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Patients` Experiences and Needs with Lifestyle Counselling in Family Practices

KadriKööp[1] RN. MSc, TiinaTõemets[2] RN. MSc, Ruth Kalda[3], MD. PhD

Abstract

Lifestyle counselling in family practices is the main strategy for influencing the risk factors of lifestyle-related chronic diseases and it requires a partnership with the patient. Health care workers acknowledge that patient-side barriers are the main obstacles to efficient lifestyle counselling. The aim of the study was to describe patients' experiences and needs with lifestyle counselling in family practices. Data was collected through semi-structured interviews. The sample (n=15) consisted of patients from two family practices who have been diagnosed with type II diabetes or hypertension or had cardiovascular disease risk. To analyse the data, an inductive content analysis method was used. Counselling must be patient-centred, based on the patient`s needs and individual peculiarities and should not be general. Mere talking is not sufficient, the patient`s motivation must be found and strengthened. In order to favour patient centred nursing aid, it is necessary to enhance the counselling abilities through motivational interviewing methodology based counselling training.

Keywords: patient experiences, needs, lifestyle counselling, family practices,patient-centred nursing

1. Introduction & Background

1.1 Introduction

The incidence of chronic illnesses caused by unhealthy lifestyle has grown in epidemic proportions even though the risk factors of those illnesses are in most cases preventable (Jallinoja et al., 2007; Nes&Sawatzky, 2010; Parker et al., 2010;Vermunt et al., 2011). The most common chronic illnesses caused by lifestyle are cardiovascular diseases, type II diabetes, tumorous ailments and chronic lung disorders. The most important lifestyle risk factors causing chronic illnesses are unhealthy dietary habits, smoking, obesity, inadequate physical activity and alcohol abuse. (World Health Organization, 2011).Lifestyle counselling on the primary level of health care makes it possible to effectively influence the risk factors of chronic illnesses caused by lifestyle (Parker et al., 2010;Vermunt et al., 2011), which is being addressed by primary level health care specialists (Fleming & Godwin, 2008; Parker et al., 2010; World Health Organization, 2011). In Estonia, primary health care specialists have the first responsibility for preventing noncommunicable diseases (Pertel et al., 2010), although only few of the patients are given recommendations for making their lifestyle healthier (Tekkel & Veideman, 2015). Primary health care specialists in the context of Estonia are family doctors, family nurses, school health care specialists and occupational health nurses anddoctors(Pertel et al. 2010). In Estonia the role of a nurse in lifestyle counselling has significantly increased in recent years, because since 2013 the family nurse has to have an independent reception time at least 20 hours per week (The work instructions…, 2016 § 5).

Challenges in counselling in the health care system's primary level reflect the viewpoints of patients, nurses and doctors – health care workers perceive counselling as complicated (Jansink et al., 2010) and patients characterise counselling as insensitive and hurried that does not correspond to the needs of the patient (Malterud&Ulriksen,2010; Walseth et al., 2011).

[1]Tallinn Health Care College, Estonia
[2]Ministry of Social Affairs, Estonia
[3]Institute of Family Medicine and Public Health, University of Tartu, Estonia

According to Pertel et al. (2010) Estonian primary health care workers acknowledge that patient-side barriers are the main obstacles to efficient lifestyle counselling and their own counselling skills are considered quite well, although family nurses counselling mainly involves just sharing advices. According to Pilv et al. (2012) patients with type II diabetes feel that the most important obstacles in coping with everyday life are related to not being able to make lifestyle changes according to the advices, the way how it is told that they have diabetes and self-management of diabetes. It shows that there might have been a gap in the explanation of different treatment options already from the very beginning of the disease.

As the nurses see the patient's reservations as main obstacle in the efficiency of lifestyle counselling (Jallinoja et al., 2007; Parker et al., 2010; Wilcox et al., 2010;Pertel et al., 2010) meanwhile being certain in their counselling skills (Parker et al., 2010; Carlfjord et al., 2012) and the patients encounter many difficulties in coping with chronic diseases, it is necessary to survey the patients' experiences and needs regarding lifestyle counselling. If the nurses understood and took into consideration the patients' viewpoints, it would increase the nurses' awareness of the aspects connected with lifestyle changes and would make it possible to support the patients' aspirations in making changes to their lifestyle (Brobeck et al., 2014), because of which their counselling efforts could become more efficient and patient centred.

