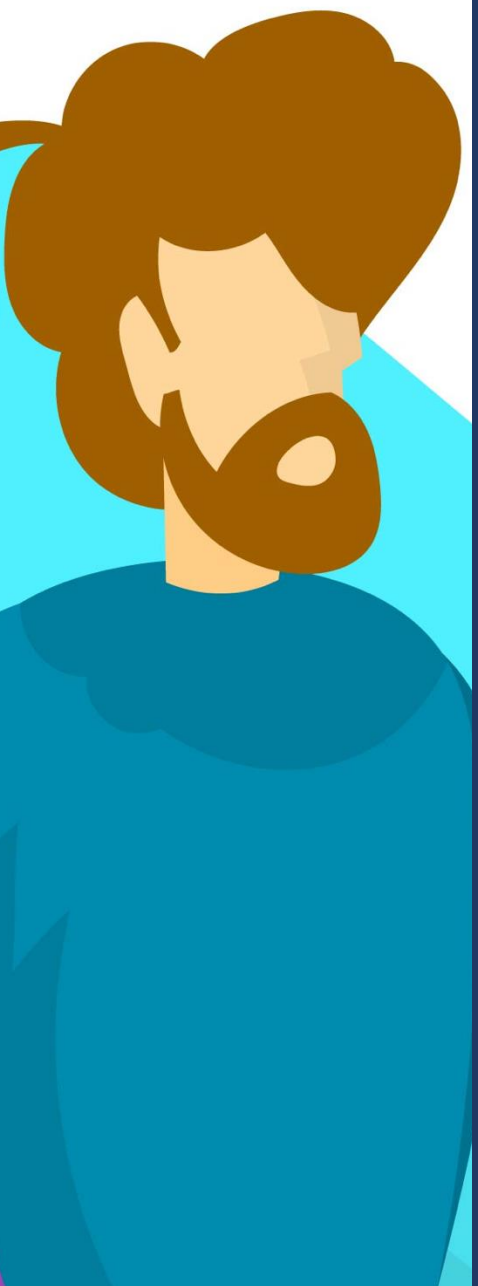

BACHELOR THESIS

“An Empowering Story”: Design study of an intervention for personal recovery

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Abstract

This research focuses on the requirements professionals and participants have for the implementation of the life story intervention "Een Sterk Verhaal" that promotes working on one's life story to achieve personal recovery in primary healthcare. This research was conducted in the form of interviews with 12 professionals from GGNet and Mindfit as well as three patients within primary mental healthcare. The audio recordings were transcribed and 50 codes for the professionals and 29 for the patients have been identified.

The interviews were analysed in a bottom-up manner and were not linked to particular theories and constructs. From the first research question *What requirements do professionals in primary mental health care have regarding the implementation of the intervention 'Een Sterk Verhaal'?*, four themes can be distinguished: *fewer sessions, making it visual, supervision* and *Individual vs. Group Sessions*. From the second research question *What requirements do participants in primary mental health care have regarding the implementation of the intervention 'Een Sterk Verhaal'?*, four themes can be distinguished: *number of sessions, benefits and difficulties of intervention, supervision before and during intervention* and *Individual vs. Group Sessions*.

Compared to a study in specialist mental health care certain aspects such as sharing your story were mentioned by professionals and participants in this design study. Overall, the professionals and participants did not always have a unified answer such as about the number of sessions and group or individual sessions. The professionals were only recruited from two organisations with a vision of using positive psychology meaning. Other organisations may have yielded different results. Follow-up research can focus on the implementation of the intervention, possibly differentiating between the group and individual sessions.

Keywords: life story intervention; primary mental healthcare; design study.

Samenvatting

Dit onderzoek richt zich op de eisen die professionals en deelnemers stellen aan de implementatie van de levensverhaalinterventie "Een Sterk Verhaal", die het werken aan het eigen levensverhaal bevordert om persoonlijk herstel in de eerstelijns geestelijke gezondheidszorg te bereiken. Dit onderzoek is uitgevoerd in de vorm van interviews met 12 professionals van GGNet en Mindfit en drie patiënten binnen de eerstelijns geestelijke gezondheidszorg. De audio-opnames zijn getranscribeerd en er zijn 50 codes voor de professionals en 29 voor de patiënten bepaald.

De interviews zijn bottom-up geanalyseerd en niet gekoppeld aan bepaalde theorieën en constructen. Uit de eerste onderzoeksvraag *Welke eisen stellen professionals in de basis GGZ aan de implementatie van de interventie 'Een Sterk Verhaal'?*, komen de vier thema's *minder sessies, visueel maken, eisen aan professionals breder* en *Individuele vs. Groepssessies* naar voren. Uit de tweede onderzoeksvraag *Welke eisen stellen deelnemers in de basis GGZ aan de implementatie van de interventie 'Een Sterk Verhaal'?*, blijkt dat de vier thema's *aantal sessies, voordelen en moeilijkheden van de interventie, communicatie voor en tijdens de interventie* en *Individuele vs. Groepssessies* kunnen worden onderscheiden.

Bepaalde aspecten uit de vorige haalbaarheidsstudie, zoals het aspect van het delen van je verhaal, werden in deze ontwerpstudie genoemd door professionals en deelnemers. Over het algemeen hadden de professionals en deelnemers niet altijd een eensluidend antwoord, zoals over het aantal sessies en groeps- of individuele setting. Echter, de professionals werden slechts gerekruteerd uit twee organisaties met een visie op het gebruik van positieve psychologie, wat betekent dat andere organisaties andere resultaten kunnen hebben opgeleverd. Vervolgonderzoek kan zich richten op de implementatie van de interventie, waarbij eventueel onderscheid gemaakt kan worden tussen een groeps- of individuele setting.

Trefwoorden: levensverhaal interventie; basis GGZ; ontwerpstudie.

Introduction

In recent years, there has been a shift in Dutch mental health care from the medical model to integrating personal recovery support, where professionals listen, ask questions and search together with the patient for what is needed (GGZ Standaarden, n.d.). The Dutch primary mental health care [Generalistische Basis GGZ] is intended for people with mild, moderate or stable chronic psychological problems or complaints (GGNet, n.d.). This care is usually short-term lasting up to a year and is complaint-oriented regardless of the recent shift in Dutch mental health care (Patiëntenfederatie Nederland, 2021). Since 2014, there are four care categories within primary mental health care:

1. *Short*: for simple but persistent disorders with low risk
2. *Medium*: for disorders of moderate severity, a single or low-complexity profile and low to moderate risk
3. *Intensive*: with serious problems, a single or low-complex profile and low to moderate risk
4. *Chronic*: for participants with stable chronic problems and a low to moderate risk. Participants often have a history of mental health care and there are often underlying personality problems (Bakker & Jansen, 2013).

For the chronic care category within primary mental healthcare, recovery and empowerment are mentioned as goals (GGZ Standaarden, n.d.). Generalist care workers support the participant in overcoming stagnation. Ideally, this should be done with a solution-focused and non-pathologising attitude (Hutschemaekers, Nekkers, & Tiemens, 2019). This is almost a paradigm shift for care workers who work within other care categories (B. Groenen, personal communication, April 28, 2021).

The primary mental health care would therefore benefit from interventions focused on well-being and personal recovery. The design of the intervention 'Een Sterk Verhaal', could complement the existing interventions as it aims at improving positive mental health through life story work. This thesis aims to conduct a design study on how the intervention 'Een Sterk Verhaal' could be implemented in primary mental health care by interviewing professionals and participants on what their requirements are for such an intervention.

The intervention Een Sterk Verhaal [An Empowering Story] facilitates working on one's life story to promote personal and social recovery (Rosenboom et al., 2019). At the

moment, this intervention is being implemented at Scelta Apeldoorn, a treatment centre within the specialist mental health care for people with personality problems (Rosenboom et al., 2019). Although the intervention has been researched in recent years, its application in primary health care has never been investigated (Z. Loderus, personal communication, March 29, 2021). In mental health care, many interventions focus on clinical and functional recovery (Rosenboom et al., 2019).

