A positive approach towards reducing health inequalities

How healthcare professionals evaluate the use of a solution focused approach for improving lifestyles of new or prospective parents with a low socioeconomic status

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Master Thesis

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Abstract

Significant health differences exist - and might be growing - between people with a high and low socioeconomic status (SES; RIVM, 2014). Many of these differences can be traced back to the lifestyles of the parents (Bradley and Corwyn, 2002), so improving the lifestyles of new or prospective parents might lead to less health inequalities. The solution focused approach (SFA) may be an effective approach towards changing lifestyles (Valve et al., 2013). This research investigates how primary healthcare professionals evaluate the use of a SFA in improving lifestyles in the target group of new or prospective parents. To do so, semi-structured interviews were held among nine professionals in the primary healthcare sector. Respondents were gathered in three groups: already using a SFA; planning to use a SFA in the near future; and not using or planning to use a SFA. The interviews showed that the healthcare professionals expected the SFA to be effective, provided that some conditions were met. The respondents expected the SFA to fit with both the goal of lifestyle changes and the target group. Most respondents could recognise the three components of solution focused thinking in their clients and expected them to be improved after a session with the SFA. Respondents expected the SFA to be most useful for social or psychological problems and less for acute medical problems. All in all, the SFA seems a promising method for improving the lifestyles of the target group, which might decrease the health inequalities between high and low SES.

Keywords: Solution focused, solution focused approach, solution focused brief therapy, socioeconomic status, pregnancy, lifestyle, health inequalities.

1. Introduction

Large differences in health status exist between people with a low – and high socioeconomic status (SES). SES can be defined by "the social standing or class of an individual or group" and can be measured by a combination of education, (relative) income and occupation (American Psychological Association, 2018; Bartley, 2004). People with a low SES have a significantly lower life expectancy and lower healthy life expectancy than people with a higher SES (Broeders et al., 2018). Men and women with a low SES have a 6.5 and 5.4 year shorter life expectancy and 14.2 and 15.5 year shorter healthy life expectancy respectively, compared to men and women with a high SES (Broeders et al., 2018). People with a low SES are at a higher risk for diseases and disabilities (Everson, Maty, Lynch and Kaplan, 2002; Broeders et al., 2018), and are more prone to an unhealthy lifestyle and risky behaviour in general (Bradley and Corwyn, 2002).

These differences between SES groups in the Netherlands were first mentioned in the 1980's and have not changed much (Broeders, Das, Jennissen, Tiemeijer and de Visser, 2018). It is expected that the differences in health between high and low SES will keep existing and may be growing (Rijksinstituut voor Volksgezondheid en Milieu (RIVM), 2014). Recent research also shows that some health interventions increased the gap between low and high SES, since they were more effective in high SES groups. This phenomenon is sometimes referred to as the Matthew effect (Broeders et al., 2018).

Health differences between high and low SES groups not only exist in adults, but start before birth (Bradley and Corwyn, 2002). Children born from parents with a low SES are more likely to be born premature, with a low birth-weight or with a birth defect. Infants and children in low SES families are at higher risk for injuries, respiratory illnesses, dental problems, nutrient deficiency and sensory problems. When children experience health problems, consequences are often more severe and they are more likely to suffer from complications, compared to adults (Bradley and Corwyn, 2002). Adolescents in lower SES families often have a higher risk of depression, obesity and a lower self-rated overall health. Children born in low SES families are also known to have more socio-emotional problems and do less well in school (Bradley and Corwyn, 2002).

Most of these negative health outcomes are related to the lifestyles of the parents, especially to poor nutrition, poor prenatal care and substance abuse (Bradley and Corwyn, 2002). Furthermore, improving lifestyles is important since smoking, being overweight, a lack of exercise and an unhealthy diet are the most important causes of disease nowadays (RIVM, 2014). Helping parents with a low SES to obtain a healthy lifestyle, may reduce the chance of health problems early in life for their children. These children will also get accustomed to a healthy lifestyle, which in turn improves health later in life (Bradley and Corwyn, 2002). A healthier start in life might also enable children born in families with a lower SES to gain a higher SES during their lives (Everson et al., 2002). This way, helping new or prospective parents with a low SES, might help narrowing the health gap between low and high SES. A bonus to this is that parents are often more cooperative in changing their lifestyles during pregnancy (O'Keeffe et al., 2016).