1.2 Background

The patients consider the role of the primary level health care specialist in changing the lifestyle to be important, believing that it is possible to change one's lifestyle with the help of a health care specialist. However, this requires deep understanding and good counselling skills from the specialist to encourage patients in increasing self-efficacy and provide support in finding the motivation necessary for self-management. (Pilv et al., 2012). The patients' unwillingness to change may be frustrating for the health care workers and may neglect lifestyle counselling deeming it inept (Jallinoja et al., 2007).Nurses have pointed out that due to a high work load they have less time to deal with questions regarding lifestyle changes while remaining confident in their counselling skills (Carlfjord et al., 2012).

Lifestyle counselling could reduce illnesses and mortality due to cardiovascular diseases and diabetes and lifestyle counselling should be offered to people who have a potentially unhealthy lifestyle (Carlfjord et al., 2012).According to Lambe et al. (2008) providing information and educating are the main methods in lifestyle counselling. According to Hörnsten et al. (2014) the methods used in lifestyle counselling are often nurse centred and presume the patient's compliance. Such traditional approaches are outdated and patient centred methods should be preferred. Sargeant et al. (2008), Brobeck et al. (2014) and Wermeling et al. (2014) find that a motivational interview could be a suitable method for lifestyle counselling.The method of motivational interviewing is a scientifically tested counselling method (Rubak et al., 2005), which lays the responsibility of change on the patient and the counsellor must respect the patient's autonomy and accept their decisions (Nes and Sawatzky, 2010;Brobeck et al., 2011).

Many patients have unprecedented expectations regarding primary level health care believing in fast solutions, however in reality the ability to make behavioural changes takes time to develop and it is difficult to maintain the new behaviour (Carlfjord et al., 2012). There were differences in the patients' expectations between lifestyle counselling and what they experienced during the counselling. Mostly patients experienced that they were forced into a routine while they were anticipating acknowledgment for their behavioural changes. Counselling sessions would be more useful for the patients, if this exceeded advice and were encouraging while focusing on the patient's needs. (Miller & Marolen, 2012).

This research is focused on lifestyle counselling in family practices. As in family practices counselling is performed by both nurses and physicians, counselling is looked at irrespectively from the practitioner. Fleming & Godwin (2008) claim that from the viewpoint of the efficiency of the counselling, there is no difference if it is provided by a nurse or a physician. Van Dillen & Hiddink (2014) add that the nurses' role in providing lifestyle counselling for dealing with chronic illnesses is increasing in importance.

This research helps explain the patients' viewpoints regarding lifestyle counselling to enable patient centred and efficient lifestyle counselling at family practices. The collected data gives the nurses an opportunity to better understand the needs and expectations of the patients and through that develop the counselling style in the nursing practice. A greater awareness of aspects connected with lifestyle changes would enable support to the patients' endeavours in making changes to their lifestyle and consider the patients' needs in the counselling process.

2. The Study

2.1 Aim

The aim of this study was to describe patients' experiences and needs with lifestyle counselling in Estonian family practices.

2.2 Design

This research is qualitative, empirical and descriptive. The qualitative research method is used in describing the individuals' experiences and giving them meaning (Burns & Grove, 2001: 61). In qualitative research, a phenomenological approach is often used (Burns & Grove, 2001: 65; Morse & Field, 2006: 20). The aim of the phenomenological method is to describe the researched subject in depth through understanding the experiences of the subjects in which the subject and the researcher are equal partners in a deep conversation (Burns & Grove, 2001: 66; Morse & Field, 2006: 20). This research is based on the phenomenological approach and a qualitative descriptive research method, the research describes the patients' experiences and needs which are researched from the viewpoint of the patients.

2.3 Sample / Participants

The sample of this research was chosen from a group of patients who had experiences with lifestyle counselling in family practices. According to family nurses' job instruction in Estonia(The work instructions…2016 § 5, Family physicians` quality system... 2015), they should have counselling appointment with patients who suffer from type II diabetes or hypertension and patients who belong to the risk group of cardiovascular diseases, whose SCORE (systematic coronary evaluation system) risk is over 5% (Conroy et al., 2003). This was the basis for the research sample, in addition to the previous, the selection criteria for the patients included Estonian language skills and age over 18.The participants were chosen from the two family practices' patient listsinNorthern Estonia – one practice in town and the other outside the town. To find participants, heads of both family practices were asked to provide the lists of patients with type II diabetes, hypertension and patients with a risk above 5% SCORE and the researcher contacted them by phone to make an appointment for the interview.