Theory

Positive mental health and Personal Recovery

For understanding the intervention in this thesis, knowledge of positive mental health is relevant. In the past, mental health, according to the medical model, was defined as the absence of psychopathology (Provencher & Keyes, 2013). Nevertheless, many individuals otherwise free of mental disorders did not feel healthy or well-functioning (Keyes, 2005). The study of positive functioning can add to the understanding and prediction of mental illness (Wood & Tarrier, 2010). With the shift in focus from complaints to strengths, a whole series of new studies, insights and effective psychological treatments have emerged (Queitsch, 2015). For example, based on research on well-being in the general population, there are 13 different dimensions of mental well-being distinguished in adults and adolescents (Provencher & Keyes, 2013; Keyes, 2006). Most important, within these dimensions there are two sub-divisions: *emotional well-being* defined by positive affect and recognised quality of life, and *positive functioning* characterised by both psychological and social well-being. As a concept, *flourishing* is thus characterised by high emotional wellbeing, as well as positive functioning. Consequently, the Complete State Model of Mental Health states that mental health is not only the absence of psychopathology but also flourishing (Keyes, 2005; Provencher & Keyes, 2013). Finally, using the dimensions of flourishing, links were made between positive mental health and personal recovery (Provencher & Keyes, 2013). Based on this model, personal recovery is understood as flourishing in life despite having a mental illness. From the combination of mental illness and positive mental health outcomes, six states of recovery emerge: (1) not recovered from mental illness and languishing, (2) not recovered from mental illness and moderately mentally healthy, (3) not recovered from mental illness and flourishing, (4) recovered from mental illness and languishing, (5) recovered from mental illness and moderately mentally healthy, and (6) recovered from mental illness and flourishing (Provencher & Keyes, 2013).

Personal recovery has its origins in psychiatry, particularly among participants dissatisfied with traditional care according to the medical model (Provencher & Keyes, 2013). In the first place, psychiatric patients emphasised the possibility of personal recovery from mental illness. To illustrate, they defined recovery as the ability to achieve a meaningful and fulfilling life despite psychiatric symptoms (Provencher & Keyes, 2013). Furthermore, Anthony (2000), director of the Centre for Psychiatric Rehabilitation in Boston, also defines personal recovery (PR) in people with mental disorders as regaining autonomy, developing a positive self-image, and finding purpose in life beyond the constraints imposed on them. In effect, systematic research and narrative synthesis yielded the concept of CHIME - five recovery processes consisting of connectedness, hope and optimism about the future, identity, meaning in life, and empowerment (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). Provencher and Keyes (2013) redefined recovery as a complete mental health experience that includes both recoveries from mental illness and the optimisation of positive mental health.

Life story work and life review

One way of promoting positive mental health and personal recovery is life story work and life review utilising private memories (Westerhof, 2015). Although life story work and life review have some overlap, they are not quite the same concept. *Life story work* (LSW) is the overarching term for biographical practices used in health and social care to provide opportunities for people to reflect on their life experiences (McKeown, Clarke, & Repper, 2006). In essence, LSW is used primarily in social work. As a social work technique, it was developed to meet the needs of children who have been separated from their biological families through adoption or long-term foster care (Baynes, 2008). Although LSW is not a form of therapy, it can be therapeutic. As can be seen in a systematic literature review on LSW and its use in health and social care settings, life story work is a complex activity that should only be implemented with a strategy, protocol and training (McKeown et al., 2006). Moreover, information about someone’s life story can be displayed in various ways, for example, in the form of a life storybook, consisting of a book of photos, text and other collectables (McKeown, Clarke, Ingleton, Ryan, & Repper, 2010).

The following are examples of studies on life story work: In terms of LSW in mental health care, a qualitative study of nineteen life stories from people aged 55-69 with ongoing long-term alcohol problems found that it can restore agency, meaning that the participant can begin to take control over their alcohol use and their life (Bergström, 2017). McKeganey (2002) examined the stories of 70 recovering Scottish heroin addicts and discovered that their

stories can be seen as recreating a new, whole identity out of a fractured identity. He found this out by reconstructing what led to their drug-taking behaviour, how they created a new sense of self and what the reason was for their personal recovery.

Life review was originally developed as a structured life re-evaluation for older people (Fry, 1983). It was intended to allow them to reconcile their end-of-life experiences. This was inspired by the eight stages of psychosocial development described in the works of Erikson (1950). The last one is *integrity versus despair,* in which life review was considered essential to promote the attainment of ego integrity and avoid despair in late adulthood. Ego integrity refers to accepting one's own life with wisdom and reconciliation (Erikson, 1950). Since there is a growing interest in offering life review to younger age groups as well, it is increasingly being studied in children, adolescents and young adults (Jones, Lyons, & Cunningham, 2003). An exploratory mixed methods study with younger survivors of critical illness showed that life review therapies can serve as a preventive intervention against future stressful events (Jones, Lyons, & Cunningham, 2003). Life review has therefore become more future-oriented and similar to life story work. By offering a structured reassessment of one's life to cope with negative memories, it gives life a positive meaning and a goal to live towards.

Life review therapy asks participants to critically evaluate and come to terms with positive as well as negative memories (Man & Ming, 2012; Westerhof, 2015). It is structured and covers the entire life of the participants (Haight & Burnside, 1993). To clarify, the therapist taps into an already ongoing life review in patients (Lewis & Butler, 1974). When this life review is taking place, psychotherapeutic techniques are utilized, such as cognitive behavioural therapy, narrative therapy and creative therapy, to relieve clinically relevant distress (Bohlmeijer, 2008; Korte et al., 2012). During the therapy, participants may create a life storybook as a form of personal documentation as in life story work (Haight & Burnside, 1993). LRT can be conducted in a dyad or group format (Man & Ming, 2012). A group format consists of a therapeutic listener and several reviewers. An exploratory study identified ten positive social processes of life review, which could be divided into three categories: first, having a good atmosphere in the group; second, disclosure to peers; and third, relating to others (Korte, Drossaert, Westerhof, & Bohlmeijer, 2014). Negative processes were mentioned less frequently, and these included difficulties with sharing in a group, not finding recognition, and anxiety caused by the prospect of not finding recognition. LRT brings with it many ethical challenges but can enhance the self-confidence and communication skills of group members by being able to share experiences with reviewers

having a similar diagnosis (Haight & Burnside, 1993). In contrast, the dyad format consists of a therapeutic listener and one reviewer, which gives the reviewer more of an incentive to focus on their life review. Furthermore, it minimizes confidentiality issues (Haight & Burnside, 1993). Taking into account this research the format of the intervention "Een Sterk Verhaal" can be decided concerning the implementation in primary mental healthcare.

A quasi-experimental study found a partial gender difference in LRT with women being less negative about the specific source of meaning in life and men being less negative about the future (Bohlmeijer, 2008). Taking these gender differences into account a life story therapy can develop specific exercises focusing on either the future or specific sources of meaning in life. In a randomised controlled trial, LRT was also found to be effective in promoting ego integrity in cancer patients in palliative care (Kleijn, 2018). Accepting one's own life is important to promote personal recovery that continues beyond therapy. A large study with a sample of 202 older adults with depression on LRT reported a significant reduction in anxiety symptoms, depressive symptoms and improvement in positive mental health in the intervention condition (Korte et al., 2012). Especially for patients in primary mental health care who suffer from anxiety and depressive symptoms such interventions could lead to overall improvement. More extroverted people benefited more from group therapy as they were more likely to share their thoughts and feelings with the other participants (Korte et al., 2012). Insofar adjustments may be needed to make group therapy suitable to introverted participants or options of individual therapy put in place. Most compelling evidence was found in a meta-analysis that showed that life review as a therapeutic intervention to reduce depressive symptoms in older adults has moderate effects (Westerhof & Slatman, 2019).

LR and LRT have also been found to be effective in increasing well-being factors related to positive mental health, thereby increasing personal recovery (Bohlmeijer et al, 2007). Interviews with participants and professionals may provide insight into whether this is also the case in primary mental health care. There are also disadvantages and complications to be considered before implementing LRT. As a method, it may increase a participants' feelings of bitterness and victimization (Korte et al., 2009; Man & Ming, 2012).