Primary healthcare professionals could play a key role in helping prospective parents with a low SES in obtaining a healthier lifestyle, since primary healthcare professionals are close to the people. Almost everyone regularly visits primary healthcare professionals, has a personal bond with them and most people trust their healthcare professionals (Vermunt et al., 2012).

One suggested approach for healthcare professionals to take in improving lifestyles of new or prospective parents with a low SES, is the solution focused approach (SFA). The SFA is a way of

communicating with clients that focuses on achieving a goal rather than focussing on the problem itself. In this, the SFA takes a positive outlook and assumes that everyone has strengths and resources they can use (Bartelink, 2011). This approach has proved useful in therapy (Bartelink, 2011), and is now investigated for its use in primary healthcare.

Current research suggests that the SFA is a promising approach for primary healthcare professionals in improving the lifestyles of their clients (Valve et al., 2013). It also seems to be useful in the target group of new parents (Ramezani, Khosravi, Motaghi, Hamidzadeh and Mousavi, 2017) and may even be more effective in people with a low SES, compared to the problem focused approach that is usually used in primary healthcare (Bartelink, 2011; Bannink, 2013).

This research looks at how primary healthcare professionals perceive the use of a solution focused approach to promote a better lifestyle in new or prospective parents with a low SES. This is expected to give information on how effective they think this approach is, how useful it is for the goal of changing lifestyles and in the target group of new or prospective parents with a low SES. This is relevant because the effectiveness of a method is largely determined by the way the healthcare professionals view the method. For example research by Wampold and Bhati (2004, in: Bannink, 2013) shows that 30% of the effectiveness of a method is determined by how much confidence a healthcare professional has in the method they use. Additionally, the respondents are professionals in their field of work, know their clients and follow them over time. Because of this, they are expected to see the effects of their own work. Therefore, the main question of this research is: ***"How do healthcare professionals evaluate the use of a solution focused approach for improving lifestyles in new or prospective parents with a low socioeconomic status?".***

This research is also relevant in the light of the 2018 policy report by the Dutch scientific council for government policy, which calls for more attention to three things: interventions aimed at the start of one's life, a focus on people with a low SES, and a focus on changing lifestyles (Broeders et al., 2018).

2. Theoretical framework

As seen in the introduction, health status differs between groups with a low and high SES. This research aims to narrow the health gap between high and low SES, using a solution focused approach. This section elaborates on the SFA and its components, in relation to SES and health status.

2.1 The solution focused approach

The solution focused approach (sometimes called the solution building approach or the solution-oriented approach) is an approach to healthcare aimed at strengthening the clients' autonomy, that focuses on the solution rather than on the problem (Bartelink, 2013). It is a way of communicating that is goal oriented and aims to use a clients' strengths and resources (Dolan, 2017). A solution focused conversation is not about analysing the problem, diagnosis and prescribing treatments, but about designing a desired outcome and finding solutions that will help a client in achieving their goal (Bannink, 2013). The SFA is about working together towards the clients' goal or desired future. It

aims to help the client in creating a goal and to find the means to achieve that goal. The client operates as the expert on their own life, with the healthcare professional as a guide (Bannink, 2013).

The SFA was developed in Wisconsin around 1980 by two family therapists: Steve the Shazer and Insoo Kim Berg, and their colleagues (Bartelink, 2013). The SFA is based on the assumption that each client is resilient and has strengths and resources. It also assumes that there are exceptions to each problem (a situation in which the problem is less of a problem) and that a focus on problems is not always helpful (Bartelink, 2013). Research shows that a focus on problems may cause a negative spiral, which can make the problem seem worse and a positive outcome hard to achieve (Bannink, 2013). This negative spiral is found to be a risk factor for depressions, low well-being and low life-satisfaction, but may also lead to low concentration and having trouble solving problems (Grant, Cavanagh, Kleitman, Spence, Lakota and Yu, 2012). Instead, the SFA focuses on goals and the resources to achieve them.