2.4 Data Collection

In this research information was collected through semi-structured interviews (Table 1). All interviews were recorded, transcribed at the first opportunity and coded. Recruitingthe participants and data collection took place between May 2015 and September 2015 mostly in family practices. On two occasions the interview was conducted upon request at the participants home. After 15 interviews, no new information was received and a saturated database had been created.

Table 1. The Questions of Semi-structured Interview

I The respondent's data	- Age - Gender - Area (town or countryside) - Health problem (chronic disease or high cardiovascular risk)
II Introductory questions	- What does lifestyle counselling mean to you? - In which areas have you received lifestyle counselling? - In which areas would you need lifestyle counselling the most? - Who has advised you on lifestyle issues?
III Experiences about lifestyle counselling	- What experiences do you have from lifestyle counselling? - How do you feel about lifestyle counselling? - What changes have you made because of lifestyle counselling? - What have been the supporting factors for you in making your lifestyle changes? - What did you like about counselling? - What did you dislike about counselling?
IV Needs for lifestyle counselling	- What are your expectations regarding lifestyle counselling? - What is important for you in lifestyle counselling? - What would you want your nurse/doctor to ask you about your lifestyle? - How can a nurse/doctor be able to support you in changing your lifestyle? - Describe what you think is ideal counselling?

2.5 Ethical Considerations

Permission to conduct the study was obtained from the Human Research Ethics Committee of the University of Tartu (Approval nr: 247/T-10). Participants were required to sign a written informed consent at the beginning of each interview. Participants were instructed that participation was voluntary and anonymous and they had the right of withdrawal. Anonymity was guaranteed by using codes not names of the participants. The codes were known only to the researcher (K.K). Audio records of the interviews and the digital transcripts were saved on a password protected PC. Participants had no contact with each other and there were no unauthorized persons present during the interview.

2.6 Data Analysis

This research used inductive content analysis for analysing the data as there was little prior information on the researched subject. Broader comprehensions corresponding to the interview questions were simplified and the simplified expressions were grouped, based on which substantive codes were formed. Substantive codes in turn formed subcategories. Subsequently the whole interview was reread to make sure that all broader comprehensions corresponding to the interview questions had been included and fitted in the given subcategory. The last stage was abstraction because of which subcategories were grouped into general categories which in turn were focused under main categories. The category formation process is indicated in Table 2.

Table 2. The Categories Formation Process

Idea from the database	Substantive codes	Subcategories	Categories	Main Category
„…in my opinion they are very friendly all the time.“ "... this person himself was very warm and friendly..."	Friendliness	Experiences with counsellor`s personality	Experiences with a counsellor	Patients' experiences about lifestyle counselling
„…doctors and nurses are so attentive…“	Attentiveness			
"I think this has been the main thing that has just been found what needs to be changed."	Need-based counselling	Experiences with counsellor`s professionalism		
"...these counsellors are very helpful and they can talk very well and can give you advice ..."	Skilled talking			

2.7 Validity and Reliability / Rigour

The reliability of the research was guaranteed by the connection between the database and the results were highlighted through authentic quotations from the data sheet. In the presentation of the quotes it was made sure that no person's or location names were mentioned so that the participants could not be identified through the quotes. In order to guarantee credibility, an analysed unit of suitable length was selected and to guarantee dependability, it was made sure that the survey period was not too long and that all the participants corresponded to the same thematic domain.To guarantee the reliability of the categories, the researcher (K.K.) referred to the raw data and read through the whole interview several times to guarantee that all broader comprehensions corresponding to the research subject was included in the categories. During the data analysis period, there were several meetings with the other author (T.T.), during which the phrasing and compatibility with the categories was discussed. The categories were presented to a nursing specialist to get an assessment of their comprehensibility and logic.