Intervention 'Een Sterk Verhaal'

The Intervention 'Een Sterk Verhaal' [An Empowering Story] falls under life story work as that is a broader concept but includes elements of life review therapy. It was realized in cooperation with therapists and participants from Scelta – a part of the GGNet that specializes in personality disorders (Rosenboom et al., 2019). The aim was to integrate the best scientific knowledge on LSW and LRT with professional expertise and the attitudes and values of the clients. A participatory design was used that came about in three phases, namely phase 1: Design study, phase 2: Feasibility study and phase 3: Implementation (Zillah, personal communication, March 29, 2021). The intervention has so far gone through phase 1 and phase 2 (Pol & Loderus, 2020). A participatory design study was conducted with experts and practitioners in several rounds of interviews and focus groups resulting in consensus on the design. This was followed by a feasibility study. Participants improved significantly in personal recovery. Their life books showed story characteristics related to recovery and both participants and supervisors appreciated the intervention positively (Pol & Loderus, 2020).

The 13 participants of the previous feasibility study (Pol & Loderus, 2020), mostly mentioned working on writing assignments in the group, sharing stories in the group and paying attention to the writing process as useful aspects of the intervention. Especially the aspect of sharing your story was mentioned by the one patient with previous experience as a with a life story intervention in this design study. Aspects that hampered the process in the specialist health care were a perceived lack of time in some sessions, an excess of impressive stories in one specific session, the need for a lot of time for homework and initial uncertainty about the deadline for the digital format. During a comparable pilot and feasibility study of the My Life Story programme, which aimed to promote positive mental health and wellbeing in adolescents and older adults, the main theme that emerged was the ability to create understanding and growth (Knight, Skouteris, Townsend, & Hooley, 2017). The themes of breaking stereotypes, recognising individual differences, making effort and personal gain through contribution are indicative of this growth and understanding (Knight, Skouteris, Townsend, & Hooley, 2017).

The current intervention as developed and tested for feasibility with persons with personality problems included a total of 13 participants. After the feasibility study, the intervention was adapted again on the basis of the problems encountered. They followed twelve weekly sessions of which each has their topic with a plenary and individual part

(Rosenboom et al., 2019). Depending on the number of participants, a session lasted 90-105 min. The themes were based on a triptych with part one about the past, part two about an important turning point in life and part three about the present with a vision for the future. To be able to make their life book the participants must refresh their memories and order the events in their lives. To do this, they lined it up schematically with a life line assignment. There was homework of about two hours per week to be completed at home which made up a personal life book. In the sessions, they began the assignments and then continued working on them as homework. After the participants had given their final approval of the book, at the latest at the end of week 10, the printing process could be started so that the personal life books were delivered on time (Rosenboom et al., 2019).

Facilitators of this module are expected to participate in training before offering the module (Rosenboom et al., 2019). The module is offered with two facilitators, one of whom is an experienced clinical psychologist or psychotherapist. The role of the facilitator does require a coaching and training approach rather than a therapeutic one. If participants need more space or support, they are referred back to the regular treatment programme. When participants are absent during the session, the facilitator needs to seek contact with them in an inviting tone. The role of the counsellor is to think along with the participants in a solution-focused way, but also to make them aware of their responsibility (Rosenboom et al., 2019). So far, professionals have only conducted the intervention in specialised mental health care for people with personality disorders and this design study will research if this can be implemented in primary mental healthcare.

For this design study, it is important to consider whether this could happen during the implementation of the intervention in primary mental health care. The development of protocols involves ethical considerations such as the issue of ownership of the life storybook and the notes taken by the professionals. This needs to be discussed as part of a design study of an intervention such as ‘Een Sterk Verhaal’.

Goal and Research Questions

The intervention “Een Sterk Verhaal” needs to be adjusted from specialized care for personality problems to primary mental health care. Considerations that need to be made regarding intervention in primary care are how to embed the intervention in the treatment context of the organisation, format of sessions, tailoring to the participants, number of sessions, homework and supervision. To adjust the intervention to the primary mental health

care, participants and professionals within GGNet are interviewed. This takes place from the participant's and professional's perspectives through semi-structured interviews. In this way, it is investigated what adjustments need to be made to the intervention. From this standpoint, the following research questions are formulated:

1. What requirements do professionals in primary mental health care have regarding the implementation of the intervention 'Een Sterk Verhaal'?
2. What requirements do participants in primary mental health care have regarding the implementation of the intervention 'Een Sterk Verhaal'?

Method

Design

An interview design was employed with semi-structured interviews about how the intervention could be implemented in primary mental healthcare. Due to the pandemic, most interviews could not be conducted face to face. However, if they were in-person all restrictions for the institutions Bas and Mindfit (face masks in public spaces, being symptom-free, 1,5-meter distance and not meeting with more than one person) were adhered to.

Recruiting participants

Notably, two separate groups were recruited:

1. Psychologists and social psychiatric nurses working in primary healthcare (basis GGZ) who can understand Dutch as the intervention handbook is written in Dutch.
2. People making use of primary health care (basis GGZ) above the age of 18. Furthermore, they needed to be able to read and understand the intervention handbook written in Dutch.

The recruitment of the professionals to the intervention took place online via LinkedIn, emails to mental health organizations Mindfit and Bas and by prof. dr. Gerben Westerhof initially contacting them. The recruitment of participants for the intervention took place via contact persons who invited participants in therapy to send the researcher an email. Furthermore, they were also recruited via Instagram Stories. The two organisations that professionals were recruited from are Bas and Mindfit. Bas Basis GGZ offers mental health care to everyone from eighteen years of age who has mild to moderately severe mental health problems. Bas Basis GGZ was set up three years ago. It was set up by the director of Bas, who wanted to work based on positive psychology and therefore wanted to make a difference

compared to many managers who were still working from a complaint-driven approach (B. Groenen, personal communication, April 28, 2021). Mindfit offers treatment for adults aged 18 and older in the basic mental health services. Based on positive psychology, their professionals work in a solution-oriented way to improve the overall mental condition.

Before the actual interview, the professionals and the participants were asked to read a copy of the workbook. Some interviewees read it directly when they received it so one week prior and others read it directly before the meeting. In addition, they were asked to fill in a demographic questionnaire and informed consent. Then, professionals and participants were interviewed individually so that the answers would not be influenced by other interviewees. Ultimately, interviews lasted 30 min - 1 h and were supported by a PowerPoint presentation which varied for participants and professionals. Initially, general questions were asked about personal recovery, well-being and life story interventions. Briefly, the intervention 'Een Sterk Verhaal' was presented. Arising from this, specific questions were asked about the intervention, the overview of the sessions and in particular session one. Interviewees were asked to voice their opinion on how the intervention should be adapted for use in primary mental healthcare.

Participants

Twelve professionals took part in this interview. Five of them were from Mindfit and seven were from Bas Zutphen. One of them was male and the other eleven were female. The average age was 38 years with an average work experience of 13 years. There were two social psychiatric nurses, seven psychologists, one Gz-psychologist and two Gz-psychologists in training. Three female participants aged 20, 21 and 38 took part in the intervention. Two participants were students: one of physiotherapy and one was about to switch to becoming an art teacher. Only one participant disclosed the disorder she was suffering from namely general anxiety disorder.

Materials

Initially, all interviewees received the digital handbook *Een Sterk Verhaal - Je verleden tegen de horizon van je toekomst* [An Empowering Story - Your past against the horizon of your future] (Rosenboom, Ullrich, Pol, Loderus, Chakhssi, & Westerhof, 2019). The handbook details the program for all twelve sessions based on a triptych. Session 1 is about getting to know the participants and facilitators and drawing their life line (part 1 of the triptych). Completing the drawing of the life line is given as homework. From session 2

onwards meditative stillness exercise, concentrating on the breath and the surroundings were integrated at the beginning of each session. Then the homework from the last session was discussed and a new topic was introduced. Lastly, Session 12 is a conclusion in which it is about the own life story as a book which the participants may take home and an evaluation of the course.

The Zoom Windows App and Google Meets were used to conduct the online interviews on an HP Elitebook 840 G5. During the interview, an eight slide PowerPoint presentation was used for the professionals (see Attachment A) and the participants (see Attachment B). The first slide was a title slide. The second slide contained three general questions which different for participants and professionals. For the professionals, it read:

1. How important is a personal recovery intervention in your institution?
2. How does an approach that focuses on personal recovery and well-being fit into primary care?
3. How does a life story intervention fit into basic mental healthcare?
4. What are the preconditions for a module in basic mental healthcare?

