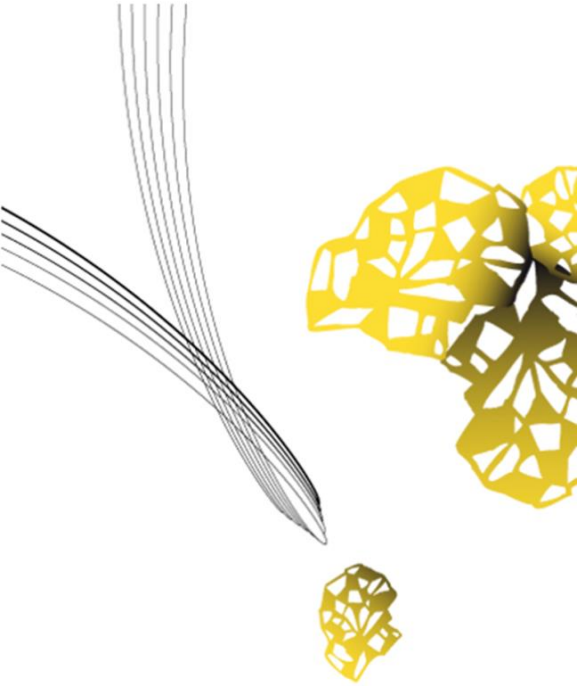

UNIVERSITY OF TWENTE.

Faculty of Behavioral, Management and Social Sciences

What are the experiences, needs and wishes of GPs and POHs regarding the strength based approach for the care of chronically ill patients? A qualitative analysis.

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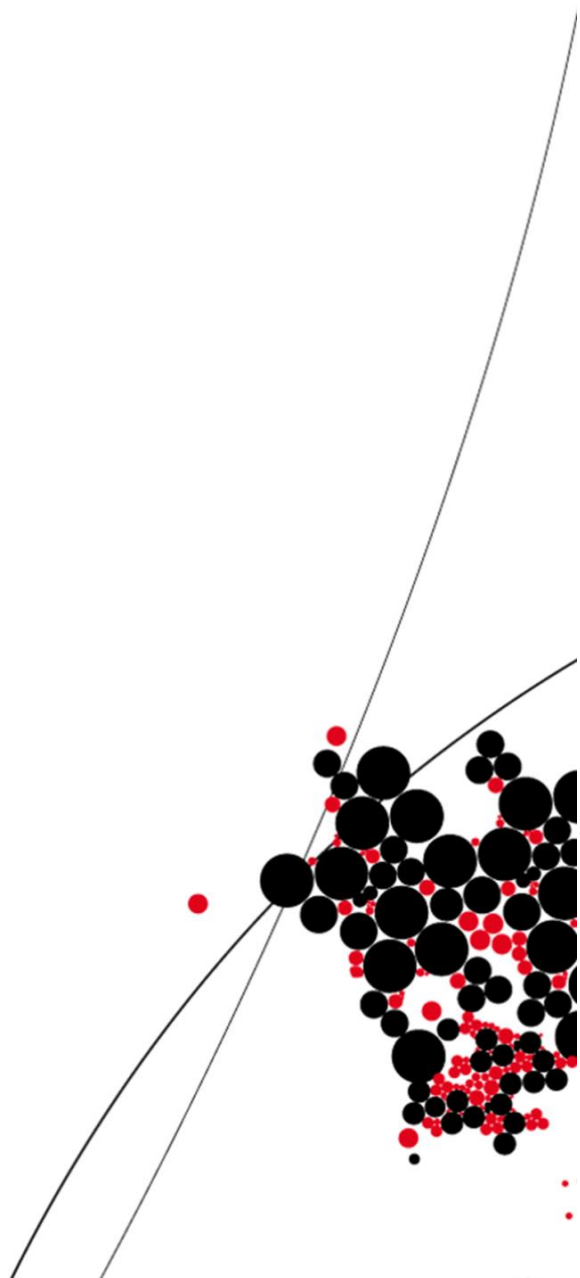

THE STRENGTH BASED APPROACH FOR CHRONIC DISEASE PATIENTS IN GENERAL PRACTICES IN THE NETHERLANDS

Abstract

Objective: The objective of this research was to analyze the experiences, needs and wishes of general practitioners (GPs) and nurses (POHs) regarding the strength based approach for the care of chronically ill patients in general practices in the Netherlands.

Background: In the care for chronic disease patients in the Netherlands, general practitioners (GPs), mental health nurses ('praktijkondersteuner geestelijke gezondheidszorg'-POH GGZ) and nurses specialized on somatic complaints ('praktijkondersteuner somatiek'-POH somatiek) experience various difficulties. They seem to need support in how to foster the patient's self-management, motivation and self-reliance. For the patients themselves, a focus on individual preferences, needs, goals and resources seems to be desirable. Patients' goals, preferences, skills, talents and positive attitudes are emphasized in the strength based approach.

Method: The data used, consisted of semi-structured interviews with 10 GPs and 12 POHs. A content analysis has been executed. Analyzed were: 1. The elements of the strength based approach that are already being used, 2. The preferences of the participants regarding a possible design of the strength based approach for chronic disease patients in general practices and 3. The support that the participants would need to be able to execute the approach.

Results: The outcomes showed that all GPs and POHs seem to use some elements of the strengths based approach, but do not apply the whole strengths based approach nor do they use it in a structured way. Following the preferences of the healthcare professionals, the strength based approach would be implemented in the form of an individual approach, mainly carried out by the POH GGZ. To be able to execute the strength based approach, participants reported to need a framework they can follow, tools to help them identify the patients' strengths and a preparational training with explanations and practical exercises.

Conclusion: Based on the results of this research, an implementation of the strength based approach in general practices for chronic disease patients seems feasible. For the implementation, an extensive preparation of the healthcare professionals seems necessary. Following the results of this research, the POH would gain more responsibility and power in the Dutch healthcare system, whereas the GP undertakes more allocating and coordinating tasks.

Table of contents

List of Figures and Tables

Figures

Tables

1. Introduction

In 2010, 4.5 million people in the Netherlands had at least one chronic disease (RIVM, 2010). A chronic disease reduces the patient's functioning in as well physical, psychological as social domains (Stuifbergen & Rogers, 1997). Based on the research by Härter et al. (2007), is the percentage of people that report to have had a mental disorder within the previous year, almost twice as high among somatic chronically ill patients than people from the general population. Most prevalent in chronic ill patients are affective and anxiety disorders (Härter et al., 2007). One important part of chronic illness care is self-management. Self-management seems to lead to an increase in the autonomy of the patient and to improvements in degree of exercising, symptom management, self-reported health and employment functioning (Lorig, 1999; Schermer, 2009). According to Lorig and Holman (2003), self-management can be divided up into three management tasks: medical and behavioral management, role management and emotional management. Medical and behavioral management includes all tasks the patient has to handle in everyday life that relate to the medical part of the chronic disease management, such as taking medication, adhering to a diet or using an inhaler. Role management refers to the tasks the patient has to perform in order to maintain, change or create new meaningful roles in life, because the old one's might have been affected by the chronic illness. Emotional management refers to managing the emotions that are related to having a chronic disease, such as frustration or depression (Lorig & Holman, 2003). However, the use of self-management seems still to be difficult for many patients and healthcare professionals (Ursum, 2011). The research by van Houtum (2016) shows that in chronic illness care the focus is mostly laid on the medical and behavioural domain of self-management. Patients report to be sufficiently supported regarding this domain of self-management. However, more support seems to be needed in the adaption to a life with chronic illness and coping with the related emotions (van Houtum, 2016). The strength-based

approach could contribute to these domains of self-management. Following the strength-based approach, the patient could be supported to discover his strengths, instead of his deficits, and the focus would be laid on his individual goals, possibilities and resources instead of his limitations. Through this, the patient could create new meaningful roles in life and positive emotions and hope would be fostered (Rapp & Gosha, 2008). One example of how the strength based approach could contribute to role management and emotional management could be the following: A COPD patient must leave his job, because of the limitations due to his illness. He now feels useless and frustrated. His personal goal is to contribute to society. By discovering his strengths sensitivity and commitment and by searching for possibilities to use them, he decides to help in a youth centre in his neighbourhood. By this, he found a new role in life and experiences joy and satisfaction. The patient's role management and emotional management are fostered.

One discussion point that comes along with using the strength based approach in the chronic illness care, is that the personal goals of the patients may differ from the medical goals (van Houtum, 2016). It is still due to research, how the focus on individual goals of the patients, that could positively influence role and emotional management, can be combined with the medical goals, that are necessary for a successful medical and behavioural management of the chronic disease.

While various researches focus on the perspective of the patient in the care of chronic illness (van Houtum, 2016; Penninx, van Tilburg, Boeke, Deeg, Kriegsman & van Eijk, 1998), only few researches consider the views of the healthcare professionals. As healthcare professionals know their way of working and problems they encounter best, this research will focus on their perspectives regarding the strength based approach. Before starting with the analysis, first, it is important to understand how the treatment of chronically ill patients looks like and what problems health care professionals encounter. The healthcare providers that will

be considered in this research are the general practitioners and the nurses, since they take over many tasks from the GP in the chronic illness care.

1.1.1 The role of the general practitioner

A cure for a chronic disease is usually not possible, hence the treatment of chronic diseases is more focused on the maintenance of an enjoyable and autonomous life (Holman & Lorig, 2000). In the Netherlands, every person is supposed to enrol for one general practitioner (GP), who is responsible for the healthcare of this patient and acts as a gatekeeper by referring to specialist when necessary (Daley, Gubb, Clarke & Bidgood, 2013). The treatment of chronic diseases by GPs involves diagnosis and disease dependent evidence based treatment, such as treatment of symptoms and pain and reducing the risk of complications (RIZIV, n.d.).

One problem that GPs are confronted with, is the rising number of patients with a chronic illness due to the aging society (Blokstra, et al., 2007). From 2004 to 2011, the percentage of chronically ill patients, who were older than 25 years and were listed in the NIVEL Primary Care Database in the Netherlands, has increased by 6.9 percentage points (van Oostrom et al., 2016). For the GPs, this means that they have to manage an increasing workload, with unchanged resources and capacities. The proposed solution for this, is to enhance the self-management of the patient. By handing tasks over to the patient, the workload of the GP should be reduced. To achieve this, the role of the GP in the healthcare process must change. At this point, however, many GPs struggle. They are educated to make evidence based decisions and to give solutions to the healthcare problems of the patients. They are not or hardly educated to fulfil a coaching or supporting role (Ursum, 2011). Summarizing this, it can be said that one problem GPs encounter in the treatment of chronically ill patients, is that they do not know how to support the patients the best in their self-management.