3. Findings

The research included a total of 15 subjects: 7 males and 8 females. The youngest was 38 and the oldest 83. The average age of the participants was 62.6 years. 6 participants lived in the town and 9 in the countryside. 9 participants had been diagnosed type II diabetes, 4 had been diagnosed with hypertension and 2 participants had high cardiovascular disease risk (according to SCORE assessment $\geq$ 5%),whohad high total cholesterol level and were smokers.

In order to illustrate the results, the participants' quotes have been presented for all subcategories with each quote accompanied by an identifying code, which represents the area and the order number (T1 – 1st interview in town, C2 – 2nd interview in the countryside). The database was based on two main subjects – the patients' experiences in connection with lifestyle counselling and the patients' needs in connection with lifestyle counselling.

3.1 Patients` Experiences about Lifestyle Counselling

The patients' experiences in regard to lifestyle counselling are explained in Table 3.

Table 3. Patients' Experiences about Lifestyle Counselling

Subcategories	Categories	Main Category
Experiences with counsellor`s personality	Experiences with a counsellor	Patients' experiences about lifestyle counselling
Experiences with counsellor`s professionalism		
Experiences concerning personal responsibility	Experiences as a counselling service recipient	
Experiences concerning feelings		
Experiences concerning motivation		
Experiences concerning obstacles		
Experiences with organisation of consulting	Experiences regarding the counselling process	
Experiences with counselling topics		
Experiences with counselling effectiveness		
Experiences of inefficient recommendations		

3.1.1 Experiences with a Counsellor

It was pointed out that an interpersonal match and compassion were important. The subjects found that the counsellor is an expert who can be trusted, who finds time for the patient and gives options to choose from. But some patients had experienced their problems were not delved into and they felt lack of counsellor`s motivation. They claimed that there is no time to delve into the person but only the results of the treatment."... nobody really has the time to delve deeper, I believe that treatment is achieved but it is not possible to deal with people /.../ at least nobody has been able to find the motivator button for me ... yet." (C8)

3.1.2 Experiences as a Counselling Service Recipient

All respondents described different aspects of experiencing personal responsibility. The patients acknowledged that health problems were the result of an unhealthy lifestyle and felt responsible for changing the lifestyle. Some patients admitted that in order to make changes in one's lifestyle they have to first think it through and be themselves ready for the changes.They experienced that the counsellor does give advice but the final decision is made by the patient.

"... still, a conscious approach to things. That knowledge that it may end very badly unless nothing is changed. /.../ That I have made and eaten me sick and me myself must get over this and deal with it." (T3)

Most of the respondents were motivated by the support received from people close to them – mainly close family, but also friends. The respondents admitted that only a serious need would force to make changes while the good feeling and normalized test results from the changes give motivation to continue with the new habits.

"What motivates is that I still must go, as I have been feeling a lot better if I do all that, what I really must do..." (C2)The patients had also different obstacles – they mentioned lack of time or laziness, lack of regularity and loss of continuity. Some patients also claimed that due to a lack of motivation, the old habits continue. "... at the moment, I really don't know what I want. If I knew in which direction to run or what to run towards, then I would run, but /.../ for me this motivating myself is one of the biggest secrets in the world." (C8)

3.1.3 Experiences Regarding the Counselling Process

Patients were not exactly aware of the role and work roles of the health care workers.

Patients had received counselling from both nurses and doctors, some patients claimed that the nurse counsels more than the doctor while it was the opposite for others. Based on the patients' experience counselling takes place during other conversations as the time of the visit is limited and taken up by a specific problem. Some patients mentioned that the nurses' recommendations were regard procedures, not lifestyle.

"I cannot imagine, what rights or obligations the nurse has, or how wide her domain of responsibility is /.../ then I would rather go to a doctor than a nurse, when I go to a nurse, then it becomes clear that I still have to go to a doctor and I don't have time for that." (T2)

Most of the patients believed that counselling covers diet and exercise, but many respondents believed that counselling meant reassurance. Active listening and encouragement had a reassuring effect on the patient which in turn improved wellbeing.

"But that the doctor or the nurse, whomever they were, I don't remember their name, knew how to talk well and calm me down ... and ... and ... I understood that I was no unique case, but it is common nowadays." (T2)

As a result of the counselling patients had made various changes to their lifestyle. The main changes the patients made were corrections to their diet and exercise. Getting medical indicators under control was considered to be an important result of the counselling. Many subjects also indicated an increase in willpower, improved wellbeing and achievement of self-confidence.