For the participants, on the other hand, it read:

1. How important is a personal recovery intervention to you?
2. How might a life story intervention help you review your past and present and plan for the future?
3. In what circumstances do you think a life story intervention might be useful?

The third slide is an explanation of the intervention and an opportunity for the participants to ask any questions they may have after reading the handbook. Then, the fourth slide is :

1. How would you like this intervention to be adapted to better meet your needs?
2. What could cause this intervention to fail for you?
3. Would you prefer to participate in this intervention as individual therapy or as group therapy?

4. Would you prefer to do this intervention with other participants with the same diagnosis or with a mixed group?

For the professionals it read:

1. What do you think are important considerations when applying this intervention to the basic GGZ?
2. How should it be embedded in the treatment context at Mindfit / Bas?
3. How do you keep it a training rather than a therapy?
4. How can the group best be composed?

The fifth slide contained the design of the intervention with the question of what they thought of the structure of the intervention. The last three slides contained a summary of the first session of the intervention and the following identical questions for both participants and professionals:

1. What do you think of these exercises for Session 1?
2. What do you think about the way this assignment is formulated?
3. What do you think of the way the workbook has been designed?

Analysis

Analyses of the interviews were conducted using ATLAS.ti 9. Moreover, the qualitative data that comprised the transcribed parts of the interviews were analysed using Braun and Clarke's (2006) thematic analysis. This was done solely in a bottom-up manner and did not involve specific theories and concepts. Sentences and coherent parts of the text were coded. The data of the professionals and the participants were analysed separately. First of all, the data was transcribed using Amberscript and initial ideas were noted. In total there were 88 quotations for the professionals and 33 for the patients. Secondly, general interesting features were coded forming initial codes. The focus was on requirements for the implementation in primary health care. In particular, there were 50 codes for the professionals and 30 for the patients. As there were only three participants there were not as many quotations and codes that could be extracted from their transcript. All the quotes of the participants are about different things, so in terms of ratio, there are almost as many quotations as codes. Thirdly, using bottom-up analysis, what looked to be recurring themes and striking remarks from the participants were examined. Subsequently, these themes were reviewed concerning the coded extracts (level 1) and the entire transcript (level 2). Meaning

that the quotes that had been coded were the extracts but these were put into context and reviewed by viewing the quotes within the transcript. Fifthly, these themes were named according to the main subjects and clearly defined. The themes were named in the researcher's own words. The quotes that explained aspects of the themes were chosen to give a detailed insight into the findings.

Results

Professionals

Overall, the interviews with the professionals were informative as the professionals themselves were knowledgeable and had studied the handbook of the intervention before the interview. Some of the professionals had also discussed it with colleagues and made shared notes on the requirements they have. The chosen organisations Bas and Mindfit are grounded in positive psychology and therefore the professionals are used to working with innovative interventions and therapy concepts. Many of the professionals had worked on life line assignments or with Narrative Exposure Therapy (NET) and therefore were aware of the benefits of telling one's life story. The professionals appreciate the intervention because it will give the participants a chance to tell their life story which often falls short in regular care due to complaint-oriented treatment and time restrictions.

From the first research question *What requirements do professionals in primary mental health care have regarding the implementation of the intervention 'Een Sterk Verhaal'?*, four themes can be distinguished: *fewer sessions*, *making it visual*, *supervision* and *Individual vs. Group Sessions*.

Fewer Sessions. Based on how primary health care is organised the professionals mentioned that the *number of sessions* should be reduced. One of the ways this can be done according to the interviewed professionals is by replacing the writing sessions with homework as participants within primary mental health care have enough self-sufficiency. One psychologist describes this as follows: *"*So maybe you should put it in the planning so that people do reserve that time. But then clearly state: This session takes place at home. Look, I would also give them the awareness exercises and the exercises for standing still. But I would have them recorded, or record them myself so that people could take them home with them because that also takes time for the therapist and is part of the treatment. Then I think it is just doable within the basic GGZ.*"* She was referring to the meditation exercises that are currently described in the handbook as a group activity. There is an awareness exercise in

which attention is paid to their breath, to leave room for thoughts, feelings and sensations, and a silence exercise that recurs in several sessions. The Gz-psychologist in training mentions that this could be pre-recorded and given to the participants as homework in between sessions. This is primarily due to limitations upheld by health insurance. The Zorgprestatiemodel 2022 was mentioned by two professionals as something that could affect the number of sessions that are possible for this intervention. *"*I don't know how that will work when the care performance model is introduced in January 2022. Funnily enough, we do not know exactly how it will work.*"*

Making it visual. Both social psychiatric nurses and a Gz-psychologist in training mentioned the need to make the tasks more visual instead of only allowing writing. *"*But in this respect, I think that for some people writing is going to be fine [...], but there will also be people who have dyslexia, for example, and find it very difficult out of shame.*"* This would also mean defining the end product more broadly. For example, professionals say: "Just the same thing, but make the intervention a little broader and take the emphasis off the writing and producing the book. The fact that that is the end goal should perhaps be relaxed a little. So, that the therapist can decide for himself: Do I make a nice collage with someone, for example, or is it just enough to work through all the sessions without coming up with an ending, a book or something?*"* Lastly, the adjustment of the life storybook to include known exercises such as the Yucel method (van Wamel & Planije, 2018). One social psychiatric nurse said: "Yucel is a very nice method with blocks in different colours, in which you lay down the blocks together with the client. They all have different forms in which you lay down someone's life story in the form of blocks and forms and colours. In which you can see at a glance, when it is finished, what someone's foundation was like. Was it strong, or was it very unstable? What elements have been added? That, for example, is a very nice visual way of getting your life story clear. We also work with that in primary mental healthcare. So we were thinking of perhaps combining several elements. For example, you could dedicate a session to the Yucel method or photographs, instead of everything being very descriptive and with lots of texts."

Supervision. This theme arose due to the provided handbook specifying that this intervention should be lead by two professionals, one of whom is an experienced clinical psychologist/psychotherapist. One psychologist said: "[...] the GZ psychologists do not give the groups either, because they are just extremely busy with other tasks that the GGZ does so that we might not be able to do [...]. So I would say: let a primary psychologist or one of the positions from a University of Applied Sciences: a nurse, a nurse specialist, or things like that, do the groups.*"* Also, the number of professionals needed to lead such an intervention was commented on: "If there is a larger group for eight to ten, then we usually do it in pairs, because if someone drops out again the other therapist can take over. If individual attention is needed, it is just a little bit easier to give. The small group I would do alone.*"* One social psychiatric nurse from GGNet Zutphen said about positive mental health: "Because at GGNet Zutphen, we work with personal recovery as the starting point for this intervention. [...] Yes, with complaints in mind, but of course also with positive psychology, so that you not only look at the complaints, but also at the positive aspects, the strengths of people, and in that case, the life story that people tell - recalling memories of one another. And so to promote well-being meaning that in the end, they do much better, that is always the idea behind it, of course."

Individual vs. Group Sessions. Overall, the concept of group sessions was supported and most professionals preferred a mixed group within the primary healthcare. This can also be related to the available sessions. As one professional described it: "Yes if I look at the packages say the minutes we have, I would say in a group, because then it is doable, I think.*"* Furthermore, the participants in primary healthcare are diverse and not ordered by the diagnosis as one professional explains: "Yes if you look at Bas chronic and then primary mental healthcare in general, it is very mixed, so we don't have a very clear target group.*"*

Nevertheless, it was mentioned that participants wanting to participate should be stable, able to take responsibility and engage in self-reflection. Moreover, there may be a need for a separate group for people with an intellectual disability as one professional points out: "Well, I think, the target group of mentally disabled people, the people with IQ problems. I would not put them in a group like that, except if you put them in a group together and simplify the intervention even more.*"* A social psychiatric nurse said the following about the chronic care category: "I think there are also a lot of people from the sGGZ who are getting out of care after years. All those protocols don't work for them

anymore. They've had so many therapists and protocols that this intervention in particular can do very well to help them get back on their feet, understand themselves, know where they come from, know where their strengths lie. So I can imagine that this is a very good intervention, especially for the Bas recovery target group, which is the Bas chronic target group."