1.1.2 The role of the nurses

GPs delegate part of their work to the nurses. In the general practices in the Netherlands, nurses treat patients independently, but on the responsibility of the GP. In the Netherlands, there are two groups of nurses: mental health nurses ('praktijkondersteuner geestelijke gezondheidszorg'-POH GGZ) and nurses specialized on somatic complaints ('praktijkondersteuner somatiek'-POH somatiek). The former is specialized on mental and social support. The latter is specialized on chronically ill patients with physical complaints. In 2016, 88% of all general practices in the Netherlands employed at least one nurse specialized on somatic complaints and in 81%, at least one mental health nurse was hired. In the following, they will be referred to as POHs. 80% of the patients of a POH somatiek are patients with diabetes type 2. 78% are patients with cardiovascular diseases and 69% are patients with asthma/COPD. Regarding the tasks of the POH somatiek that involve contact with patients, they primarily carry out periodical controls for chronic diseases and provide counselling and education (van Hassel, Batenburg & van der Velden, 2016). The role of the POH GGZ in the treatment of chronically ill patients is not clearly specified yet. Some of her tasks are to analyze the psychological complaints, have conversations with the patients and give the patients tasks to carry out at home. The POH GGZ is also responsible for diagnostic investigation, to get to know if referring to a psychologist or psychiatrist is necessary (Huisartsenpraktijk Berkenlaan, 2017).

Many chronic diseases are triggered and maintained by risk factors such as smoking, physical inactivity and unhealthy nutrition (Stuckler, 2008). Therefore, one important task of a POH is to motivate the patient to a lifestyle change, such as to stop smoking or to become more active. From the 161 nurses that were asked in the research by Jallinoja et al. (2007), the majority regards the patients' unwillingness to change always or nearly always as the key barrier to treatment. For the condition 'high blood pressure' and 'adult obesity' 77% of all

nurses stated that the unwillingness to change was nearly always the key barrier to treatment. For Dyslipidemia and Type 2 diabetes this percentage was 72%. The nurses considered the patients' insufficient knowledge of the risks of the condition much more seldom as a barrier to treatment (Jallinoja et al., 2007). This means that nurses seem to need more support in how to motivate the patients.

Furthermore, in the Netherlands, POHs are supposed to treat their patients according to the disease-specific approach of the Dutch care standards and disease management programs. This makes the treatment of patients with less prevalent chronic diseases or with multimorbidity difficult. If the focus would be placed less on the patient's chronic disease type and more on individual goals, preferences and competencies, the care might be improved (van Houtum, 2016).

All in all, it can be said that POHs seem to need support in motivating the patient. A focus on goals, preferences and competencies of the patient could customize the treatment to the needs of the individual patient as opposed to a specific disease type.

The question that appears by reading this, is that if ways of motivating the patient are needed, why then, the strength based approach and not motivational interviewing (MI) should be used. The strength based approach seems better suitable for chronic ill patients, because for chronic ill patients, sometimes, the ambivalence between a current behavior and the patient's values or goals cannot just be resolved, as it is supposed to be done in MI, but alternative goals have to be found that fit with the patients' strength and resources (Hettema, Steele & Miller, 2005; Rapp & Gosha, 2008).

For both GPs and POHs it seems as if they could need more support in enhancing the patient's self-reliance. This shows the research by Elissen et al. (2013) that includes interviews with 27 healthcare professionals (GPs, nurses and managers) involved in disease management for type 2 diabetes in the Netherlands, to assess their perspectives of the level of

and barriers to self-management support in daily practice. In the interviews, the healthcare professionals explained that they still make the decisions regarding what information and skills to teach the patient, rather than to leave this decision to the patients themselves.

1.1.3 The role of the patient

The patients themselves also play an important role in treating their chronic illness. Each day, they make their own personal decisions regarding their daily activities, medication intake, exercise and nutrition. By this, they take responsibility for disease related decisions, this means that to some extent, they self-manage their disease (Bodenheimer, Lorig, Holman & Grumbach, 2002).

However, if the perceived burden of illness, goals and natural resources of patients with a chronic disease are not in balance, they need more support with self-management (van Houtum, 2016). An imbalance could occur for example, if a patient perceives his burden of illness as high, his own resources as low and sets unrealistic goals. Based on these findings, it might be assumed that by focusing on goals and resources of people their self-management could be improved.

Looking at the role of the GP, the POH and the patient in the treatment of a chronic disease, various necessities have been found. The GPs and POHs seem to need support in how to foster the patient's self-management, motivation and self-reliance. For the patients themselves, a focus on individual preferences, needs, goals and resources seems to be desirable. Patients' goals, preferences, skills, talents and positive attitudes are emphasized in the strength based approach.

1.2 The strength based approach

The strength based approach focuses on the innate strength of individuals, and not on their deficits, that exist, regardless of being affected by a difficult life-situation, such as having a

chronic disease. The focus on strengths could rise the feeling of competency and hope within a patient (Lightfoot, 2014). By this, the patient's self-esteem and motivation to pursue one's goals might be enhanced (Ryan & Deci, 2000). Next to that, various researches show that the use of strengths leads to an increase in subjective and psychological well-being, even when adjusted for the effects of self-efficacy and self-esteem (Govindji & Linley, 2007; Linley, Nielsen, Gillett & Biswas-Diener, 2010). Next to that, by discovering one's strengths, possibilities of contributing to society and building a social network can be identified (Rapp & Goscha, 2008). This in turn, could help the patient to create new meaningful roles in life. This can lead to acquiring power, access to resources and control over one's own life (Robbins, Chatterjee & Canda, as cited in Pulla, 2012, p. 56). In the strength based approach, problems are not overlooked but rather observed from different angles, namely by discovering, activating and valuing the inherent and environmental resources of individuals or groups (Pulla, 2012).

Characterizing for the strength based approach is firstly, the use of personal strengths and community resources to achieve the personal goals of the patient. Secondly, the professional-client relationship and thirdly, the fact that the client makes the decisions regarding the healthcare process (Rapp et al., 2006; Rapp & Goscha, 2008).

The definition of the strength-based approach that has been presented to the participants in this research, is the following: According to the strength-based approach, every person has strengths. It is possible, that the strengths are no longer or only partially visible due to several factors, such as being affected by having a chronic disease and struggling with its consequences. Following the strength-based approach, the person learns what his or her strengths are and how these strengths can help him or her in burdensome situations. Next to that, the person learns to use the strengths to achieve his or her goals.

1.2.1 Effectiveness

The strength based approach was firstly developed and implemented in the field of mental health. Since then, the strength based approach has been implemented in other fields, such as in the care of elderly people or social work (Brun &Rapp, 2001). Growing empirical evidence shows the effectiveness of the strength based approach (Rapp & Sullivan, 2014). For instance, the results of a controlled clinical trial of strength-based case management (SBMC) for people with substance abuse issues, over a period of nine months, has shown that SBCM, provided during after care treatment, led to decreased drug use, fewer criminal acts and enhanced employment functioning. Furthermore, SBCM led to a maintenance of after care services (Siegal, Li & Rapp, 2002; Siegal et al., 1996). This is especially noteworthy, because many drug addicts' drop out from drug abuse treatment (Ball, Carroll, Canning-Ball & Rounsaville, 2006). Next to that, it has been shown that clients experience the focus on strength and the relationship with their case manager as decisive to persist in treatment (Brun & Rapp, 2001). Based on nine studies that tested the effectiveness of the strength model, applied in a population of psychiatric patients, a general positive effect has been found. The studies showed a positive effect on hospitalizations, housing, employment, reduced symptoms, leisure time, social support and family burden. Especially a reduction in symptoms and enhanced quality of community life have been found (Rapp & Gosha, 2008). However, the field of strength based approaches is still a relatively young field and more research, especially regarding its implementation in the field of chronic diseases, is still necessary. No research outcomes seem to be available yet concerning the use of strength based interventions in general practices.

1.3 Designing a strength-based intervention: importance of stakeholder opinions

Based on the above outlined argumentation and outcomes of earlier researches, an implementation of the strength-based approach in general practices seems desirable for the

healthcare of chronically ill patients. It has been shown that the transition from research outcomes into practice can be a slow and uncoordinated process. In the United States, on average only half of evidence based healthcare practices are actually used in practice (McGlynn et al., 2003). To ensure a successful implementation of a new intervention, such as the strength-based approach, it seems important to include the healthcare professionals early in its development. Unfortunately, no research outcomes are available regarding the question if interventions in the field of healthcare are more effective when the opinions of the healthcare professionals were taken into account during the design of the intervention, then when they were not taken into account. However, it seems a promising strategy, because the healthcare professionals know their way of working and characteristics of their patients best and can contribute to a design that fits best with these aspects. Furthermore, only by doing so, it is ensured that they can use the intervention effectively in their everyday work life. This could also increase the involvement of the healthcare professionals. Consequently, this might improve their attitude and acceptance regarding the new intervention (van Gemert-Pijnen, Peters & Ossebaard, 2013). The objective of this research is to enlighten the experiences, needs and wishes of the GPs and POHs concerning the strength based approach. Therefore, the participants have to be studied individually and the data has to be analyzed qualitatively (Keele, 2012). Semi-structured interviews with GPs and POHs have been conducted and a qualitative content analysis has been executed.

1.4 Research questions

Main research question

1. What are the experiences, needs and wishes of GPs and POHs regarding the strength based approach for the care of chronically ill patients?

Sub questions

1.1 What elements of the strength based approach do GPs and POHs already use?

1.2 How could the strength based approach be implemented in the treatment of chronic diseases in a general practice from the point of view of GPs and POHs?

1.3 Which support do GPs and POHs need to be able to implement the strength based approach in practice?

2. Methods

2.1 Participants

The interviews of 10 GPs and 12 POHs were included in this research. One POH GGZ was male, all other POHs were female. Three GPs were male, the other seven were female. The participants were working in a general practice between one and a half year and more than 20 years. The detailed distribution can be found in table 1. Regarding the educational background of the participants, it can be said that some of the GPs have specializations, such as palliative care or diabetes. Most of the POHs followed higher education for psychiatric nursing and did specializations in psychological subjects, such as cognitive behavioral or psychosocial therapy.

Table 1.

Demographic characteristics of the participants.

Demographics	POHs (*N* = 12)	GPs (*N* = 10)
Sex		
Male	1	3
Female	11	7
Working in a general practice since		
1-5 years	7	
5-10 years	3	3
> 10 years	2	7

The professionals were informed and recruited by means of an email. This email contained information about the background, goals and the duration of the interview. Participants were included who work as general practitioners, as somatic practice nurse or mental health practice nurse. Professionals were excluded who work shorter than one year in their profession, who don't speak Dutch or can't read. The participants were informed about the goal and the consent of the research by an informed consent. Also, information was given about data privacy and methods of data processing. The participants were asked to sign an informed consent. GP's received 80€ and nurses 50€ per hour of participation.

2.2 Materials

The semi-structured interviews contained 3 topics: general questions, treatment of chronic diseases in the general practice and the strength based approach. The ‘general questions’ referred to specializations and work experience of the participant, generally and in the specific general practice. The topic ‘treatment of chronic disease’ contained questions about the definition of a chronic disease, the treatment of chronic diseases and the participant’s opinion regarding this treatment. Before questions were asked belonging to the topic ‘strength based approach’, the participant was asked if he knew about this approach before the start of the study. Then, the strength based approach was explained by the interviewer and the main principles of the strength based approach were read out and given to the participant. Afterwards, the participant was asked to give his opinion about these principles. Then, the interviewer read out a case study were the main principles of the strength based approach were used and gave it to the participant. The participant was asked to give his opinion regarding the case study. The following questions were related to the actions of the healthcare professional and the characteristics of the patient in the case study. Next to that, the participant was asked to think about how the implementation of the strength based approach could look like in practice and what possible consequences of implementing the strength

based approach could be. Finally, the interview was completed by asking the participant about final remarks and his opinion on the interview. The interviews were conducted in Dutch and lasted approximately 45 minutes each.