"... at the moment, my sugar is under control ... all thanks to guidance and advice /.../ this way I have managed to control my sugar, so at the moment there are no problems at all..." (C2)

Some patients had also experiences of inefficient recommendations – they claimed that the recommendations were too generalized and were not justified. Patients were not motivated by mere sharing of information and in the case of excess information it was difficult to memorize the essentials.

"... often, I say, I have often heard things that are not explained. They say that eat this and eat that, but they don't explain why. This bothers me, because I will not start doing things unless I know why they are necessary." (T4)

3.2 Patients` Needs about Lifestyle Counselling

The patients' needs in regard to lifestyle counselling are explained in Table 4.

Table 4. Patients' Needs about Lifestyle Counselling

Subcategories	Categories	Main Category
Needs for competent counselling	The needs concerning professionalism	Patients' needs about lifestyle counselling
Needs for comprehensive counselling		
Needs for specific recommendations		
Needs for well-organised consulting		
Needs for a relationship based on trust	The needs concerning individuality	
Needs for a caring attitude		
Needs for a personal approach		
Needs for creating motivation		

3.2.1 The Needs Concerning Professionalism

Most patients considered it important that the counselling should be productive and would be based on the patient's needs. Patients deemed regularity of counselling essential, because they believed that a single visit has no effect. Patients noted that the first session of counselling is the most important and that in the beginning counselling should be more frequent and later take place at a certain frequency. Patients deemed it necessary that the counsellor should be unbiased and competent, for that one must constantly train themselves and not give wrong advice.

"... this counsellor must be a real professional, that they know all of these things, that they don't give a flawed recommendation, because if one counsellor gives a wrong recommendation to a hundred people, the result would be catastrophic. /.../ Really, a job with a lot of responsibility, you cannot give wrong advice." (T4)

For most respondents, the ability to cooperate was necessary – that meant the skills of approaching people, listening and asking questions. Patients have noted that it is necessary to focus on the positive and they stressed that the counsellor should not give personal assessments.

According to patients, alternatives must also be recommended, because offering a choice would make it possible for the patient to select the most suitable way for changing their lifestyle. Many respondents pointed out that it is important to reach the cause as dealing with the consequences does not remove the cause of the problems.

"Yes, because if you reach the roots, because there is where it all begins. Because if we just caress something, then what good does it do? /.../ but what were the causes and how it happened, this isn't talked about much." (T2)

Patients have needed diet related counselling the most, exercise related counselling was required less than dietary. Patients felt a lack of a connection between the size of portions and injecting insulin, they also needed more information on balancing their diet. Many patients also required counselling regarding medication, both pills and injected.

"... but does this injecting go only in accordance with that food or your measurements, maybe I eat and I don't have it so, that I need to inject that much because when you over inject, the sugar goes down ..." (C7)

Some patients have required stress relief counselling. They deem calming and stress relief to be essential prerequisites for making lifestyle changes.

"... I think that the human nervous system is also a part of the lifestyle. Maybe the first thing to do is to calm a person down to help them get over their nervousness and only then start developing the conversation toward changing the lifestyle." (T1)

Many respondents found that a separate person is required for the counselling. Some of the subjects believed that personal counsellors would be necessary in order to guarantee thorough personal counselling and it was stressed that counselling should be voluntary.

"... perhaps it should be so, that a family health centre has a diabetes nurse or ... who specialises in it /.../ perhaps there should really be some specialised counsellor in a family practice to deal with them ..." (T3)

According to patients the implementation of technology would aid in the better organisation of counselling. Examples of technology implementation were web based programs, voice recordings, information exchange via email but also smart watches and phone apps.Many respondents found that one suitable form of counselling would be group counselling which would help use both time and human resources more rationally and patients could share their experiences within the group.

"Another thing is that perhaps counselling depends on the person, around two-three people could so to say converse with the counsellor and also not so that one lectures and the others. /.../ Well and also not in a big group..." (C4)

3.2.2 The Needs Concerning Individuality

Many respondents valued a trusting relationship, warmth and keeping eye contact. In the case of a trusting relationship it would then be easier to cover also unpleasant subjects.Patients also needed to be accepted as they were.