The SFA has some similarities with the social constructivist theory, which states that what an individual perceives as reality, is constructed in social interaction (Bannink, 2010; Bannink, 2013). This includes what an individual beliefs to be true about their problems, competences and possible solutions. Within a solution focused conversation, the professional and client try to challenge and change this perception of reality towards a more positive one.

The solution focused healthcare professional uses a set of techniques and questions to find solutions and means for achieving a goal: they look for previous solutions and for exceptions (When is the problem less noticeable?); focus on the future and present, not on the past; use compliments to encourage clients; invite clients to do more of what works; use scaling questions (on a scale of 1-10, how close are you to your goal?); and the miracle question (If you would wake up tomorrow and your problem were gone, what would you do?; Dolan, 2017).

2.2 Relationships between professional and client

The SFA acknowledges the importance of the relation between professional and client. It recognises three types of relationships between client and professional: the visitor type, the complainer type and the customer type relationship (Høigaard and Johansen, 2004; Bannink, 2013).

In a visitor type relationship, clients are often referred to a healthcare professional by someone who is worried about them, but they do not see a problem themselves. Clients with a visitor type relationship are not willing to change the problem that they were sent for and the solution focused professional tries to find something else that the client would like to change, and to come back to the original topic in a later stage (Bannink, 2013).

In a complainer type relationship, the clients see the problem and want it to change, but do not see themselves as part of the problem. Clients in a complainer type relationship often expect the healthcare professional to find the solution to their problem or blame someone else. The client is not willing to change (Høigaard and Johansen, 2004; Bannink, 2013).

In a customer type relationship, the clients see themselves as part of the problem and are willing to change. Clients in a customer type relationship are also willing to do some work to achieve a goal (Høigaard and Johansen, 2004; Bannink, 2013).

Clients need to recognise something as a problem and be willing to take responsibility in order for interventions to be accepted (Bannink, 2013). Therefore, it is important that the healthcare professional knows how to deal with the different types of client relationships.

2.3 The SFA compared to other approaches

The SFA is often compared to the 'problem focused approach', or the traditional approach most healthcare professionals were taught during their studies, since they are opposites in several ways (Bartelink, 2011). Where the SFA assumes that it is not always necessary to focus on the problem to find solutions, the problem focused approach assumes that understanding the cause and structure of a problem will lead to more effective ways of acting. It also assumes that the professional is the expert who diagnoses the problem and knows best how to act, as opposed to the SFA, which assumes that the client is the expert and knows their own situation best. In the problem focused approach, the healthcare professional works for the client, but in the SFA, the client and professional work together to find the best solutions (Bartelink, 2011).

The SFA has some similarities with motivational interviewing. Both approaches focus on the competences and skills of the client, both focus less on the problem and more on health promotion and they both have grounds in social-constructivism (Bartelink, 2011). Both approaches also embrace change. Differences between the approaches are in the techniques they use to create change: motivational interviewing aims to change the intrinsic motivation of the client (the reasons for doing something), while the SFA aims to set goals and to help a client reach them in a way that suits the client best; motivational interviewing is focused on the present, the SFA on both the present and the future; and the use of reflection differs, motivational interviewing sees reflection as a tool, where the SFA sees it as a goal in itself (Bartelink, 2011).

Interesting is that the SFA could be used on its own, or combined with the problem focused approach or with motivational interviewing (from personal conversation with Bannink, 2017). This enables the professional to choose the approach that best suits the client or situation.