Both social psychiatric nurses and another professional mentioned the intervention possibly also working as individual sessions. One professional said that: "But it is precisely those people who are somewhat introverted who want it offered as individual sessions. And we get a lot of those people in our target group - the introverts."

Participants

Overall, the interviews with the participants were informative to get an individual opinion of the intervention but the participants had not studied the handbook of the intervention before the interview. One of the participants had already gathered some experience with life story interventions in a group setting and the other participants had only had more symptom-based therapy. The participants were supportive of the intervention although two of them would have preferred a different set-up with individual sessions instead. Overall, the participants spoke of viewing the relationship to the psychologist as more important than the intervention itself and two had also had bad experiences with psychologists in the past that did not listen to their concerns.

From the second research question *What requirements do participants in primary mental health care have regarding the implementation of the intervention 'Een Sterk Verhaal'?,* it emerges that the four themes *number of sessions, benefits and difficulties of intervention, supervision before and during intervention* and *Individual vs. Group Sessions* can be distinguished.

Number of sessions. Overall, the number of sessions was not agreed upon. The patient that had already gathered some experience with life story interventions in a group setting said that the eight sessions recommended by the primary healthcare would be enough. The other student mentioned that twelve sessions would be more realistic explaining: "Yes because I also think that eight, maybe just a little bit too little. Indeed, because you also just want to go a bit in-depth. So yes, I think 12 would be more appropriate." The patient from GGNet Zutphen would prefer to work with the life storybook on her own throughout a year

or more so as not to feel the pressure of being selective with her own life story. About homework, only the two students were enthusiastic claiming it would help them work through what they experienced in the several sessions. One student suggested eight sessions with homework in between. The first sessions would just be for mapping out where the patient is at and then the first real session would include sketching of the life timeline: “I'm convinced, but that would be a bit of homework for your participants. At that point of mapping out and maybe with the first session, or so just throw the idea out there as well, dot some dots, a rough sketch, we'll talk about that as you progress comfortably, move forward with it.” The other one who suffers from general anxiety disorder described how she feels in the session and why she wants to do some homework: “Only then you are very much occupied with your thoughts. So I think that maybe it would suit me more if I did it at home, that piece, I think.”

Benefits and difficulties of intervention. The three benefits to this intervention mentioned by the participants were getting to know yourself better, having a clear overview of each session and nice exercises. One patient with general anxiety disorder described: “Yes, I think it would help me to understand myself a bit because sometimes I just think: where does all this stress and anxiety come from? But if I look back sometimes, I think, gosh, some things have happened that have made me this way, because I understand that myself and can apply it more easily. How did I react then and why did you have a positive experience, that things did go better?” By describing such benefits of the intervention to potential participants, participants could be motivated to join the group sessions when implementing this intervention in primary mental healthcare. On the other hand, all participants also touched on the difficulty of speaking about your past and the feelings that can go with it. One student said: “It is especially confronting at the moment when you don't always realise how hard things have been, especially going back to my childhood.” This could increase feelings of bitterness and lead to participants dropping out of the intervention. The other student who had experience with life story interventions confirmed this point of view by elaborating: “It is quite difficult to hear everyone's difficult life story.” These are difficulties that need to be considered when implementing this intervention in primary mental healthcare by focusing on aspects mentioned under supervision or considering a (partial) switch to individual sessions. The participant with anxiety disorder thought it could help her deal with past experiences and give her self-insight, therefore, naming important components of personal recovery but not the term as such: “You do notice that life in the past causes problems, but that you bring it

with you now. Such interventions can help you not to carry it with you later on, but to solve it now, so that it becomes a little better, which is very important."

Supervision before and during intervention. In terms of the supervision before and during the intervention, two participants thought the communication with and relationship to the therapist are important. This was explained by one patient that compared a good with a bad therapist: "In my case, it was mainly communication between me and the therapist, because I went to an intake meeting with a completely different person a few times, which went very well. We just talk to each other easily, seemed to understand me and I didn't have to use a lot of words to express something small. I also had several people, who were supposed to be doing my treatment, who just didn't listen to you, or put their spin on it." Furthermore, it is important a patient said from her past experiences with life story work that you share your story in your own time: "Find the border but don't cross it. And some do cross it. But do it of their own accord and not under pressure from others. But anyway, they had a hard time starting the story and some people just really talked through the tears." Lastly, one participant thought it was important that the participants are motivated: "Think it's exactly right that you have the motivation to do that."

Individual vs. Group Sessions. Two participants would prefer the intervention to be offered as individual sessions – one-on-one with the therapist. When doing so they would not be distracted by other peoples stories and find it easier to tell their own. As one patient describes: "I think I would prefer to do it in person with a psychologist, so that you have more personal interaction with that person and can go into your own story because otherwise, you are with others, and sometimes that seems to me to be more difficult." The third patient on the other hand had had her previous life story work interventions in a group setting and said: "If you have people with, for example, depression or an anxiety disorder or something else, a bit like that, then it might be possible. Borderline personality disorder, that sort of thing. But if you have clients with post-traumatic stress disorder, you shouldn't do it in a group, I think." So in general she would recommend a group setting just not for participants with certain diagnoses such as post-traumatic stress disorder.

Discussion

The possible implementation of the intervention 'Een Sterk Verhaal' in primary mental health care was investigated for this study. The focus was on the requirements that participants and professionals with primary health care would have. There are differences between specialist and primary mental health care, and it was not yet evident how the intervention could be adapted to these differences. Furthermore, not all care categories within primary mental health care have interventions in place that focus on wellbeing and personal recovery. From the interviews with the professionals, four themes emerged. Within each of the themes, several requirements have been formulated. The professionals agreed that the *number of sessions* should be reduced due to limitations from the health insurances but added that this could be based upon the upcoming Zorgprestatiemodel 2022 which would determine the number of sessions allowed for an intervention. To adjust the intervention for a mixed group of participants it was suggested *making it visual*. Also, the *supervision* should not only include experienced clinical psychologists/psychotherapists as these are in-demand within primary mental healthcare. The issue of *Individual or Group Sessions* was not agreed upon instead it was mentioned that some patients might need more changes to the intervention than others making the one-on-one setting more suitable but most participants can participate in group sessions.

In contrast, the participants mentioned four themes that were related to their personal opinion and experiences instead of considering organisation and professional frameworks. As to the *number of sessions*, the participants disagreed and indicated a range between eight sessions and one year. Their answers depended on the experience they had with life story interventions and their motivation for therapy as a result of setbacks. Among the *benefits and difficulties of the intervention* were the difficulty in listening to others' past experiences in the group and also facing one's past, which might lead to discontinuing the intervention, making the support of the benefits of the intervention advisable. Therefore it is important when implementing the intervention to possibly consider individual sessions or discuss the others' past experiences in the group in a reflective manner to process it. Regarding the *supervision before and during the intervention*, the relationship and communication with the therapist were considered to be decisive factors for the successful implementation of this intervention in primary health care. Finally, regarding the consideration of *Individual vs. Group Sessions*, participants preferred that the intervention be offered as individual sessions.

Most themes professionals mentioned were focused on the requirements for the intervention within their organisation. Therefore the number of sessions should be reduced, for participants a visual approach to the life storybook may be beneficial to include intellectually disabled individuals and also the professionals involved should be more widely defined to include psychologists in training and psychiatric nurses as well. Research has shown that sharing experiences with participants with similar diagnoses provides benefits that would not be the same in a mixed group (Haight & Burnside, 1993). This broadening of the requirements for creating a life story book would be in line with the statement by McKeown, Clarke, Ingleton, Ryan, and Repper (2010) who suggest that a life story book can also consist of photographs and other collectables.

The participants did not have a unified answer to the number of sessions as they wanted to have enough time to work through any difficult themes that may come up during the intervention. Many life story interventions include 12 group sessions, each lasting 1 to 2.5 hours and focus on a different theme (Bohlmeijer et al., 2005). Shortening the number of sessions would mean to them that concessions may be made in the quality and personal attention. The professionals mentioned that the number of sessions should be reduced. In general, professionals and participants alike acknowledge that the process might be challenging for (some) participants and therefore requires appropriate care. As a method, life story therapy can strengthen a participant's bitterness and victimisation feelings, thus making proper handling of difficult issues of the utmost importance (Korte et al., 2009; Man & Ming, 2012). In addition, when group sessions were held, introverts were less likely to benefit as they were less inclined to discuss their ideas and emotions with other participants, thereby potentially increasing feelings of bitterness (Korte et al., 2012).