2.3 Procedure

This research is a qualitative research and follows the naturalistic paradigm. The naturalistic paradigm suggests that reality depends on the interpretation of each individual and therefore, multiple realities can exist next to each other. To gain insight into these realities and to understand the subjective experiences, needs and wishes of the participants, they have to be studied individually and the data has to be analyzed qualitatively (Keele, 2012). Semi-structured interviews have been conducted by one interviewer (Y.S.v.V.). The interviews were recorded and transcribed.

2.4 Data analysis

A content analysis has been carried out. The focus of a content analysis is placed on the contextual meaning of the text. This research tool is often used in health studies to analyze verbal data (Hsieh & Shannon, 2005). The development of the coding scheme has been guided by the research questions. The coding has been carried out by one researcher. The constant comparison method has been used (Dye, Schatz, Rosenberg & Coleman, 2000). The first transcripts were read and themes brought up by the participants that related to one of the research questions were identified. After no new themes emerged, the themes were compared, organized and categorized into an initial coding scheme. The initial coding scheme has been discussed in the supervision team, resulting in a few changes. The code ‘Identification of strengths’ has been divided up into ‘identification of strengths in conversation’ and ‘Identification of strength by using a tool’ and a different subdivision has been made in the category ‘Number of meetings’. More transcripts were coded according to the initial coding

scheme. Passages that could not be coded with the initial coding scheme were attributed with a new code. Newly added codes to the category 'Elements already used' were: 'Identification of the patients' passion', 'Giving hope', 'Foster the autonomy of the patient' and 'using external resources'. In the category 'Number of sessions' a new division of five codes has been made: 2-3 sessions, 3-5 sessions, 6-7 sessions, 8-10 sessions and 'Number of sessions not limited'. In the category 'Identification of strengths', to the code 'Tools', the sub-code 'Card game' has been added. In the category 'Target group' 6 codes have been added: 1. 'Patients with mild to intermediate psychological complaints (no severe psychological complaints)', 2. 'Patients without comorbidity', 3. 'Patients that are generally motivated to change', 4. 'Patients with at least basic cognitive capacities', 5. 'Chronic disease patients with severe somatic, but no psychological complaints', 6. 'Patients that were recently diagnosed with a chronic disease'. In the category 'Support', to the code 'Guidance' the sub-codes: 'Not specified', 'Tools to use during treatment', 'Instruction video' and 'Scientific background' have been added. Finally, in the same category, to the code training, the sub-code 'Try out the strength based approach for oneself' has been added. This final coding scheme can be found in Appendix A. Afterwards, all transcripts were reviewed and where appropriate, coded again. This process has been continued until new transcripts provide no new information (Hsieh & Shannon, 2005; Elo & Kyngäs, 2008). The codes were grouped according to the research question and profession of the participants (GP and POH). The quotes presented in this thesis were translated into English, the original quotes can be found in Appendix C.

Ethical approval for the interview study was obtained by the ethics committee of the faculty of Behavioral, Management and Social Sciences of the University of Twente, dossier number: 16490.

3. Results

In the following paragraph, the outcomes of the analysis are described. For the various coding categories tables have been made. The tables show which codes have been attributed to the interviews of which participant. The tables can be found in Appendix B.

3.1 What elements of the strength based approach do GPs and POHs already use?

The analysis showed that all 12 POHs and all 10 GPs said that they already use some of the elements of the strength based approach in their daily practice. Three POHs and three GPs mentioned that they have a general strength based mindset, which means that they are convinced that every patient has strengths.

Quote 1 "Everyone has strengths, I do agree with that. Everyone has indeed something that he is good at." (POH GGZ 12)

In the following paragraph, first of all, the elements of the strength based approach that are related to a positive-focused healthcare process are discussed. Secondly, elements that are related to enhancing the self-sufficiency of the patient are elaborated. Finally, elements that are aimed at supporting the patient in his or her healthcare process are explained and a conclusion will be given.

3.1.1 Positive-focused elements

Six POHs and four GPs said that they focus on solutions instead of problems. Three POHs explained that working solution-focused means for them that they focus on the positive aspects in the patients' life. They do this, by asking the patients about moments in their life when they felt better, by asking the patients to name what's still going well or by using the scale method.

Quote 2 "That we, solution focused, like okay it's now like this ... it often works with the scale model from 0 to 10, why is it now a 5 and no 0. And then, they are already going to name positive things." (POH GGZ 4)

Two POHs and two GPs said that solution-focused means that they focus on the present instead of what happened in the past.

Quote 3 "I often work solution focused myself, I never really go deep into the problems and the past unless it is necessary." (POH GGZ 12)

The others, one POH and two GPs, said that they work solution-focused, but did not give further explanations about it.

Four POHs and 2 GPs said to identify the patients' strengths in their treatment.

Quote 4 "I ask the patients what are strengths, what are positive characteristics. If people have survived difficult time periods, what are things that helped you in this. But I am not busy with using them [the strengths] to achieve goals." [POH GGZ 9]

One POH even said to use the card game "Art of living" to help her identify the patients' strengths.

Quote 5 "What I recognize, is the card game. I also have the card game myself, whereby you are first looking for good sides and who in your surrounding ... […What is the name of the card game?] Art of living, or something like that." (POH GGZ 1)

Four POHs and two GPs also have named that they try to give the patient new hope. One POH explained that she tries to give hope by telling the patient from her own chronic illness and how she is now able to live with it. Another POH said that she tries to give hope by telling the patients that she beliefs in them.

Quote 6 "That they [the patients] leave with a bit of hope, that is actually my big goal. And if people say, for me, it does not work anyways, I often hear that, or I cannot do it, then, I always say, I would not be sitting here, if I would not believe it is possible." (POH GGZ 4)

The other two POHs and two GPs have not given any explanations about how they try to give hope. Finally, two POHs and two GPs have mentioned that they try to identify the patients' passions.

Quote 7 "[…] and that you try to open up wells, of which people have not yet… or maybe have forgotten about again. Searching for their passion, that's how I call it sometimes." (POH GGZ 2)

3.1.2 Self-sufficiency of the patient

Six POHs and 3 GPs said that the patients themselves make the decisions that guide the healthcare process.

Quote 8 "[And do you recognize things in your own way of working?] Yes, actually, the fact that my patients themselves have to determine their question." (POH GGZ 1)

Five GPs and 4 POHs mentioned that they identify personal goals of the patients. Five GPs and three POHs said that they try to foster the patients' autonomy. Three GPs and one POH explained that they try to foster the autonomy of the patient by explaining the patients what they can do about the problem themselves and by explaining the value of particular steps in the healthcare process.

Quote 9 "I do talk with patients about what they can do about it themselves." (GP 9)

The other two GPs and two POHs do not give explanations on how they try to foster the autonomy of the patient.

3.1.3 Support mechanisms

Four POHs and three GPs have pointed out that they see the client-professional relationship as very important element of the healthcare process. Five GPs, but no POH, mentioned that they consider how to use external resources to help the patient.

Quote 10 "[...] that you then have a look at, okay what do you like, what are your hobby's, what gives you satisfaction. And what could be, out of a social perspective, a beginning. [...] that is a question of using resources, what are currently the possibilities, the POHs, the social team of the community, employment bureau of the community, that could give some hints where you could still be deployable." (GP 8)

3.1.4 Conclusion

Summarizing, it can be said that the outcomes showed that all participants seem to use some elements of the strengths based approach, but the answers also showed that they do not apply the whole strengths based approach in a structured way. The elements of the strength based approach that were most often mentioned as already being used by the POHs were: a focus on solutions, the patient as the decision-maker in the healthcare process and the identification of strengths. The GPs reported most often to use the elements: identification of goals, fostering autonomy and enhance the patient to use external resources.

Quote 11 "This [the strengths based approach], in itself, is an old concept, and it is definitely often used in psychology and also within the general practice. But, it all happens relatively unstructured. More as a tool, there is not really a fixed guideline or solid protocol of how a person or a group can be guided with it." (GP 8)

3.2 How could the strength based approach be implemented in the treatment of chronic diseases in a general practice from the viewpoint of GPs and POHs?

In the following paragraph, the preferences and ideas of the POH's and GP's regarding the implementation of the strength based approach in the general practice will be discussed. First of all, the task division between POH's and GP's will be explored. Secondly, the preferred number and duration of the sessions will be assessed. Thirdly, the different preferences regarding an implementation as a group or individual approach will be considered. Fourthly, it will be looked at how the identification of strength should take place. Finally, probable selection procedures and target groups will be discussed.

3.2.1 Task division between POH's and GP's

Four POHs and five GPs reported that they think that the GP is the most appropriate to lead the first session of the strength based approach. All POHs and GPs, except one POH and one GP who did not explain their preference, reported two reasons for why the GP is most suited to lead the first session. They reported that the patients, first of all, go to the GP. This means that out of practical aspects, the GP would be the first who could introduce the approach. Furthermore, they reported that the GP has not enough time to execute the whole approach, but however should be included in the approach. They conclude that this problem could be solved by letting the GP execute the first approach, which would only be an introduction and could be done in short time. By this, the patient would get the feeling that the GP and POHs work together and the GP makes part of it and is not excluded.

Quote 12 "I think it's good to have one conversation with the general practitioner about this. And the POH can continue it and then I know that I can get back at it, if that's necessary, but that I know what's going on. If someone then comes to me for another problem, that I know about this part of treatment and that I know where I can refer back to. Then I know the context, otherwise I totally lose the context. I do not think that would be good." (GP 10)

The opinions of the other participants regarding which healthcare professional should execute the first session of the strength based approach differed widely. To get an overview of

the different preferences, the detailed distribution of the opinions of the participants regarding the task division can be found in figure 1 and 2.

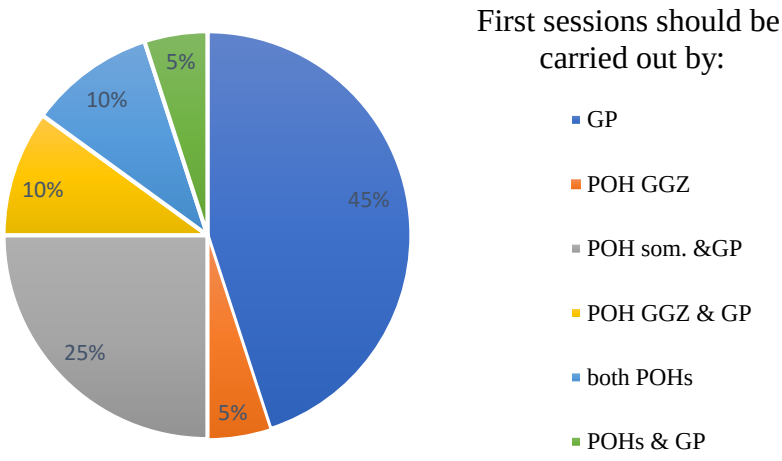

Figure 1. The opinions of POHs and GPs regarding the task division in the execution of the first sessions of the strength based approach.