2.4 The SFA related to health status over the life-course

In this study, the SFA is investigated for its use to improve lifestyles of new or prospective parents, and thereby also their health status. The aim is to improve health at the beginning of one's life, to give children a healthy start to their life and to counteract the effects of negative early-life exposures. The effect of early-life exposures on health later in life is hypothesised in two ways:

The programming hypothesis claims that chronic diseases are biologically programmed in the womb or during infancy. Evidence shows that in areas with a high infant mortality -as a measure of poor health- higher rates of heart disease were present by the time these infants would be adults (Gatrell and Elliott, 2009). Supporters of this hypothesis argue that poor health and physique of the mothers, combined with poor nutrition, lead to compromised health in infants. This programmes the infants for more health problems later in life. If one accepts this hypothesis, a focus on improving lifestyles and diet of prospective mothers may decrease chronic illnesses in adults. Critics of this hypothesis however, state that SES influences both birth in a poor family as well as risks later in life and propose the life-course hypothesis (Gatrell and Elliott, 2009).

The life-course hypothesis says that chronic illnesses are influenced by a cumulative effect of biological, psychological and social factors experienced by an individual over the life course (Bartley, 2004). This hypothesis is designed around three models: First, exposures may result in effects much later on. Second, multiple exposures add up. Third, every life event influences the next, for example if one's parents divorced during childhood, they would be less ready for school and therefore do less well in school. By doing less well in school, they would also get a lower-paid job, with more health risks (Gatrell and Elliott, 2009). This indicates that advantages and disadvantages are combined over

the life-course and together influence the health status of an individual, and that this is also affected by one's SES (Bartley, 2004).

Both hypotheses emphasise the importance of a focus on pregnancy and infancy. Focussing on improving the lifestyles of new or prospective parents may result in positive effects throughout the life of an individual, either through programming or through a accumulation of positive life events.

2.5 The SFA in relation to SES

To improve the health status of people with a low SES, it is important to know which factors are related to the lower health status of those with a low SES. Research shows that the relation between SES and health is influenced by several factors, divided into behavioural -, material - and psycho-social factors (Bartley, 2004; Gatrell and Elliott, 2009).

The behavioural factors, including lifestyle or cultural factors, explain that people with a lower SES are more likely to have unhealthy behaviours. Lifestyle or behavioural factors often lead to victim-blaming, indicating that those with diseases should have had a better lifestyle. Lifestyle is, however, strongly influenced by both education and material factors (Bartley, 2004; Gatrell and Elliott, 2009). People with more years of schooling and more qualifications, often have healthier lifestyles, reflected in healthier diets, less smoking and more exercising (Bartley, 2004).

The material factors consist of, for example, (relative) income, education, job, home ownership, car ownership (Bartley, 2004; Gatrell and Elliott, 2009), but also housing- and working conditions (van de Mheen, 2003). Having a higher quality of material factors is linked to better health. However, research shows that people are willing to spend less money on food and heat, so they can afford social occasions, presents for friends and families and holidays. Therefore, material deprivation arises when people are unable to pay for both social participation and health improving basics like food and heat (Bartley, 2004).

The psycho-social factors influence health through stress, which may be caused by differences in control and autonomy in the workplace, balance between home and work and between efforts and rewards (Bartley, 2004; van de Mheen, 2003), but also through a monotonous or non-learning environment (McKee, Sim and Pomerleau, 2011). People with a low SES are often less well equipped for dealing with stressors. For example social support, coping strategies, locus of control and optimism, can help in dealing with stress (van de Mheen, 2003, Bradley and Corwyn, 2002). Studies also show that parents' social support improves the well-being of children and it improves skills and resilience, which enable them to deal with stressors (Iguacel et al., 2016).

The SFA is related to both the behavioural and psycho-social factors that influence the relation between SES and health. The link with behavioural factors is slightly more straight-forward as this study evaluates the use of the SFA for improving lifestyles of individuals with a low SES. The SFA does this without blaming the client. The psycho-social factors are more reflected in the aim of the SFA to give the clients control and autonomy, helps them find their own solutions and ways of coping. The SFA might also give people a more optimistic outlook on life.