The participants answered the question about the requirements for the intervention from their perspective and experience instead of taking into account an organisation or framework. Among the themes addressed were the difficulties and benefits of such an intervention, including feelings of bitterness as a result of sharing one's own past experiences, feeling overwhelmed by the life stories of other participants, but also gaining self-insight. In a study of recovering Scottish heroin addicts, who were reviewing their lives, this recovery of self-identity was also found (McKeganey, 2002). Coping strategies can also be learned by reflecting on how the past is affecting the future as well. This more positive outlook for the future is essential for personal recovery according to the concept of CHIME (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). LRT has also been shown to reduce anxiety symptoms,

as experienced by the participant who cited this benefit (Korte et al., 2012). That LRT provides coping strategies for future stressful events was also demonstrated in a study with younger survivors of critical illness (Jones, Lyons, & Cunningham, 2003). The excess of impressive stories was mentioned in this design study by the patient with previous experience as a disadvantage of group sessions. To avoid failure of the intervention, these difficulties should be taken into account and the benefits should be further supported to ensure that the participants are satisfied with the implementation.

In terms of their requirements for supervision, all participants mentioned the relationship with the professional as formative for the success of the intervention. They did not mention that the particular qualification of the professional was important to them. Nevertheless, the right professional should be able to listen and also address the participants concerns. However, participants who had previously participated in a life story intervention mentioned more rewarding aspects of the intervention and fewer potential difficulties. Thus, as in the previous feasibility study (Pol & Loderus, 2020), the participants had a different view after than before a life story intervention. This shows that it is important to address the participants' initial doubts and name the potential benefits of this intervention possibly by quoting previous participants or even inviting a previous participant to answer a few questions. The lack of time for homework was a concern for one of the three participants in the design study. So then more homework should be given. Nevertheless, the professionals in the design study predicted that overall, participants in primary mental healthcare can do homework independently and promptly.

These results do not directly relate to previous research as to the impact of this intervention in primary mental healthcare. Certain choices made in the earlier studies are now different, such as the number of sessions, who exactly are the participants and how the intervention in this design study can be adapted to this, e.g. by using visual aids. The results may be compared with the feasibility study carried out on the intervention for participants in specialised mental health care with personality disorders at Scelta. In a subsection of the final report about the feasibility study, it was noted that the experience of the clinical psychologist/psychotherapist was necessary for this target group, which usually struggles with a fraught personal history, to reassure the participants and get them on board with the assignments, which could demand a lot in terms of time and emotions. This is in opposition to the theme of *supervision* in this design study. Hereby the professionals mentioned that in

primary mental health care there are a lot of social psychiatric nurses who are also essential in the programme. They are systemically trained and precisely for this type of intervention they are well suited and trained. The opportunity to create understanding and growth was the leitmotif that emerged during a similar pilot and feasibility study of the My Life Story programme (Knight, Skouteris, Townsend, & Hooley, 2017). Indicative of this growth and understanding are the themes of breaking stereotypes, recognising individual differences, making an effort and personal gain through contribution (Knight, Skouteris, Townsend, & Hooley, 2017). For participants in the design research discussed in this bachelor thesis, the main theme of growth and in particular understanding was also important. In contrast, the specific themes differ from this design study in that there are no two intergenerational cohorts that could learn from each other in A Strong Story.

The intervention “Een Sterk Verhaal” was based upon LSW and LRT. The issue of individual versus group sessions was discussed by professionals who agreed with previous findings that LRT in a group format can enhance the self-confidence and communication skills of group members and in a dyad format, the participant focuses more on their life review (Haight & Burnside, 1993). Based on the current results, it seems that both a group format and an individual format should be developed but that the life storybook should be extended to include different visual techniques apart from writing. Still, the positive effects of the group, such as a good atmosphere in the group, disclosure to peers and relating to others, should not be forgotten (Korte, Drossaert, Westerhof, & Bohlmeijer, 2014). On the other hand, the individual format would enable the participant to concentrate on their life review and reduce confidentiality problems to a minimum (Haight & Burnside, 1993). In terms of the four care categories in primary mental healthcare (Bakker & Jansen, 2013), the intervention might be most suited for chronic patients which have had several therapy sessions and need to work on personal recovery to be able to reduce the therapy need slowly. Finally, on to positive mental health and personal recovery, the participants think that the intervention can also contribute to self insight.

The limitations and strengths of this research are discussed in turn. Since the researcher was the only one who coded the data, no inter-rater reliability could be calculated. Describing the analysis process and including the group codes in Figures 1-8 (see Appendix C) increased the replicability of the analyses. As the implications of the upcoming Zorgprestatiemodel 2022 on the primary health care sector are unknown this could not be

taken into consideration without a margin of error. It would therefore be advisable to consider it when implementing the results from this design study. Another limitation may be that only three participants were interviewed and this is not enough to come to valid conclusions about the requirements participants within primary mental healthcare have for such an intervention. However, the inclusion of both professionals and participants perspectives provided contrast and a variety of viewpoints on the requirements within primary mental health care.

The professionals were only recruited from two organisations and different results might have been found in other organisations would have been including. These two organizations were founded with a vision of using positive psychology to improve the participant's mental wellbeing and not only treat their symptoms. Due to the pandemic, many organisations did not want their professionals spending their time helping with voluntary studies and instead focus on participants whose mental health was affected by lockdowns and other restrictions in 2021. Nevertheless, this design study has been insightful in terms of the requirements needed for application in primary mental health care. It has also offered both professionals and participants an introduction to both life story interventions and in particular the intervention "Een Sterk Verhaal".

From this design study, a final advice can be formulated about the implementation of this intervention in primary healthcare. As the interviews with the participants and the professionals generated different results the final advice cannot be clear-cut in all areas. The number of sessions would need to be further discussed concerning the implications of the upcoming Zorgprestatiemodel 2022 on the primary health care sector. If the number of sessions needs to be shortened then eight sessions would be advisable according to the professionals and the participant with previous experience with a life story intervention. Yet, if the number of sessions can remain the same, the professionals and especially the participants would prefer the additional time for in-depth conversations and getting to know the group before beginning with the first exercises. For participants who prefer individual sessions, this can be arranged with their psychologist with arrangements to promote connectedness for personal recovery without the group. Furthermore, the requirements for professionals to be clinical psychologists/psychotherapists might need to be reconsidered within primary mental healthcare following this design study. In terms of the frequency of the group session, they should be held every two weeks with planned homework sessions in between. To avoid participants getting overwhelmed by hearing other's past experiences

there is guidance from the professionals as foreseen by the handbook in the form of follow-up discussions and enough time between sessions to process past experiences with support questions. The instructions for the homework sessions could be written in the participant's handbook and meditation exercises could be pre-recorded. To meet the needs of mixed groups in primary mental health care, the intervention should be more comprehensive in defining the tasks for the participants, so that they also have the opportunity to add photos, drawings, carvings or other creative outputs to the life storybook. By beginning implementation in organisations with a focus on positive mental health and personal recovery such as Mindfit and Bas, participants can experience all the benefits of this intervention.

Conclusion

This qualitative design study aimed to gain insights into the requirements that participants and professionals have for the intervention 'Een Sterk Verhaal'. Already known information from the feasibility study of this intervention in specialist mental health care could be partly confirmed in terms of the benefits. It is necessary to consider for which people this study is suitable and how it can best be carried out. It has proved useful to include the perspectives of practitioners and participants in the study and to reflect on them from the scientific literature. This design study has shown that the number of writing sessions can be reduced and that homework can be scaled up to make up for the missing writing sessions. Mainly, the group needs to accommodate a variety of participants in primary mental health care, as people and treatments are not prescribed based on the diagnosis but instead made available to all interested participants. For this reason, the professionals want to reduce the limitations set on professionals and participants by including psychiatric nurses who have more time to focus on such group interventions than a much-needed GZ psychologist. Follow-up research can focus on the implementation of the intervention possibly differentiating between a group or individual setting. This may provide more insight into the effectiveness of this intervention within primary mental healthcare. This can be informative for the developers as well as the professionals who get a chance to execute this intervention. This could be done with interviewed professionals from GGNet and Mindfit as they have already read the handbook and thought about the possible implementation.