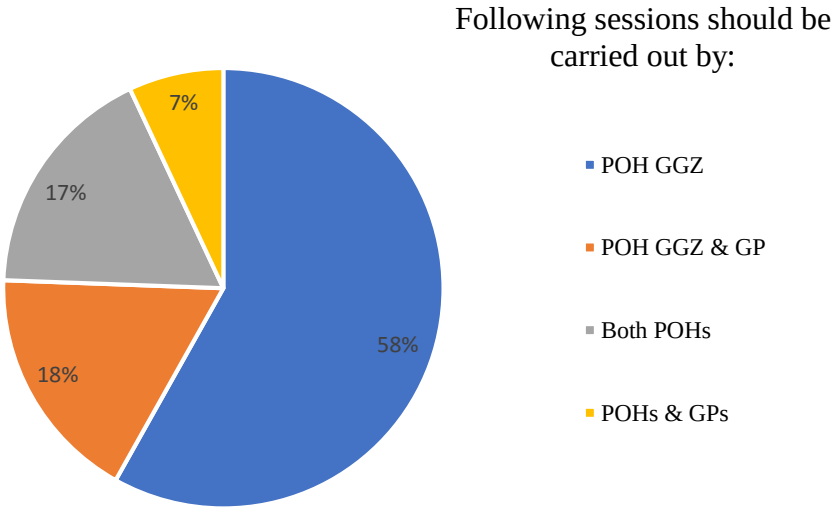

Figure 2. The opinions of POHs and GPs regarding the task division in the execution of the following sessions of the strength based approach.

Regarding the following sessions, the opinions of the participants were more homogenous. Four POHs and six GPs reported that the POH GGZ should lead the following sessions. Only two participants reported reasons for their preference. The first reason

mentioned, was that the POH GGZ has more time per session than the GP or the POH somatiek. The second one, was that the GP and the POH somatiek do not necessarily have the skills, they need to execute the approach. However, it was assumed that the POH GGZ should have these skills. The participant did not exactly specify the skills that he expected to be needed, but generally some of participants seemed to refer to the experience of the POH GGZ of handling psychological complaints.

Quote 13 "The first is, is this work of the doctor or is this another discipline. I think this supposes other skills. I think we can give a boost but cannot do the execution. [...] The welfare coach or the POH GGZ, who looks more at the psychiatric things, can do that very well." (GP 9)

Three POHs also reported that as well the POH GGZ as the GP should lead the sessions, however no GP agreed with this. More generally speaking, it seemed as if the respondents had the wish that the work of the whole practice reflects one approach. They considered it as important that all professionals have and express the same vision.

Quote 14 "If the general practitioner starts to work very problem-focused and then, here we are working strengths-based, that's a bit strange, I think. Perhaps it would be also good to have a session with the GP in between. So, at the beginning and one in between and one afterwards, something like this." (POH GGZ 9)

Another POH reported that she would prefer if POH GGZ and GP work together in this, because by this the GP could gain information about the patient out of another perspective.

Quote 15 "[What does the GP? Does he also lead conversations?] That would be nice, he would then also get some view on the healthy side of the patient." (POH GGZ 11)

As can be seen in table 2, a collaboration of the POH somatiek is reported less frequently. A reason to not include her in the execution of the strength-based approach, was that she has other tasks to handle and therefore less time to engage in this.

Quote 16 "For example diabetes, I see them for half an hour. But there, you have to do the check-ups and discuss the values. All of this." (POH somatiek 6)

A reason mentioned to include her in the approach was that she is especially responsible for chronic disease patients and might already have contact with some of them.

Quote 17 "I think the POH-GGZ, although the POH-S could also do it. They sometimes already have the contact with the chronic patients." (POH GGZ 2)

Summarizing, it can be said that most participants reported that the POH GGZ is most appropriate to execute the strength based approach, but that also the GP should play a role in it. As the GP has less time per patient than the POH, the GP could have an introducing task, while the POH GGZ executes the main part of the strength based approach. Regarding the role of the POH somatiek the opinions of the participants were divided and no clear answer regarding his or her role in the execution of the strength based approach can be given.

3.2.2 Number and Duration of sessions

Five POHs and four GPs reported that 3-5 sessions would be sufficient to execute the strength based approach. Two POHs and one GP considered 6-7 sessions as the optimum and one POH said that 8-10 sessions would be necessary. One POH and one GP assumed that the number of sessions should not be limited to a predetermined number, because it depends on the characteristics of the individual patient how many sessions are necessary.

Quote 18 "It depends a bit on the patient. It seems to me, that it would be more efficient if you have multiple short appointments. For the follow up, that you then have one very long session.

And one patient you have to keep in line, because he abandons more easily than the other one." (GP 10)

Three POHs and five GPs reported that the first session could be carried out in less than 30 minutes. Four POHs, but only one GP said that they think that more than 30 minutes are necessary for the first session. Six POHs and five GPs agreed that the following sessions should not take longer than 30 minutes. Only two POHs and one GP reported that more than 30 minutes would be necessary.

Only a few participants mentioned reasons for their preferences. One reason for a lower number of meetings was that the healthcare in the general practice is not meant for extensive psychological treatment and that the length of treatment is limited by predetermined rules.

Quote 19 "We have a deadline, so we normally see people 3 times and then an evaluation. And in the evaluation, we look at whether we can or cannot, go on with a number of sessions, if that makes sense. And there is also a limit, we do not go on endlessly, we will not do unlimited treatments in the first line. That is not the intention. If it takes so much time then you can ask yourself, does it belong to the POH GGZ." (POH GGZ 12)

Other participants based their preference on the experiences they made with other interventions.

Quote 20: "[what do you mean with 5 steps plan?] That this kind of interventions do not need more than 5 sessions. 5 times half an hour, something like this." (GP 6)

For as well the duration of the session as the number of sessions the interviews showed that the participants seemed to rely their preferences on the duration and number of meetings they normally have or they used to have in earlier interventions. One last reason that

was mentioned, was that the self-reliance of the patient should be enhanced and that therefore, too much time with the healthcare professional would not be helpful.

Quote 21 "Well, she has half an hour per patient. But I think, if you have a concrete plan, you can already get far in 20 minutes. I see that here, if someone has just taken steps, and certainly if you give the responsibility partly to the patient. Then, you do not even need to have so much time for it." (GP 10)

Summarizing, it can be said that most participants reported that 3-5 sessions would be sufficient and that all sessions, except the first one, should not take longer than 30 minutes. Regarding the first session the opinions of the participants differed. However, a slight preference for a duration of less than 30 minutes for the first sessions has been found.

3.2.3 Group vs. individual approach

Six POHs and five GPs reported that they would choose to implement the strength based approach as an individual approach. Two POHs and three GPs justified their preference with the reason that they think that most patients do not want to take part in a group approach and would therefore be difficult to motivate to join the group.

Quote 22 "People do not want to be in a group, they want to have one to one conversations. And as much as we want it, if you have a group, people really do not go there." (POH GGZ 12)

One POH and two GPs reported that they think that in a group, there would be less focus on the individual strengths of the patient. One POH said that in an individual approach there would be more space for emotional topics of the patient. One POH explained that groups are difficult to organize and one GP reported that group approaches take too much time.

Quote 23 "I really do not like the groups-idea, at the moment, they do a lot with this and I really do not like it. It takes way too much time and you need so much time to structure it, so that it actually goes to expanse of the individual patient, in my opinion." (GP 8)

Two POHs reported that they would chose a group approach. Also, one GP said that she would choose a group approach, she specified that she would put 5-10 patients in one group. Reasons for their preference were that they think the group dynamic could help the patients and that they could benefit from each other.

Quote 24 "I'm very pro group at the moment, because otherwise I'm telling the same thing ten times. And because I really believe in the strength of helping each other." (POH GGZ 3)

Two POHs and five GPs reported that they would prefer if the strength based approach could be implemented in a combination of both forms: individual and group approach.

Quote 25 "For chronic patients, yes, if you do it in a group it can have two sides: either they motivate each other, or they start lamenting all together. That's it. Thus, I think, you should first do something individually and on a certain moment it can be done in a group, because in a group they can reinforce each other. "(GP 1)

To sum it up, it can be said that the majority of the POHs would prefer an individual approach. Half of the GPs would also prefer an individual approach and the other half would prefer a combination of group and individual approach.

3.2.4 Identification of strength

Nine POHs and six GPs reported that they would like to use a questionnaire, four POHs and four GPs said they would like to use an app and three POHs and four GPs reported that they would use a website to help identify the patients' strength. Reasons to use a questionnaire were that it provides structure and clear outcomes that could be given back to the patient as a

feedback. Reasons for using an app or a website were that it can be time-saving to use them and that they can be used at home or at work. However, it has been mentioned that they might not be useful for all age groups. One GP reported that they might be useful for the working generation, but not for older patients.

Quote 26 "I think I would use a combination [of questionnaire, website and app] [….] I like all three, because I think with the computer it is also handy, then, people can do it at home." (POH GGZ 1)

One POH said that she would use a card game to identify the patients' strengths. One POH and three GPs reported that they would use the tool before the first session. The reasons that was mentioned to use the tool before the first session, was that by this, the patients could already start thinking about their strengths which might reduce the time they need in the face to face session.

Quote 27 "I think a questionnaire alone is not enough. That you finally also have to come together at one table, but maybe you can reduce their [the sessions'] frequency, by doing some preparatory work." (GP 3)

Two POHs and two GPs said that they would use it after the first session and one POH and one GP said that they would use it during the session. They did not mention reasons for their preferences.

Summarizing, it can be said that the participants reported most often that they would use a questionnaire to identify the patients' strengths, followed by an app and a website. No clear answer can be given to the question at which timepoint the tool should be used.

3.2.5 Selection procedure & Target group

Eleven POHs and five GPs reported that they would select a patient to take part in the strength based approach based on the needs of the individual patient. They reported that they know the

patients best and therefore can decide if the approach would be beneficial for them and if they would be motivated to take part in it.

Quote 28 "[…] that I first get to know the person and then, I think 'yes, maybe this would be something for him'." (POH GGZ 3)

One reported reason for this selection procedure was that simply inviting all chronic patients could cause resistance.

Quote 29 "I think the GP refers to us, because not everyone [with a chronic disease] also has the need to [take part in the strength based approach]. It can trigger resistance, if people are simply invited to something, if you say you belong to the target group of… I would always do that in collaboration with the GP." (POH somatiek 7)

Furthermore, they reported that inviting the whole group of chronic disease patients might cost too much time.

Only one POH and three GPs reported that they would approach the whole group of chronic disease patients and ask them generally to take part in the strength based approach. The reason that was mentioned for this preference, was that if they only ask patients to take part in the approach that they already know, that maybe other patients who would need it, would miss their chance.