"It is very important, well especially, young people don't notice it, but the older you get the more you need that warmth and that you are taken the way you are. /.../ But when I go to the doctor's, the doctor should look me in the eye, the same as the nurse, the nurse looks me in the eye, does not deal with her own things, but listens to me." (C3)Most respondents believed that each person is different and the counsellor should approach each person separately. Patients see intuition and communication skills important to determine who needs a softer and who a stricter approach. It was also mentioned that what is important, is not what is being said, but the tone of voice and demeanour of its presentation to the patient. While most of the patients noted that they would not respond well to scaring and commands, then others preferred scaring and very precise instructions and a stricter supervision. Patients also see the necessity of interpreting their test results to make the situation more concrete.

"Perhaps for one person it is one way, the second and third things are different /.../ this is why the approach must be very individual /.../ Everyone has their own style and one must find a corresponding style, I mean that is suitable for that person." (T1)

According to patients the motivation for changes comes when the problem is already dire and in that case the motivation must be improved. Many patients require constant reminders for motivation and for keeping up the motivation regular supervision is required.

"This moment should be used, when a person has a really strong motivation, that now I will start changing my lifestyle, then that person should be given the most support." (T4)

4. Discussion

Patients who participated in the research considered professionalism a very important trait in a health care worker but equally important were the counsellor's personal traits, a thought which is also supported by Walseth et al. (2011), according to whom the patients see the health care worker as a specialist and caring person at the same time while having a motivating effect. Humanity and mutual compatibility were also considered important as that support the creation of a free environment. Also, Persson & Friberg (2009) and Brobeck et al. (2014) have pointed out that patients desired a sincere and open dialogue to achieve mutual understanding. From the professional aspect, the participants noted that the counsellor is a trustworthy specialist while some patients had experienced that there had been a lack of focus and the ability to motivate. The participants themselves put more emphasis on the length of the appointment and workload than a lack of counselling skills. Surely those are important factors, but in addition attention should be paid also to work organisation and the motivation of counsellors.

All participants experienced that they are themselves responsible for changing their lifestyle and for the negative consequences of their unhealthy lifestyle. The cognition of personal responsibility has also been pointed out by several authors (Brown et al., 2006; Persson & Friberg, 2009; Miller & Marolen, 2012; Brobeck et al., 2014;Wermeling et al., 2014). Patients in the research have experienced that while the counsellor gives advice, the patient is the one making the final decision which also coincides with the position of Carlfjord et al. (2012) that the nurses should accept the patient's autonomy as the decision to change is made by the patient.

Most of the participants have been motivated by support from their close ones, while also contradictory experiences have been mentioned relating to that support – in the research of Wilcox et al. (2010) and Brobeck et al. (2014) it was pointed out that social support could prove to be a hindering factor. The researcher agrees with the viewpoint that despite the need for support from close ones, their over caring may cause tensions and it is simpler to find an open contact as a neutral bystander that could very well be a health care worker.

Patients acknowledged that one must be ready for the lifestyle changes in order for the health care worker to even help. Hence comes an important cause to why counselling might not always be effective, as Jansink et al. (2010) claim that nurses have trouble determining the patient's level of change. If the counsellor sets expectations that are too high for the patient for which they are not ready yet, then this will cause resistance. Thus, it should be necessary to offer health care workers training based on motivational interviewing techniques, which would make it possible to assess the patient's level of change and from there, offer suitable and appropriate support in moving forward at that level of change.

According to Nes & Sawatsky (2010) the method of motivational interviewing helps patients overcome ambivalence and resistance to change and thus shape the change of their behaviour. For this purpose in Estonia has been createdEstonian Motivational Interviewing and Training Association (EMITA), which offers trainings among others also for family nurses and family doctors (EMITA, 2017). Until today more than 500 primary health care specialists have passed at least the basic course of motivational interviewing.

Different obstacles have been mentioned that hinder the implementation of changes. Patients who participated in the research named laziness and a lack of time as excuses and the disappearance of consistency and lack of motivation as impediments. Also, Miller &Marolen (2012) claim that the main barriers in changing one's lifestyle the patients experienced were lack of time, lack of motivation and laziness. Here again the need to have motivational interviewing training that would teach health care workers how to bring forth the motivation in patients and enhance it. According to Rollnick et al. (2008) it does exist in the patient; the health care worker's task is to bring forth that hidden motivation. In order to make persistent life changes, it would be necessary to guarantee the continuity of support in the work process so that the counselling would not remain a onetime appointment. Regarding the organisation of counselling the participants pointed out that they didn't exactly know what the nurses' scope of responsibility is which could also be the reason why patients would prefer an appointment with a doctor rather than a nurse.