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Appendix A

Presentation slides interview professionals

Interview Een Sterk Verhaal

De mening van een professional

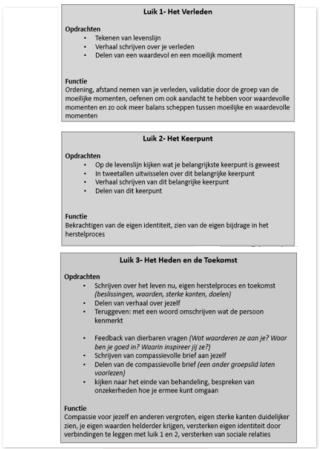
UNIVERSITY OF TWENTE. Bas. Bas is dichtbij

Algemene Vragen

- Hoe belangrijk is een interventie voor persoonlijk herstel in uw instelling?
- Hoe past een aanpak die gericht is op persoonlijk herstel en welzijn in de basis-GGZ?
- Hoe past een levensverhaalinterventie in de basis-GGZ?
- Welke randvoorwaarden gelden voor een module binnen de basis GGZ?

Een Sterk Verhaal

Interventie richt levensverhaalwerk in 12 groepssessies	De thema's zijn gebaseerd op een drieluik
Kwam tot stand in samenwerking met therapeuten en patiënten van Scelta	Afhankelijk van het aantal deelnemers duurt een sessie 1h 30min - 2h
Huiswerk zijn schrijfopdrachten van ~ 2 uur	Resultaat van alle schrijfopdrachten vormt een persoonlijk levensboek



Luik 1- Het Verleden

Opdrachten
- Tekenen van levenslijn
- Verhaal schrijven over je verleden
- Delen van een waardevol en een moeilijk moment

Functie
Ordening, afstand nemen van je verleden, validatie door de groep van de moeilijke momenten, oefenen om ook aandacht te hebben voor waardevolle momenten en zo ook meer balans scheppen tussen moeilijke en waardevolle momenten

Luik 2- Het Keerpunt

Opdrachten
- Op de levenslijn kijken wat je belangrijkste keerpunt is geweest
- In tweetallen uitwisselen over dit belangrijke keerpunt
- Verhaal schrijven van dit belangrijke keerpunt
- Delen van dit keerpunt

Functie
Bekrachtigen van de eigen identiteit, zien van de eigen bijdrage in het herstelproces

Luik 3- Het Heden en de Toekomst

Opdrachten
- Schrijven over het leven nu, eigen herstelproces en toekomst *(beslissingen, waarden, sterke konten, doelen)*
- Delen van verhaal over jezelf
- Terugpraten: met een woord omschrijven wat de persoon kenmerkt
- Feedback van dierbaren vragen *(Wat waarderen ze aan je? Waar ben je goed in? Waarin inspireer jij ze?)*
- Schrijven van compassievolle brief aan jezelf
- Delen van de compassievolle brief *(een ander groepslid laten voorlezen)*
- kijken naar het einde van behandeling, bespreken van onzekerheden hoe je ermee kunt omgaan

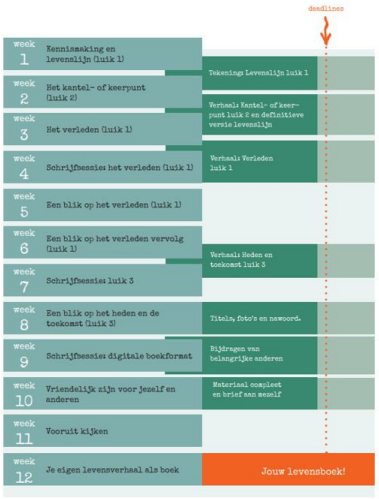
Functie
Compassie voor jezelf en anderen vergroten, eigen sterke kanten duidelijker zien, je eigen waarden helderder krijgen, versterken eigen identiteit door verbindingen te leggen met luik 1 en 2, versterken van sociale relaties

Een Sterk Verhaal

- Wat zijn volgens u belangrijke overwegingen te nemen bij de toepassing van deze interventie op de basis GGZ?
- Hoe moet het worden ingebed in de behandelingscontext bij Bas?
- Hoe houd u het een training i.p.v. therapie?
- Hoe kan de groep het best worden samengesteld?

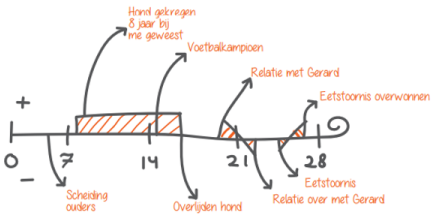
Indeling Interventie

Wat vind u van het overzicht van de sessies?



Sessie 1

- Wat vind u van deze oefeningen voor sessie 1?
- Wat vindt u van de manier waarop deze opdracht is verwoord?
- Wat vind je van de manier waarop het werkboek is vormgegeven?

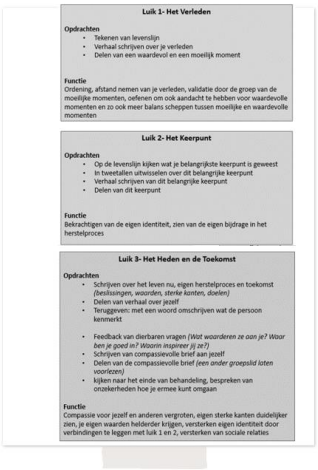


Appendix B

Presentation slides interview participants

Een Sterk Verhaal

- Interventie richt levensverhaalwerk in 12 groepssessies
- De thema's zijn gebaseerd op een drieluik
- Kwam tot stand in samenwerking met therapeuten en patiënten van Scelta
- Afhankelijk van het aantal deelnemers duurt een sessie 1h 30min - 2h
- Huiswerk zijn schrijfopdrachten van ~ 2 uur
- Resultaat van alle schrijfopdrachten vormt een persoonlijk levensboek



Luik 1- Het Verleden

Opdrachten
- Tekenen van levenslijn
- Verhaal schrijven over je verleden
- Delen van een waardevol en een moeilijk moment

Functie
Ordening, afstand nemen van je verleden, validatie door de groep van de moeilijke momenten, oefenen om ook aandacht te hebben voor waardevolle momenten en zo ook meer balans scheppen tussen moeilijke en waardevolle momenten

Luik 2- Het Keerpunt

Opdrachten
- Op de levenslijn kijken wat je belangrijkste keerpunt is geweest
- In tweetallen uitwisselen over dit belangrijke keerpunt
- Verhaal schrijven van dit belangrijke keerpunt
- Delen van dit keerpunt

Functie
Bekrachtigen van de eigen identiteit, zien van de eigen bijdrage in het herstelproces

Luik 3- Het Heden en de Toekomst

Opdrachten
- Schrijven over het leven nu, eigen herstelproces en toekomst *(beslissingen, waarden, sterke kanten, doelen)*
- Delen van verhaal over jezelf
- Teruggeven: met een woord omschrijven wat de persoon kenmerkt
- Feedback van dierbaren vragen *(Wat waarderen ze aan je? Waar ben je goed in? Waarin inspireer jij ze?)*
- Schrijven van compassievolle brief aan jezelf
- Delen van de compassievolle brief *(een ander groepslid laten voorlezen)*
- kijken naar het einde van behandeling, bespreken van onzekerheden hoe je ermee kunt omgaan

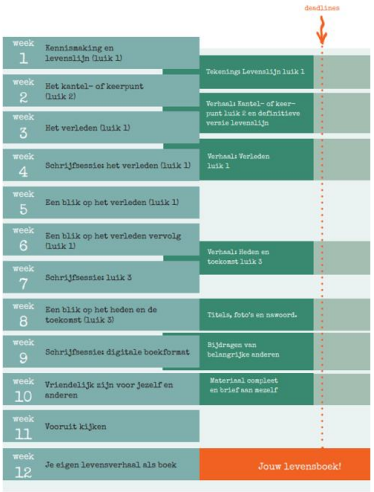
Functie
Compassie voor jezelf en anderen vergroten, eigen sterke kanten duidelijker zien, je eigen waarden helderder krijgen, versterken eigen identiteit door verbindingen te leggen met luik 1 en 2, versterken van sociale relaties