Quote 30 "I would prefer to specially invite people and not just people who are already coming to your consult. Because especially with copd you have a very large group of people who do not come. But anyways, there are many people we do not see, from who we know that they do not have it too easy in their life."

Regarding the target group for the strength based approach, two POHs and three GPs reported that they think that all chronic disease patients would be suitable for this approach. They seemed to assume that all chronic disease patients experience constraints and therefore,

all of them would benefit from the strength based approach. Four POHs and two GPs said that chronic disease patients with mild to intermediate psychological complaints would be the most suitable target group.

Quote 31 "[…] I would start with the chronic ill with which we can't go any further. […] Sometimes COPD patients, sometimes diabetics, but it is particularly in the field of mental health care and then, especially mild mental health care, thus not psychiatric." (GP 9)

One POH and two GPs reported that they think that only chronic disease patients that are generally motivated to change should be eligible for this approach.

Quote 32 "[which target group in the group of chronically ill patients would be most suitable for this approach?] They must be open for change." (GP 1)

Other possible groups that have been mentioned were: only stable chronic disease patients (POH $N = 1$; GP $N = 1$), only chronic disease patients with a basic level of self-management (POH $N = 1$), chronic disease patients without comorbidity (POH $N = 1$), chronic disease patients that were recently diagnosed with a chronic disease (POH $N = 1$) and chronic disease patients with severe somatic, but no psychological complaints (GP $N = 1$) and chronic disease patients with at least basic cognitive capacities (POH $N = 1$; GP $N = 1$). The participants did not mention reasons for their suggested target groups, they just assumed that the target group they mentioned would benefit the most from the approach, but did not specify why.

Generally, it can be said that the great majority of the participants would prefer a selection based on their evaluation of the patients' needs. Regarding the target group, it can be said that many different possible target groups have been mentioned. The target group that has been suggested by most participants was 'Chronic disease patients with mild to intermediate psychological complaints', followed by 'Chronic disease patients generally'.

3.3 Which support do GPs and POHs need to be able to implement the strength based approach in practice?

In the following paragraph, it will be discussed what the POHs and GPs think they need to be able to use the strength based approach in practice. The paragraph is divided up into three parts: 1. The requisites POHs and GPs think they would need to be generally able to execute the strength based approach, 2. The materials they would like to use while executing it and 3. the preparation they would like to receive before starting to execute it.

3.3.1 Requisites for POHs and GPs

One POH and two GPs said that they would need time and two GPs, but no POH, stated that they would need money to be able to execute the strength based approach.

Quote 33 "…there must be time for everything, time and money. Thus, there has to be a pot, almost a kind of a tariff for this kind of work." (GP 10)

One POH and two GPs said that they would like to have a flowchart that gives guidance in how to react in and what to do in particular situations while executing the strength based approach. Six POHs and three GPs reported that they would like to have a protocol they can follow. Two POHs said that they think that implementing a team discussion on a regular basis, would be useful to talk over the experiences they encounter with executing the strength based approach.

3.3.2 Materials to use during treatment

Four POHs and five GPs mentioned that they would like to have tools, such as questionnaires, apps or websites, to use during treatment.

3.3.3 Preparation of POHs and GPs before executing the strength based approach

One POH reported that she would like to see an instruction video and one GP said that he would like to receive more information about the scientific background of the strength based approach before starting to execute it. Six POHs and two GPs reported that they would like to receive a training wherein the strength based approach and its execution is explained. One POH and two GPs mentioned that they would like to have a training to practice with case studies. One POH and one GP reported that they would like to practice in roleplays during the training.

Quote 34 "[…] then, we would need a kind of protocol wherein a thing or two are explained. Maybe a midday of training to explain it, to give additional information. Maybe some worksheets. And maybe a website or an app, thus in addition to the story, that you have access to it. Yes, then I can start." (POH GGZ 10)

Quote 35 "I think it would be good to discuss a kind of case study. And then, maybe to practice with each other in roleplays." (POH GGZ 9)

One GP said that he would like to have a training to learn communication techniques. One POH reported that she would like to try out the strength based approach for herself before using it with her patients.

Summarizing, it can be said that the participants seem to need a framework they can follow while executing the strength based approach, for example in the form of a protocol. They also seem to like the idea of using tools to help them identify the patients' strengths. Almost all the participants would like to receive a training before starting with the strength based approach. Regarding the content of the training, most participants reported that they want to receive explanations, but also practical exercises seem to be desired.

4. Discussion

In the following paragraph, the outcomes of this research will be evaluated based on already existing literature. Some general theoretical considerations and methodological limitations of this research will be discussed. Finally, suggestions for further research and a conclusion will be given.

4.1 Current use of elements of the strength based approach

Regarding the first research question "What elements of the strength based approach do GPs and POHs already use?" it might have been expected that the participants do not use many elements of the strength based approach yet, because in healthcare settings biomedical and problem focused approaches seem to prevail (Harris & Thoresen, 2006). However, all participants in this research reported that they already use some elements of the strength based approach. This suggests a change, from a deficit focused to a more positive focused healthcare. Nonetheless, it seems that mainly the stance of the healthcare professionals has changed, but adjusting these new insights, in their actual way of working seems to be left behind. What still seems to be missing, is a clear and in-depth understanding of the new concepts and an accurate application of them. One example for this assumption is that participants reported to work solution focused. However, for some of them it seems to be unclear what solution focused means. While they reported that solution focused means that they focus on the present, the definition of the solution focused approach involves a focus on the future (Greene et al, 2000).

The literature discussed in the introduction showed that both the POHs and the GPs seem to have difficulties in supporting the self-management and self-reliance of the patient (Elissen et al., 2013; Ursum, 2011). In this research, however, many POHs and GPs reported that they see the patient as the decision-maker in the healthcare process and that they foster

the patient's autonomy. Nonetheless, if we look at how the POHs and GPs would like to implement the strength based approach in practice, it seems as if they still want to keep the control over the healthcare process. They want to be in command over the decision who is suitable for the strength based approach and who is not. Furthermore, only a few of the participants reported that they think that the patient should already work on identifying his or her strengths before the first session. This suggests that they might not find the patients capable to do this by themselves. Summarizing, this means that the healthcare professionals share the belief that it is important to enhance the patients' autonomy, but they seem not to be fully able to do that in practice. Moreover, it leads to the impression that they do not seem to be ready to give up their role as the expert yet. The findings of the research by Blakeman, Macdonald, Bower, Gately and Chew-Graham (2006) underline this statement. They conducted semi-structured interviews with 16 GPs from England regarding their attitudes towards self-management for chronic diseases. The results show that to have the feeling of fulfilling their professional responsibility, GPs seem to need to feel in control over the treatment process. Also, GPs seem to be concerned that when giving the patient to much responsibility, problems in their treatment could arise. Next to that, Ursum et al. (2011) reported in their article that they think that healthcare professionals are not yet trained to fulfill a coaching role.

4.2 Design of the strength based approach in general practices for chronic disease patients

Regarding the second research question: "How could the strength based approach be implemented in the treatment of chronic diseases in a general practice from the viewpoint of GPs an POHs?", the following design can be based on the results of this research: The strength based approach would be implemented in the form of an individual approach, consisting out of three to five sessions. The sessions would last up to 30 minutes, except the first sessions which may take longer. The main part of the approach would be executed by the

POH GGZ, an introduction regarding what the patient could expect in the strength based approach, would be made by the GP. The patients would be selected to take part in the approach based on the healthcare professional's evaluation of the patients' needs.

This last aspect -the selection of the participants- should be evaluated critical, as it stands in contrast to the principle of the strength based approach, that the patients themselves make the decisions in the healthcare process (Rapp and Goscha, 2008). If the professional decides which patients should or should not take part, some patients might be misjudged by the professional and miss their chance. Next to that, based on this research, no clear target group can be determined, as well as no clear answer regarding the role of the POH somatiek in the implementation of the strength based approach can be given. Considerations regarding the target group and possible effects of the task division on the healthcare system will be discussed in the following paragraphs.

The target groups that have been suggested by the participants in this research mainly include patients with characteristics that make a treatment success more likely. These are: mild, not severe psychological complaints, being motivated to change or being in a stable condition. The most difficult patient groups, for example hopeless cases - patients for whom all treatment possibilities did not lead to improvements- were not mentioned. Prejudices that seem to come along with the strength based approach are that it ignores the experienced difficulties, loss or grief in a person's life and that it is mainly directed at making healthy people happier (Harvey & Pauwels, 2003). As has been pointed out in the introduction, the strength based approach can be used in a wide array of settings and patient groups. In the literature, it can be found that the strength based approach is also beneficial for highly endangered patient groups. For example, the successful treatment of client-groups with a high drop-out and relapse rate, such as drug addicts or juvenile delinquents, has been reported (Siegal et al., 2002; Laursen, 2000). Therefore, the strength based approach might be

especially useful for chronic disease patients, who achieve no improvements through the regular healthcare treatment. The participants in this research, however, do not seem to be aware of this yet.

What is noteworthy in this research, is that based on the preferences of the participants, the leading role in executing the strength based approach should have the POH GGZ. This would lead to the result that the POH gains more responsibility and power in the Dutch healthcare system, whereas the GP undertakes more allocating and coordinating tasks. This corresponds with the estimation of the National General Practice Association and the Dutch general Practitioners cooperative, which expects that in the upcoming years the GPs will delegate more of their tasks (Hassel, Korevaar, Batenburg & Schellevis, 2015). In the future, the POH seems to take over more practical tasks in the healthcare process in general practices, while the tasks of the GP involve more coordination of the healthcare process (Heiligers et al., 2012). In the introduction, the problem was mentioned that GPs have to manage an increasing workload, due to a rising number of chronic disease patients, with unchanged resources and capacities (Blokstra et al., 2007). If a change in the function of the GP leads to a reduction of workload, however, cannot be answered yet. For now, a reduction of workload has not been found, but a shift in responsibilities can be observed (Heiligers et al., 2012).

4.3 Support needs

Regarding the third research question “Which support do GPs and POHs need to be able to implement the strength based approach in practice?”, it can be said that the participants have asked for a lot of practical support in order to execute the approach, such as training, protocols or helping tools. Grol and Grimshaw (2003) conducted a research investigating what health professionals need to adapt a new approach to improve the hand hygiene in healthcare settings. The outcomes show that if healthcare professionals are supposed to adapt

a new approach, educational interventions, such as training sessions, newsletters, classes and videos, are useful. But these alone are not enough. To be fully able to adapt a new approach adequately, the healthcare professionals should be provided with a combination out of educational materials, performance feedback and reminders. This should be taken into account for the implementation of the strength based approach. The support need that the participants ask for in this research might be good to prepare them before implementing the approach, but when using the approach in practice, more support, such as reminders and performance feedback, might be necessary. The healthcare professionals could for example come together with an expert of the strength based approach on a regular basis and discuss their use of the strength based approach. The expert should give feedback and point out what could be improved. It might also be useful if the healthcare professional would receive emails repeatedly to remind them of applying the strength based approach.