It was pointed out that conversations with nurses were mostly on lifeline subjects and the nurses' recommendations regard procedures. Nurses could deal more with lifestyle counselling because as Van Dillen&Hiddink (2014) claim, the nurses' part in lifestyle counselling for dealing with chronic disease is constantly increasing.

New information from the research that hasnot been mentioned in other researches was participants pointing out calming as a part of counselling. The importance of the subject is emphasised by the fact that there was a need for stress relieving counselling as patients considered calming and stress relief to be important prerequisites for making lifestyle changes.

Patients who participated in the study had also experiences with ineffective recommendations. The patients experienced that the recommendations were general knowledge which was not justified and that just giving out information is not motivational. This is important information as based on literature, mediating common knowledge information does not lead to changes (Poskiparta et al., 2006;Lambe et al., 2008; Strong & Nielsen, 2008;Wermeling et al., 2014). Thus, more efficient patient centredcounselling methods are required which is also confirmed by Poskiparta et al. (2006) and Hörnsten et al. (2014). A motivational interview could be a suitable method for implementation in lifestyle counselling as also Sergeant et al. (2008), Brobeck et al. (2014) and Wermeling et al. (2014) have pointed out in their research.

Patients considered it important that the counselling be productive and would be based on the patient's needs. It is also claimed by Miller &Marolen (2012), that counselling sessions would be more useful for the patients, if this exceeded advice and were encouraging while focusing on the patient's needs. Patients deem it important that they are acknowledged and stress that the counsellor should not give personal opinions. This has also been mentioned in literature, for example according to Persson&Friberg (2009) patients valued it greatly when they were not treated as culpable but as an equal adult.

The patients have reached an understanding that instead of dealing with the consequences, the most important cause of the problems should be discovered and dealt with. According to patients, alternatives must also be recommended in the course of the counselling. Strong & Nielsen (2008) believe that researching alternatives is also important. They say that this makes it possible to find possibilities and solutions, and achieve changes.

The participants also had different needs in terms of the organisation of counselling. The patients found that a separate person is required for the counselling. One suitable form of counselling would be group counselling which would help use both time and human resources more rationally and patients could share their experiences within the group. As lack of time is mentioned as one of the main obstacles and problems in organising lifestyle counselling, then group counselling could be one solution that would help save time and resources.

Patients believed that establishing a trusting contact was important and also that the trust should be mutual. Patients who have participated in earlier research have also valued the establishment of a relationship based on trust (Brobeck et al., 2014; Wermeling et al., 2014). Patients have needed that the counsellor showed interest in them and kept eye contact. Also, according to Walseth et al. (2011) a good relationship between the patient and the counsellor creates a situation where the patients experience caring and respect in the counselling despite the sensitive subjects. Patients see both intuition and also communication skills as important traits of a caring counselling. Most participants held the position that scaring and ordering would not suit them. Also, the participants in the Wermeling et al. (2014) and Brobeck et al. (2014) researches deemed scaring tactics unfitting. On the other hand, participants in this research and that of Wermeling et al. (2014) said that more precise orders suited them best and according to one interviewee, they needed scaring, but that was an exceptional example. Scaring and ordering should rather be avoided as this triggers reluctance to change in patients.

The participants believed that counselling should take into consideration the peculiarities of patients and that they were accepted as they were. Also, according to Persson&Friberg (2009) it was important to the patients that they were taken as individuals for whom the message was meant in particular. The participants have deemed it necessary that their analyses results be interpreted, which has also been pointed out in the literature – according to Persson&Friberg (2009) and Walseth et al. (2011) the patients wished numeric information regarding their cholesterol, blood sugar and blood pressure levels to make the problem more concrete and emphasise the seriousness of the situation.

According a patient, the motivation for changes comes when the problem is already dire and in that case the motivation must be improved. The seriousness of a problem as a motivator was described also by Persson&Friberg (2009), Walseth et al. (2011) and Vermunt et al. (2011) according to whom increased values of the analyses made patients think of the need for changes. In counselling, it is important to offer information in measurable numeric units, for example the body mass index, waist circumference, body fat percentage, blood pressure, cholesterol and blood sugar analyses values that would enable the patient to understand different health risks and their seriousness, and this would be the common factor for increasing motivation.

