head of household. This option can easily be rejected on the grounds of sexist bias. Where the male head procedure is combined with the use of occupational class (as has frequently been the case), many critics have argued that this tends to conceal the extensive sex discrimination in the labour market. This is not to argue against household measures *per se* but merely that there is no inherent *a priori* reason
why the household location should always be determined by the male. In Norway most of the women have joint responsibility for the financial support of the family.

An alternative procedure is to take both spouses into account by employing a system of joint classification where the occupational locations of both spouses are incorporated into the classification. Many are critical of this because, since women move between manual and non-manual jobs, it’s supports the view that this movement does not represent a shift in class location. Moreover, movement of one of the spouses into or out of the labour market adds to the amount of spurious class mobility generated by the joint classification system.

The third possibility is to consider all adult members of the household and then locate the household according to the principle of dominance. Then households are classified according to the highest occupational class in the family unit. Applications of the dominance principle for household measures of class allow the husband or wife or significant other person in the household to determine the class location of the household. Support for this has been advanced on both theoretical and empirical grounds in the context of the debate on women in class analysis.

There are, however, several important arguments against the dominance method. First, the method requires a hierarchical class scheme with a clear order of dominance. But many schemes have qualitatively distinct class locations with upper and lower classes clearly defined - but the dominance order in the intermediate class is less apparent. Second, a single dominance measure of household class loses information on the distinctive components of the household. And third, the empirical effect of using the dominance method is to reduce the size of the working class - because the dominance principle is applied upwards rather than downwards.

The final alternative is to include the class location of both respondent and others in the household in the form of multiple indicators. Many have argued that a set of variables are preferable to a single household indicator in that they describe more accurately the location and circumstances of a household. This solution allows the influence of either or both to be displayed in the analysis. The use of multiple indicators also copes better with the frequent existence in research data sets of more detailed information on the respondent than the spouse and others in the household. The number of categories can be varied with multiple indicators.
to accommodate the differing levels of information. In short, the multiple indicator approach has many advantages and is therefore a preferred method.

3. The degree of coverage: all adults or the economically active only
A second element in the choice of whom is to be classified is whether to include or exclude the economically inactive. The decision is complicated further by the existence of different degrees of economic activity/inactivity. Economic activity is divided conventionally into full-time and part-time work with a variable boundary line depending on the purpose of the research. There are even more types of economic inactivity which range from the permanently inactive, through the possibly temporarily inactive (ie unemployed and housewives), to the temporarily inactive (ie students).

There has been a widespread practice to exclude unpaid housework and thereby exclude women from a lot of analysis. A pragmatic justification for the “economically active only” option rests on its convenience - you don't have to decide what to do with the inactive categories, and comparability - previous research employing this option.

A general criticism of all studies that exclude economically inactive adults is their resultant restrictive and distorted view of the class structure. Generalisations about the class structure and class relationships are not valid when they are based on small and unrepresentative sections of the adult population.

The economically inactive can be classified (wherever possible) by their previous class location. This is possible for retired people because pensions are occupationally related. Some have underlined the importance of classifying the previous main job rather than simply the last job, which may have been a part-time semi-retirement position.

Less agreement is apparent over the classification of housewives. It has been argued that last occupation is a good predictor for unwaged women, although others have suggested that when only the most recent occupation is available this provides a poorer indication of class position than the occupation held prior to their first child's birth.
A similar dilemma exists regarding the classification of the unemployed. A distinction between temporary and long-term unemployed is thus suggested, with only the former to be categorised by previous occupation. Some researchers have treated the unemployed as a separate underclass. The number of teenagers on some form of state worktraining scheme has highlighted the need for a separate category of economic status to cover this group.

Movements into or out of the labour market should not automatically change the class location of the household. Thus a move into domestic labour, unemployment or retirement does not result in the respondent or the family "falling off" the edge of the class structure to become "non-persons" and thereby be excluded from empirical analysis of class. The current record numbers of both unemployed and retired serve to underline the salience of this point.

Which definition of economically active and inactive? Studies which utilise a respondent based measure for the economically active only must simply decide whether or not to include part-timers. Equivalent household based measures may face the additional problem of households where one (or more) adult is working full-time and one (or more) part-time. One possibility is that the occupations of those that work full-time should dominate the occupations of those that work part-time.

Further empirical research on social inequalities should be more comprehensive at the data collection stage and be more explicit about research methods at the reporting stage. This would facilitate secondary analysis and replications beyond the restrictive confines of any one single operational procedure. Second, information should be collected on both the respondent and other adults in the household. Third, it should also be routine to obtain relevant data for the economically inactive. Finally, more qualitative open-ended data are required to assist in clarifying marginal borderline categories.
Three choices in operationalising class: conceptual and technical elements

<table>
<thead>
<tr>
<th>Choice</th>
<th>Conceptual elements</th>
<th>Technical elements</th>
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</thead>
<tbody>
<tr>
<td>1. Conceptual scheme</td>
<td><strong>What is the basis of class?</strong></td>
<td><strong>Which particular operational scheme?</strong></td>
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<tr>
<td></td>
<td>Occupational class based on divisions within technical relations of production</td>
<td>Occupational class, egs Registrar General, Goldthorpe, Skrede, Prestige</td>
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<tr>
<td></td>
<td><em>versus</em></td>
<td><em>versus</em></td>
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<tr>
<td></td>
<td>Social class based on divisions within social relations of productions</td>
<td>Social class, egs Eric Olin Wright</td>
</tr>
<tr>
<td>2. Unit of analysis</td>
<td><strong>What is the appropriate unit of class analysis?</strong></td>
<td><strong>Which method of measuring household class?</strong></td>
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<tr>
<td></td>
<td>The household or family</td>
<td>Single indicator, eg head of household or combinations or dominance</td>
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<td></td>
<td><em>versus</em></td>
<td><em>versus</em></td>
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<tr>
<td></td>
<td>The respondent or individual</td>
<td>Multiple indicators</td>
</tr>
<tr>
<td>3. Degree of coverage</td>
<td><strong>Who is included in class analysis?</strong></td>
<td><strong>Which definitions of economically active and inactive?</strong></td>
</tr>
<tr>
<td></td>
<td>Economically active only</td>
<td>Economically active: full/part time boundary</td>
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<tr>
<td></td>
<td><em>versus</em></td>
<td><em>versus</em></td>
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<tr>
<td></td>
<td>Include inactive as well</td>
<td>Economically inactive: same or different rules for retired, housewives, unemployed etc</td>
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