4.4 General theoretical considerations

Quote 36 "But you must first recognize the situation and that it is difficult. That really is essential for your relationship. And from there on you can emphasize someone's strengths." (POH GGZ 12)

Quote 37 "If you leave it to the patient, it is not always the case that they want the same things as we want, for example, I am thinking of losing weight and exercising. That is something that comes more from us." (POH somatiek 7)

Reading these two quotes, it becomes clear that, next to practical considerations, the participants struggle with more abstract concerns regarding the strength based approach. The first question that the participants bring up is, if there is enough place to show empathy for the patient's sorrow in the strength based approach. The second question is, what to do if treatment and personal goals disagree. This second discussion point has also been mentioned in the introduction as it has also been found in other researches (van Houtum, 2016). In the

following paragraph, these two questions will be discussed, because people are more likely to use a new approach, if they have a positive attitude regarding it (Ajzen, 1991). Therefore, the concerns and insecurities of POHs and GPs regarding the strength based approach should be discussed and at the best, resolved.

4.4.1 What do we do with the patients' sorrow?

In the strength based approach, the focus lies on the patients' strengths and resources and not on their problems or deficits (Rapp & Gosha, 2008). This principle seemed to encounter resistance in some of the participants. They reported that before focusing on solutions or strengths, they want to listen to the patients' problems and sorrows, because they think that without doing this, the patient would feel unheard and they would not be able to build a relationship.

Listening and trying to understand the patient's problems actively and empathically, gives the patient the feeling of being understood and enhances a feeling of safety and appreciation, which nurtures a good therapeutic relationship (Elliott, Bohart, Watson & Greenberg, 2011). If this, however, stands in an opposition to focusing on strengths, as it is advocated in the strength based approach, is due to discussion. The famous paper by Saleebey (1996) discusses this issue. Saleebey points out the need of a patient for the opportunity of catharsis of declaring their suffering, their anger, their sadness or their anxiety. According to Saleebey (1996) this opportunity should also be given when working with the strength based approach. It is an important part of the healthcare process and should not be denied. Additionally, the healthcare professional should asses the patients' suffering out of a different perspective. The focus should be laid on what the patients have learned in their struggles and what made them survive (Saleebey, 1996). This means that emphatically listening and focusing on strength and resources, should complement each other. Taking this into account, one recommendation would be, to train the professionals in combining the

appreciation of the patients' sorrow and focusing on their strengths before implementing the approach in practice. Even more importantly, it should be considered to leave enough time for empathic listening and understanding in the design of the strength based approach itself. As a consequence for the practical design of the strength based approach, this means that especially in the beginning of the treatment, more than 30 minutes per session might be necessary.

4.4.2 What do we do if personal and treatment goals do not match?

The problem that has also been found in other researches (van Houtum et al., 2016) and has been mentioned in the introduction, has also been named by participants of this research: If the personal goals from the patients differ from the medical goals, the healthcare professional takes over the responsibility and makes the decisions.

No clear answer to the question "What should be done if personal and healthcare goals disagree?" has been found yet and it exceeds the scope of this research to find a full-on answer to it. However, the problem should be taken into consideration before implementing the strength based approach. Morgan et al. (2016) describe in their article the tension healthcare professionals experience between the responsibility of reducing harm and to recognize the patient as having the right to make important lifestyle decisions themselves (Morgan et al., 2016). Rapp et al. (2006) named as one principle of the strength based approach: "The provision of meaningful choices is central and clients have the authority to choose." (p. 82). This means, according to the strength based approach, the decision which goals are pursued is made by the patient and not by the healthcare professional. When applying this principle strictly, the consequence is that even if the personal goal is not consistent with the treatment goal it should be free to the patient to pursue it. The tension the healthcare professional might feel in this changing understanding of purpose of support should be taken into account and made discussable, while implementing the strength based approach. In the literature over motivational interviewing this topic has also been discussed.

Emmons and Rollnick (2001) recommend in their article that if the client and therapist priorities disagree, the therapist should not neglect the client's wishes. However, the therapist should be honest about his or her concerns and make them transparent to the client. Summarizing, this means that the role of the healthcare professional is to support the patient even if he or she does not agree with the patient's wishes. If this, however, is something the healthcare professionals can and want to do, is still due to discussion.

4.5 Methodological limitations

One limitation of this research is that the coding has only been carried out by one coder. This makes the analysis vulnerable for researcher dependent influences. However, in the context of a master thesis no other research design was feasible and the supervisors checked and commented on the coding and quotes as a first step to reach intercoder agreement.

One issue that often plays a role in interview studies and could be one possible explanation for the highly positive responses regarding the strength based approach by the participants in this research, is social desirable responding (Van de Mortel, 2008). Social desirable responding means that participants give deliberately or unconscious the answers that they think the researcher would like to hear, or they think would create a positive image of themselves (Johnson & Fendrich, as cited in Van de Mortel, 2008, p. 41; King & Brunner, 2000). One argument for the assumption that socially desirable responding could play a role in this research, is the gap between what the participants say they do, and what they actually do. To some extent, this seems to differ. If this, however, is due to social desirable responding, to a lack of understanding of the concepts or to difficulties in the practical application of them, is not assignable.

Another explanation for the highly positive responses regarding the strength based approach could also be that the participants of this research form a highly selective group. It

might be that only the healthcare professionals agreed to take part in the interviews who already had some interest in the strength based approach. Five POHs also followed a positive psychology intervention before the interviews were conducted, so they already were familiar with the ideas of positive-focused working.

The phenomenon that there is a discrepancy between what healthcare professionals say, and what they are observed to do, has also been found in the research by Denford, Frost, Dieppe and Britten (2013). In their research, it has been shown that the reports of the healthcare professionals regarding how the medication treatment should be modified to the needs and wishes of the individual patient did not always match with the corresponding examples from their practice. Denford et al. (2013) see this dissonance between rhetoric and experience as stemming from a tension the healthcare professionals experience in treating social and medical needs of the patient simultaneously. This aligns closely with the above discussed issue of dissonance between personal and treatment goals. How this tension could be reduced is an important question that should be taken into account when implementing the strength based approach.

4.6 Further research

As in this research the opinions of the POHs and GPs have been analyzed, further research investigating the opinions of the patients regarding the strength based approach should be carried out. Based on the outcomes of this research and also taking into account the perspective of the patients themselves, a design of the strength based approach for chronic disease patients in general practices should be worked out. Then, it should be implemented in the practices. Afterwards, the implementation should be evaluated, especially regarding the role of the POH somatiek, the target group and the selection procedure.

4.7 Conclusion

All in all, it can be said that the participants seem to share most of the beliefs underlying the strength based approach, such as that it is important to enhance the patients' autonomy and work positive-focused, but they seem not to be fully able to put these beliefs into practice. Next to that, a clear comprehension of some of the concepts, such as solution-focused treatment, seem to be missing. Therefore, providing explanations, training and structure for the implementation of the strength based approach seems necessary and desired by the healthcare professionals. Generally, the implementation of the strength based approach for chronic disease patients in general practices seems to be feasible, nevertheless, it still seems to be a long way to change the role of the healthcare professional from being the expert to entrust the expert-role to the patient.

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Appendix A

Final coding schemes per research question

1.4 *What elements of the strength based approach do GPs and POHs already use?*

Category	**Code**
Elements already used	General strength-based mindset: everyone has strengths
	Identification of strength during conversation
	Identification of strength by using a tool
	Identification of personal goals
	Identification of the patients' passion
	Importance of client-professional relationship
	Focus on solutions instead of problems
	Patient as director of healthcare process
	Giving hope
	Foster the autonomy of the patient
	Using external resources

3.2 How could the strength based approach be implemented in the treatment of chronic diseases in a general practice from the viewpoint of GPs and POHs?

Category	**Code**	**Sub-Code**
Task division		*Carried out by*
	First meeting (FM)	GP *(FM)*
		POH GGZ
		POH som. & GP
		POH GGZ & GP
		Both POHs
		POHs & GP
	Following meetings (FolM)	POH GGZ *(FolM)*
		Both POHs
		POH GGZ & GP
		POHs & GPs

Category	**Code**	**Sub-Code**
Number of meetings	2-3 meetings	
	3-5 meetings	
	6-7 meetings	
	8-10 meetings	
	Number of meetings not limited	
Duration of one meeting		
	First meeting	≤ 30 minutes (FM)
		> 30 minutes (FM)
	Following meetings	≤ 30 minutes (FolM)
		> 30 minutes (FolM)
Kind of Approach	Individual Approach	
	Group Approach	
	both	
Identification of strength	Tools	Questionnaire
		App
		Website
		Card games
	Time point	Before first meeting
		After first meeting
		During meeting
Selection procedure	Selection based on the needs of the individual patient	
	Selection of chronic disease patients generally	
Target group	Chronic disease patients generally	
	Stable chronic disease patients (no actual exacerbations)	

	Only patients with a basic level of self-management as prerequisite	
	Patients with mild to intermediate psychological complaints (no severe psychological complaints)	
	Patients without comorbidity	
	Patients that are generally motivated to change	
	Patients with at least basic cognitive capacities	
	Chronic disease patients with severe somatic, but no psychological complaints	
	Patients that were recently diagnosed with a chronic disease	

3.3 Which support do GPs and POHs need to be able to implement the strength based approach in practice?

Category	**Code**	**Sub-Code**
Support	Money	
	Time	
	Guidance	Not specified
		Flowchart
		Team discussion
		Protocol
		Tools to use during treatment
		Instruction video
		Scientific background
	Training	
		Practice with case studies
		Roleplaying
		Receiving explanations
		Try out the strength based approach for oneself

Appendix B

Tables with codes and participant numbers

Table. 3

Codes and participant numbers belonging to the research question: What elements of the strength based approach do GPs and POHs already use?

Category	Codes	Participant number POHs	Participants number GPs
Elements already used	General strength based mindset	POH 3, POH 7, POH 12	GP 6, GP 9, GP 10
	Identification of strength in conversation	POH 3, POH 9, POH 10, POH 11	GP 5, GP 8,
	Identification of strength by using a tool	POH 1 (card game)	
	Identification of the patients' passion	POH 2, POH 3	GP 5, GP 8
	Identification of personal goals	POH 3, POH 4, POH 7, POH 9	GP 2, GP 4, GP 7, GP 8, GP 9
	Importance of client-professional relationship	POH 1, POH 3, POH 6, POH 12	GP 1, GP 3, GP 6
	Focus on solutions instead of problems	POH 1, POH 4, POH 9, POH 10, POH 11, POH 12	GP 2, GP 4, GP 5, GP 6
	Patient as director of healthcare process	POH 1, POH 3, POH 6, POH 7, POH 8, POH 12	GP 1, GP 4, GP 6
	Giving hope	POH1, POH 2, POH 4, POH 10	GP 2, GP 8
	Foster autonomy of the patient	POH 5, POH 10, POH 12	GP 1, GP 2, GP 5, GP 6, GP 9,
	Using external resources		GP 2, GP 4, GP 5, GP 8, GP 10

Table 4.