Een Sterk Verhaal

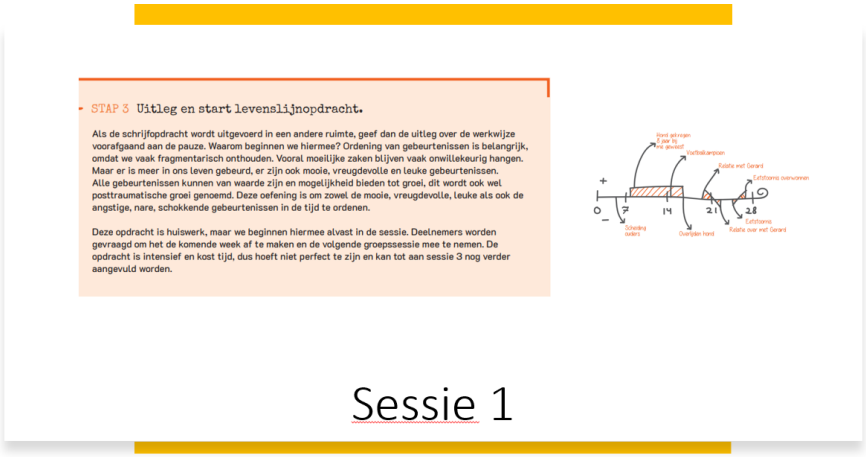
- Hoe zou je willen dat deze interventie wordt aangepast om beter aan je behoeften te voldoen?
- Waardoor zou deze interventie voor jou kunnen mislukken?
- Zou je er de voorkeur aan geven om aan deze interventie deel te nemen als individuele therapie of als groepstherapie?
- Zou je deze interventie liever doen met andere deelnemers met dezelfde diagnose of met een gemengde groep?

Indeling Interventie

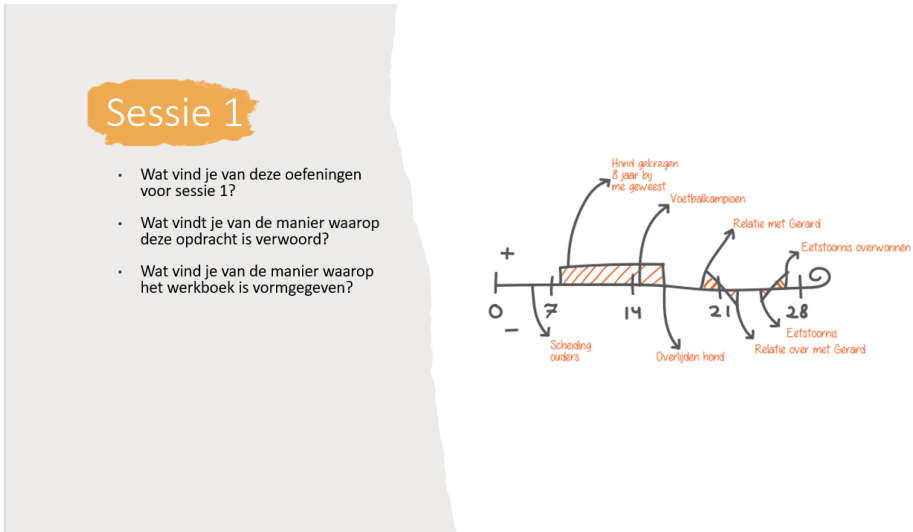
Wat vind je van het overzicht van de sessies?



Sessie 1



Sessie 1



Appendix C

Figure 1

Code Group Participants: benefits and difficulties of intervention

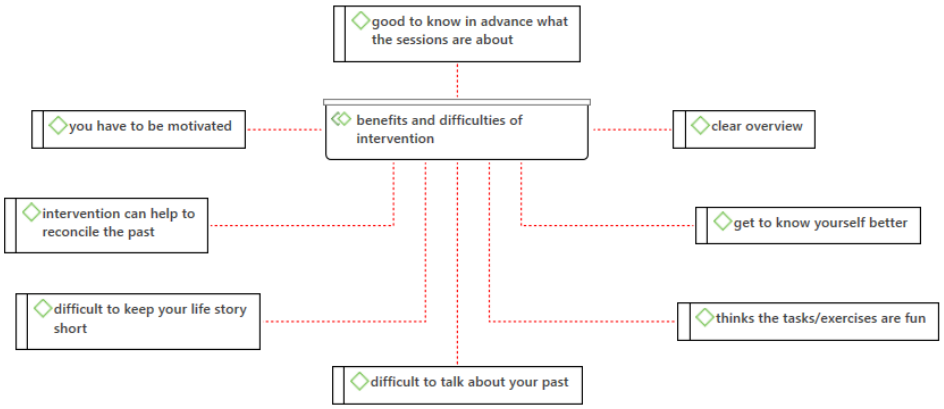


Figure 2

Code Group Participants: Individual vs. Group Sessions

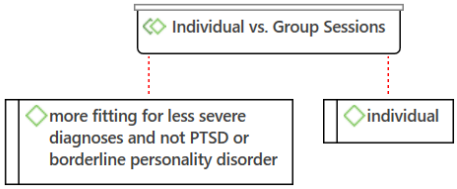


Figure 3

Code Group Participants: number of sessions

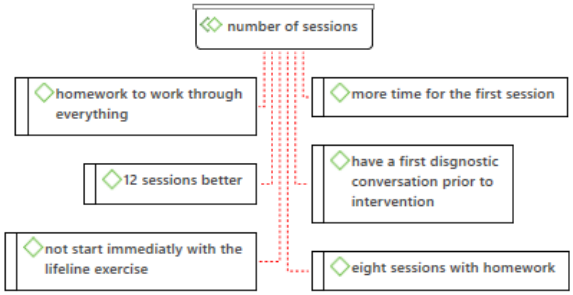


Figure 4

Code Group Participants: supervision before and during intervention

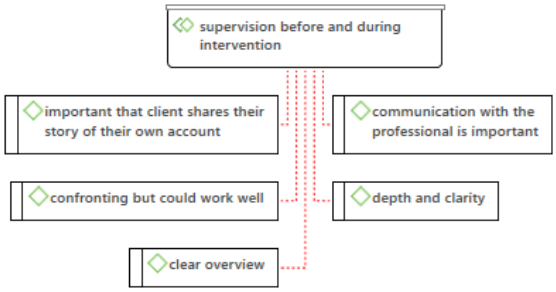


Figure 5

Code Group Professionals: fewer sessions

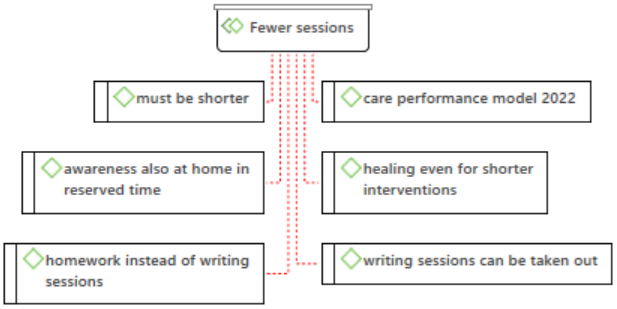


Figure 6

Code Group Professionals: Individual vs. Group Sessions

Figure 7

Code Group Professionals: making it visual

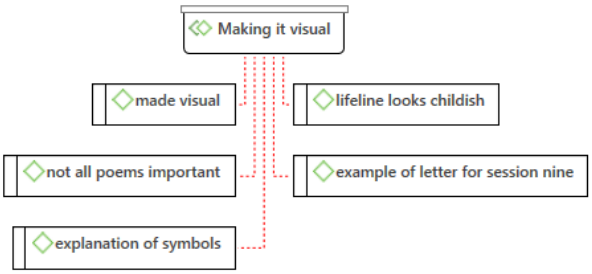


Figure 8

Code Group Professionals: Supervision