The opportunity for implementing the research results into practice is in the implementation of the research results into the higher educational institution's curriculum where one of the researchers works as a lecturer at the nursing chair. The importance of integrating lifestyle counselling teachings into the nurses' curricula and additional training of practicing nurses as also been pointed out by Jallinoja et al. (2007) and Parker et al. (2010). Here it is important not to forget additional training for experienced nurses, because as Jallinoja et al. (2007) and Parker et al. (2010) claim that nursing students and novice nurses may have better counselling experience than experienced nurses which may also be confirmed based on personal experience as a lecturer. We agree with the aforementioned authors' viewpoint that the cause here is the changes in the nurses' curriculum – during the studies of nurses who graduated earlier, lifestyle counselling was yet to be integrated into the curriculum. The authors of this research second the opinion of Jansink et al. (2009) that a onetime counselling training is not sufficient and in order to achieve effective counselling, additional training, supervision and application programmes on the job are necessary.

Implications for Future Research

In the future work organisation should be researched in addition to health care workers' counselling abilities, how it would be possible to allocate more time to lifestyle counselling at family practices, as often the lack of time resources is emphasised as an impediment. Many participants of the research claimed that due to limited time, the counselling takes place in-between other activities, which is also confirmed by the claim of Kettunen et al. (2006) that a busy schedule creates superficial advice which is not useful.

Limitations

One of the limitations of the research would be that in order to reflect different experiences, the sample was chosen from both patients suffering from chronic illnesses (type II diabetes, hypertension) caused by unhealthy lifestyles and also patients with a high risk (SCORE $\geq$ 5%) of cardiovascular disease, who had not been diagnosed with cardiovascular disease or diabetes. However, patients with high cardiovascular disease risk (SCORE $\geq$ 5%), had less experiences in lifestyle counselling than other interviewees and lacked a vision regarding their future needs in counselling.

In a qualitative research, another limitation would be that the results cannot be extended to all family practices or other primary level health care areas where lifestyle counselling also takes place. Despite that the authors of the research hope that the health care workers of other family practices and lifestyle counselling specialists on the health care primary level can get ideas and advice on improving counselling services.

5. Conclusion

The counselling process is affected by the counsellors' and patient's experiences and the counselling process starts with the establishment of a mutual relationship. Younger patients pointed out that there was no focus and their needs were not attended to. Older people were more content as for them the doctor is an authoritative figure, whose orders must be obeyed. From this arises the need for a personal approach where in addition to the patient's health condition also their age should be taken into consideration.

It could be acknowledged that calming is one important subject in counselling. This has not been indicated by earlier research. As health problems cause enough concern for the patient already, the counselling should not add the stress and worries but should instead be calming. Also, we should understand the difference of patients – some of them need concrete advices while others would not have been content with such commands. This aspect should also be taken into consideration in counselling. Counselling must be patient-centred, based on patient`s needs and individual peculiarities and should not be general. The aspect of consistency should also be taken into consideration in planning the counselling as regular contact is needed for keeping up the motivation.

In order to guarantee consistency, the next appointment should be made and the process continued from where it was last left off; interest should be shown in the patient's progress between the appointments.

As one of the obstacles mentioned in lifestyle counselling is the lack of time resources, then time should specially be planned for such appointments. In the counselling, it is important to focus on listening to the patient and understanding their needs. Whenever possible, more time should be allocated for counselling and also group counselling should be considered which would help save both time and human resources. Based on the patients' experiences mere talking is not sufficient, their motivation must be found and strengthened. In order for counselling abilities to favour patient centred nursing aid, it is continually necessary to enhance the counselling abilities through motivational interviewing methodology based counselling training.Also regular feedback from patients in everyday work would be a great help to counsel the best way and consider the patients` needs.

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Conflict of Interest

The Authors declare that there is no conflict of interest.

Author Contributions

KK conducted the interviews, analysed the data and wrote the manuscript.KK and TT designed the study and TT contributed to analysis and discussion of findings. RK supervised the manuscript. All authors read and approved the final manuscript.

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