Codes and participant numbers belonging to the category number of meetings and duration of meetings

Category	Code	Participants numbers POHs	Participants numbers GPs
Number of meetings	2-3 meetings	POH 4	
	3-5 meetings	POH 2, POH 5, POH 7, POH 9, POH 12	GP 6, GP 7, GP 8, GP 9
	6-7 meetings	POH 10, POH 11	GP 2
	8-10 meetings	POH 1	
	Number of meetings not limited	POH 8	GP 10
Duration of one meeting			
First meeting	≤ 30 minutes	POH 8, POH 9, POH 11	GP 6, GP 7, GP 8, GP 9, GP 10
	> 30 minutes	POH 2, POH 4, POH 7, POH 10	GP 1
Following meetings	≤ 30 minutes	POH 4, POH 6, POH 7, POH 9, POH 10, POH 11	GP 6, GP 8, GP 9, GP 10
	> 30 minutes	POH 1, POH 2	GP 7

Table 5.

Codes and participation numbers belonging to the category kind of approach

Category	Code	Participant numbers POHs	Participant numbers GPs
Kind of approach	Individual Approach	POH 1, POH 5, POH 6, POH 7, POH 10, POH 12	GP 2, GP 3, GP 4, GP 7, GP 8
	Group Approach	POH 2, POH 3	
	both	POH 9, POH 11	GP 1, GP 5, GP 6, GP 9, GP 10

Table 6.

Codes and participation numbers belonging to the category tools and time point of using tool

Category	Codes	Participant numbers POHs	Participant numbers GPs
Tools	Questionnaire	POH 1, POH 2, POH 3, POH 5, POH 6, POH 7, POH 8, POH 9, POH 11	GP 1, GP 3, GP 4, GP 5, GP 2, GP 8,
	App	POH 1, POH 3, POH 4, POH 11	GP 3, GP 6, GP 7, GP 8
	Website	POH 1, POH 10, POH 11	GP 4, GP 8, GP 10
	Card game	POH 3	
Time point of using tool	Before first meeting	POH 7	GP 3, GP 5, GP 6, GP 10
	After first meeting	POH 9, POH 10	GP 5, GP 8
	During meeting	POH 5	GP 2

Table 7.

Codes and Participant numbers belonging to the category Selection strategy and target group

Category	Codes	Participants numbers POHs	Participant numbers GPs
Selection strategy	Selection based on the needs of the individual patient	POH 1, POH 2, POH 3, POH 4, POH 5, POH 6, POH 7, POH 9, POH 10, POH 11, POH 12	GP 1, GP 4, GP 5, GP 2, GP 6,
	Selection of chronic disease patients generally	POH 8,	GP 7, GP 9, GP 10
Target group	Chronic disease patients generally	POH 6, POH 7,	GP 4, GP 5, GP 6
	Patients that were recently diagnosed with a chronic disease	POH 2	
	Stable chronic disease patients (no actual exacerbations)	POH 4	GP 7

Chronic disease patients with severe somatic, but no psychological complaints		GP 3
Chronic disease patients with mild to intermediate psychological complaints (no severe psychological complaints)	POH 1, POH 9, POH 11, POH 12	GP 9, GP 10
Only chronic disease patients with a basic level of self-management as prerequisite	POH 8,	
Chronic disease patients without comorbidity	POH 10	
Chronic disease patients that are generally motivated to change	POH 1	GP 1, GP 8
Chronic disease patients with at least basic cognitive capacities	POH 4	GP 9

Table 8.

Codes and participant numbers belonging to the research question: Which support do GPs and POHs need to be able to implement the strength based approach in practice?

Category	Codes	Participants numbers POHs	Participant numbers GPs
Money			GP 6, GP 10
Time		POH 6	GP 6, GP 10
Guidance	Not specified	POH 7	GP 4
	Flowchart	POH 8	GP 2, GP 8
	Team discussion	POH 7, POH 9	
	Protocol	POH 1, POH 2, POH 3, POH 10, POH 12	GP 5, GP 6, GP 9
	Tools to use during treatment	POH 1, POH 2, POH 10, POH 11	GP 1, GP 4, GP 5, GP 8, GP 9
	Instruction video	POH 12	
	Scientific background		GP 9
Training			

Practice with case studies	POH 9	GP 5, GP 7
Roleplaying	POH 9	GP 7
Receiving explanations about the strength based approach	POH 5, POH 6, POH 7, POH 9, POH 10, POH 12	GP 7, GP 9
Learning communication techniques		GP 3
Try out the strength based approach for oneself	POH 4	

Appendix C

Original quotes in Dutch and corresponding English translations

Table 9.

*Original quotes in Dutch and corresponding English translation*s

Quotes in Dutch	Quotes in English
"Iedereen heeft sterke kanten, daar ben ik het ook met eens. Iedereen heeft inderdaad kanten die hij goed beheerst." (POH 12)	Quote 1 "Everyone has strengths, I do agree with that. Everyone has indeed something that he is good at." (POH GGZ 12)
"…dat we oplossingsgericht, van oké het is nu zo…het werkt vaak met het schaalmodel van 0 tot 10, waarom is het nu een 5 en geen 0. En dan gaan ze al positieve dingen opnoemen." (POH GGZ 4)	Quote 2 "That we solution focused, like okay it's now like this ... it often works with the scale model from 0 to 10, why is it now a 5 and no 0. And then, they are already going to name positive things." (POH GGZ 4)
"Ik werk zelf ook vaak oplossingsgericht, ik ga nooit echt diep in op de problemen en het verleden, tenzij het noodzakelijk is." (POH GGZ 12)	Quote 3 "I often work solution focused myself, I never really go deep into the problems and the past unless it is necessary." (POH GGZ 12)
"Ik vraag aan patienten wat zijn sterke kanten, wat zijn positieve eigenschappen. Als mensen moeilijke perioden hebben doorgestaan, wat zijn dan dingen die je hierin hebben geholpen. Maar ik ben nog niet bezig met ze bewust inzetten om doelen te bereiken." (POH GGZ 9)	Quote 4 "I ask the patients what are strengths, what are positive characteristics. If people have survived difficult time periods, what are things that helped you in this. But I am not busy with using them [the strengths] to achieve goals." [POH GGZ 9]
"Wat ik herken is het kaartspel. Ik heb het kaartspel zelf ook, waarbij je dus inderdaad eerst op zoek gaat naar goede kanten en wie dat in jouw omgeving… […. Hoe heet dat kaartspel?] Levenskunst ofzo." (POH GGZ 1)	Quote 5 "What I recognize is the card game. I also have the card game myself, whereby you are first looking for good sides and who in your surrounding ... […What is the name of the card game?] Art of living, or something like that." (POH GGZ 1)
"Met een beetje hoop de deur uit, dat is eigenlijk mijn grote doel. En als mensen zeggen, bij mij werkt het toch niet, dat hoor ik toch ook regelmatig, of dat lukt me niet, dan zeg ik altijd, ik zou hier niet zitten als ik daar niet in geloof, dat iets mogelijk zou kunnen zijn." (POH GGZ 4)	Quote 6 "That they [the patients] leave with a bit of hope, that is actually my big goal. And if people say, for me, it does not work anyways, I often hear that, or I cannot do it, then, I always say, I would not be sitting here, if I would not believe it is possible." (POH GGZ 4)

"Dat je dat in kaart gaat brengen en dat je probeert bronnen aan te boren waar de mensen zich nog niet… of misschien even weer vergeten waren. Op zoek naar hun passie, zo noem ik het ook weleens." (POH 2)	Quote 7 "[…] and that you try to open up wells, of which people have not yet… or maybe have forgotten about again. Searching for their passion, that's how I call it sometimes." (POH GGZ 2)
"[En herken je ook dingen in je eigen werkwijze?] Jawel, eigenlijk het feit dat mijn patiënten zelf hun vraag moeten bepalen." (POH GGZ 1)	Quote 8 "[And do you recognize things in your own way of working?] Yes, actually, the fact that my patients themselves have to determine their question." (POH GGZ 1)
"Ik heb het met patient wel erover wat ze zelf aan kunnen doen." (GP 9)	Quote 9 "I do talk with the patients about what they can do about it themselves." (GP 9)
"[…] dat je dan toch naar kijkt, okay wat vindt je leuk, wat zij je hobby's, war kun je wel bevrediging in vinden. En waar is ook maatschappelijk gezien een opening. En kom je daar niet snel uit, dan is het toch een kwestie van hulpbronnen inschakelen, wat zijn tegenwoordig de mogelijkheden, de POHs, het sociaal team van de gemeente, het arbeidsbureau van de gemeente, die nog tips zou kunnen geven, waar je nog wel inzetbaar kunt zijn." (GP 8)	Quote 10 "[…] that you then have a look at, okay what do you like, what are your hobbies, what gives you satisfaction. And what could be, out of a social perspective, a beginning. […] that is a question of using resources, what are currently the possibilities, the POHs, the social team of the community, employment bureau of the community, that could give some hints where you could still deployable." (GP 8)
"Dat is op zich een oud begrip, en dat wordt zeker binnen de psychologie en ook binnen de huisarts zeker vaak gebruik van gemaakt. Tenzij het allemaal relatief ongestructureerd gebeurt. Meer een tool, er is niet echt een vaste richtlijn of vast protocol van gemaakt hoe een mens of een groep ermee wordt begeleid." GP 8	Quote 11 "This [the strengths based approach], in itself, is an old concept, and it is definitely often used in psychology and also within the general practice. But, it all happens relatively unstructured. More as a tool, there is not really a fixed guideline or solid protocol of how a person or a group can be guided with it." (GP 8)
"Ik denk dat het wel goed is er een gesprek met de huisarts over te hebben. En de POH het dan wel kan vervolgen en dan weet ik kan het terugkoppelen als dat nodig is, maar dat ik dan zelf weet wat er speelt. Als dan iemand bij mij komt voor een ander probleem, dat ik dan ook dat stukje dan heb meegekregen en weet waar ik naar terug kan verwijzen. Dan ken ik wel de context, anders ben ik de context helemaal kwijt. Ik denk niet dat dat goed is." (GP 10)	Quote 12 "I think it's good to have one conversation with the general practitioner about this. And the POH can continue it and then I know that I can get back at it, if that's necessary, But that I know what's going on. If someone then comes to me for another problem, that I know about this part of treatment and that I know where I can refer back to. Then I know the context, otherwise I totally lose the context. I do not think that would be good." (GP 10)

„De eerste is, is dit doctor werk of is dit een andere discipline. Ik denk dat dit andere vaardigheden veronderstelt. Ik denk dat wij een aanzet kunnen geven maar niet de uitwerking kunnen doen. […] De welzijnscoach of de POH GGZ, die meer op de psychiatrische dingen kijkt, die kan dat ook heel goed."

Quote 13 "The first is, is this work of the doctor or is this another discipline. I think this supposes other skills. I think we can give a boost but cannot do the execution. [...] The welfare coach or the POH GGZ, who looks more at the psychiatric things, can do that very well." (GP 9)

"Als de huisarts eerst heel probleemgericht gaat werken en dan gaat het hier heel krachtgericht, dat is wat apart denk ik. Misschien is het ook nog goed tussentijds nog een gesprek bij de huisarts in te plannen. Dus aan het begin ervoor en een daartussen en een keer daarnaar of zo." (POH GGZ 9)

Quote 14 "If the general practitioner starts to work very problem-focused and then, here we are working strengths-based, that's a bit strange, I think. Perhaps it would be also good to have a session with the GP in between. So, at the beginning and one in between and one afterwards, something like this." (POH GGZ 9)

"[Wat doet de huisarts dan nog? Ook nog gesprekken voeren?] Dat zou wel mooi zijn, dan krijgt hij ook nog wat zicht op de gezonde kant van de patiënt." (POH GGZ 11)

Quote 15 "[What does the GP? Does he also lead conversations?] That would be nice, he would then also get some view on the healthy side of the patient." (POH GGZ 11)

"Bijvoorbeeld diabetes, die zie ik dan een half uur. Maar daar moet je dan ook de controles doen, en de waardes bespreken. Alles bij elkaar." (POH somatiek 6)

Quote 16 "For example diabetes, I see them for half an hour. But there you have to do the check-ups and discuss the values. All of this." (POH somatiek 6)

"Ik denk de POH-GGZ, hoewel de POH-S het volgens mij ook zou kunnen. Die hebben soms het lijntje ook al met de chronische patiënten." (POH GGZ 2)

Quote 17 "I think the POH-GGZ, although the POH-S could also do it. They sometimes already have the contact with the chronic patients." (POH GGZ 2)

"Het ligt een beetje aan de patiënt. Het lijkt mij meer efficiënter als je meerdere korte afspraken hebt. Voor het follow-up, dan dat je een heel lang gesprek hebt. En de ene patient moet je aan het lijntje houden, omdat die eerder afdwaalt dan de ander." (GP 10)

Quote 18 "It depends a bit on the patient. It seems to me, that it would be more efficient if you have multiple short appointments. For the follow up, that you then have one very long session. And one patient you have to keep in line, because he abandons more easily than the other one." (GP 10)

"Wij hebben een termijn, dus wij zien mensen in principe 3 keer en den een evaluatie . En in de evaluatie bekijken wij of wij met een aantal gesprekken nog verder kunnen of

Quote 19 "We have a deadline, so we normally see people 3 times and then an evaluation. And in the evaluation, we look at whether we can or cannot, go on with a

niet, of dat zin heeft. En daar zit ook wel een maximum aan, wij gaan niet onbeperkt door, wij gaan niet onbeperkt behandelingen doen in de eerste lijn. Dat is niet de bedoeling. Als het zo veel tijd vergt dan kun je je vragen, hoort dat dan bij de POH GGZ." (POH GGZ 12)

number of sessions, if that makes sense. And there is also a limit, we do not go on endlessly, we will not do unlimited treatments in the first line. That is not the intention. If it takes so much time then you can ask yourself, does it belong to the POH GGZ." (POH GGZ 12)

"[wat bedoel je met de 5 stappen plan?] Dat zo interventies niet meer dan 5 consulten nodig hebben. 5 keer een half uur of zo iets."

Quote 20: "[what do you mean with 5 steps plan?] That this kind of interventions [the strength based approach] do not need more than 5 sessions. 5 times half an hour, something like this." (GP 6)

"Nauw zij heeft een half uur per patiënt. Maar ik denk dat als je een concreet plan hebt, dat je in 20 minuten best ver kan komen. Dat zie ik hier, als iemand gewoon stapjes heeft gezet, en zeker als je de verantwoordelijkheid ook gedeeltelijk neer zet bij de patiënt. Dan hoef je daar niet ineens zo veel tijd voor te hebben." (GP 10)

Quote 21 "Well, she has half an hour per patient. But I think, if you have a concrete plan, you can already get far in 20 minutes. I see that here, if someone has just taken steps, and certainly if you give the responsibility partly to the patient. Then, you do not even need to have so much time for it." (GP 10)

"Mensen willen niet in een groep, zij willen een op een gesprekken hebben. En hoe hard wij dat ook willen, als je een groep hebt, mensen gaan daar echt niet naar toe." (POH GGZ 12)

Quote 22 "People do not want to be in a group, they want to have one to one conversations. And as much as we want it, if you have a group, people really do not go there." (POH GGZ 12)

"ik houd zelf helemaal niet van dat groepsidee, er wordt tegenwoordig best veel mee gedaan en ik kan er echt niks mee . Het kost veel te veel tijd, en er zit zo veel tijd in structureren, dat het eigenlijk ten koste gaat van de individuele patient, in mijn ogen." (GP 8)

Quote 23 "I really do not like the groups-idea, at the moment they do a lot with this and I really do not like it. It takes way too much time and you need so much time to structure it, so that it actually goes to expanse of the individual patient, in my opinion." (GP 8)

"Ik ben wel erg voor groep tegenwoordig, omdat ik anders tien keer hetzelfde zit te vertellen. En omdat ik heel erg geloof in de kracht van elkaar helpen." (POH GGZ 3)

Quote 24 "I'm very pro group at the moment, because otherwise I'm telling the same thing ten times. And because I really believe in the strength of helping each other." (POH GGZ 3)

"Bij chronische patiënten, ja, als het in een groep doet dan kan dat twee kanten opgaan: of ze motiveren elkaar of ze gaan met z'n allen in klaagzang. Dat is het. Dus als je dat,

Quote 25 "For chronic patients, yes, if you do it in a group it can have two sides: either they motivate each other, or they start lamenting all together. That's it. Thus, I think

ik denk dat je eerst gedeeltelijk individueel wat zou moeten doen en op een gegeven moment kan dat in een groep, want een groep kan elkaar heel erg versterken." (GP 1)

you should first do something individually and on a certain moment it can be done in a group, because in a group they can reinforce each other. "(GP 1)

„[zou je dan, dan komt zo'n patiënt dus bij jou, zou je dan willen werken met een vragenlijst of een website of app of zou je zeggen: die sterkte kanten identificeren doe ik toch liever gewoon in een gesprek of een combinatie?] Ik denk dat ik een combinatie zou doen. [Tussen welke?] Nou, ik vind eigenlijk alle drie, want ik vind via de computer ook wel handig, dan kunnen mensen het ook thuis doen." (POH 1)

Quote 26 "I think I would use a combination [of questionnaire, website and app] [….] I like all three, because I think with the computer is also handy, then, people can do it at home." (POH GGZ1)

"Ik denk dat je met die vragenlijst alleen niet helemaal uitkomt. Dat je uiteindelijk wel ook een keer om tafel moet, maar daar kan je de frequentie misschien wel van verlagen, dat je wat voorwerk doet." (GP 3)

Quote 27 "I think a questionnaire alone is not enough. That you finally also have to come together at one table, but maybe you can reduce their [the sessions] frequency, by doing some preparatory work." (GP 3)

"[…]dat ik eerst de mensen iets leer kennen en dan denk ik van 'goh, misschien zou dit iets zijn'." (POH GGZ 3)

Quote 28 "[…] that I first get to know the person and then, I think 'yes, maybe this would be something for him'." (POH GGZ 3)

"Ik denk de huisarts verwijst naar ons, omdat niet iedereen zou ook de behoefte hebben . Dat roept soms ook weerstand op als mensen zomaar naar iets uitgenodigd worden. Vooral met kwetsbare ouderen, die zijn soms ontzettend beledigd, als je zegt u valt in de doelgroep van…ik zou dat altijd in samenspraak met de huisarts doen." (POH 7)

Quote 29 "I think the GP refers to us, because not everyone [with a chronic disease] also has the need to [take part in the strength based approach]. It can trigger resistance, if people are simply invited to something, if you say you belong to the target group of… I would always do that in collaboration with the GP." (POH somatiek 7)

"Het liefst zou ik mensen gericht uitnodigen en niet alleen maar mensen die je op consult hebt. Want vooral bij copd heb je een heel groot groep aan mensen, die niet komt. Maar überhaupt, er zijn veel mensen die we niet zien, waar we wel van weten dat ze het niet al te makkelijk hebben in het leven." (GP 9)

Quote 30 "I would prefer to specially invite people and not just people who are already coming to your consult. Because especially with copd you have a very large group of people who do not come. But anyways, there are many people we do not see, from who we know that they do not have it too easy in their life."

"Maar als ik naar onze groep kijk, dan zou ik beginne bij de chronisch zieke met wie wij niet verder komen. En dat zijn copd'ers soms, diabetes soms, maar dat zit vooral in de GGZ hoek en dan vooral in lichte GGZ, dus niet psychiatrisch. Die "ik ben zo moe"-mensen. Heel veel ziekte beelden die we op een ander manier niet kunnen helpen. Die thuis zitten en wachten dat er uiteindelijk iets is gevonden in de geneeskunde. En dat vinden wij voorlopig niet."(GP 9)	Quote 31 "[…] I would start with the chronic ill with which we can't go any further. […] Sometimes COPD patients, sometimes diabetics, but it is particularly in the field of mental health care and then, especially mild mental health care, thus not psychiatric." (GP 9)
"[En welke doelgroep binnen chronisch zieken zou hier het meest geschikt voor zijn? aan welke eigenschappen moet zo iemand voldoen?] Die moeten wel openstaan voor verandering."	Quote 32 "[which target group in the group of chronically ill patients would be most suitable for this approach?] They must be open for change." (GP 1)
"…overal moet tijd voor zijn, tijd en geld. Dus er moet een pots komen, bijna een soort tarief voor deze soort verrichting." (GP 10)	Quote 33 "…there must be time for everything, time and money. Thus, there has to be a pot, almost a kind of a tariff for this kind of work." (GP 10)
"dan zouden wij denk ik een soort protocol nodig hebben waarin je dan het een of ander beschrijft. Misschien een trainings middag om dat uitteleggen, om dat toeteleggen. Misschien wat werkbladen. En misschien dus een site of een app, dus een toevoeging op het verhaal, dat je daar toegang tot hebt. Ja, dan kan ik wel aan de slag." (POH 10)	Quote 34 "[…] then, we would need a kind of protocol wherein a thing or two are explained. Maybe a midday of training to explain it, to give additional information. Maybe some worksheets. And maybe a website or an app, thus in addition to the story, that you have access to it. Yes, then I can start." (POH GGZ 10)
"Ik denk dat het goed is om ook een soort casus te bespreken. En dan misschien in een rollenspel oefenen met elkaar." (POH 9)	Quote 35 "I think it would be good to discuss a kind of case study. And then, maybe to practice with each other in roleplays." (POH GGZ 9)
"Maar je moet wel eerst herkenning geven voor de situatie en dat het lastig is. Dat is wel heel essentieel in je contact. En van daaruit kun je wel iemands sterke kanten benadrukken. " POH GGZ 12	Quote 36 "But you must first recognize the situation and that it is difficult. That really is essential for your relationship. And from there on you can emphasize someone's strengths." POH GGZ 12
"Wat wel is dat als het aan de patiënt ligt, is het niet altijd zo dat zij dezelfde dingen willen als jij, ik denk daarbij bvb aan afvallen	Quote 37 "If you leave it to the patient, it is not always the case that they want the same things as we want, for example, I am thinking of losing weight and exercising. That is

en bewegen. Dat komt dan toch meer van ons." (POH somatiek 7)

something that comes more from us." (POH somatiek 7)