2.6 Evidence and criticism

Research shows that solution focused therapy has positive effects, that it works better than no treatment and that it is as effective or more effective than traditional ways of therapy (Bartelink, 2011). In a research by de Jong and Berg (2004; in: Bannink, 2013), 77% of the persons treated with a SFA reported progress towards their goal, while only 66% of the persons treated with a problem focused approach reported improvement. Treatments with the SFA often need less sessions than traditional treatments, indicating that results are seen more quickly. Research also shows that positive results do not weaken over time (Bartelink, 2011). Because of this, the SFA might also be more cost-effective than a problem focused approach (Bannink, 2013).

A meta-analysis by Kim (2008) showed that the SFA has significant positive effects on internalising problems like fear, self-esteem and depression; and non-significant positive effects on externalising problems like aggression. Positive effects are also shown in depressed students, psychiatric patients, self-rated mental health and parents that had conflicts with their adolescent children (Bannink, 2013). Additionally, it seems that the SFA is useful in people with both higher and lower SES. The SFA is expected to be better suited to people with a low SES, compared to a problem focused approach (Bartelink, 2011; Bannink, 2013).

Grant and O'Connor (2010; in: Bannink, 2013) showed that a SFA caused a rise in positive emotions, where the problem focused approach only decreased negative emotions. They also found that solution focused questions brought more insights in the problems than did problem focused questions. Furthermore, a SFA seems relatively easy to learn and increases the morale of professionals (Bannink, 2013).

Some concerns about the effectiveness of the SFA are that in some cases it might not be possible or beneficial to have a conversation with the client (for example when someone has a psychosis or is intellectually limited), in these cases one could first use a problem focused approach and later on use the SFA (Bannink, 2013). It can also be that a client has a negative experience with a SFA, or that the SFA is too positive for a clients liking. Also, the professional should be willing to adapt their way of working (Bannink, 2013). In addition, a concern is that the SFA does not acknowledge the clients feelings enough (Antin, 2018), this is why Bannink emphasised the importance of acknowledgement in her courses (from personal conversation with Bannink, 2017).

2.7 Solution focused thinking

Grant and colleagues (2012) state that the SFA can positively influence well-being, through a more solution focused way of thinking by reflecting on goals and stimulating pathways thinking. They developed a tool to measure the amount in which people themselves have a solution focused way of thinking. They state that solution focused thinking has three broad core aspects: ‘goal orientation', ‘resource activation’ and ‘problem disengagement’ (Grant, 2011; Grant et al., 2012). Those three core aspects are represented in the questionnaire that Grant et al. developed and validated in 2012.

Goal orientation is about how much people are oriented towards goals and solutions. The questionnaire measures this aspect using statements like: *"I imagine my goals and then work towards them"* or *"I'm very good at developing effective action plans"*.

Resource activation is about how well people are able to identify and use personal strengths and resources and how well they recognise exceptions. Statements like *"there is always a solution to every problem"* or *"there are always enough resources to solve a problem if you know where to look"* are used to measure this aspect.

Problem disengagement is about how capable people are in letting go of a focus on the problem. This aspect is measured by statements like *"I tend to spend more time analysing my problems than working on possible solutions"* or *"I tend to focus on the negative"* (using reversed scoring; Grant, 2011 p.103).

Using their own tool, Grant and his colleagues showed that a high level of solution focused thinking is positively related to well-being, resilience and perspective taking, and negatively related to psychopathology (Grant et al., 2012).

2.8 Sub-research questions

To investigate how healthcare professionals evaluate the use of a SFA for changing lifestyles in new or prospective parents with a low SES, four sub-questions were formed:

1. How do healthcare professionals evaluate the effectiveness of a solution focused approach in improving lifestyles?
2. How do healthcare professionals evaluate the effectiveness of a solution focused approach for the target group of new or prospective parents with a low SES?
3. What role does a solution focused way of thinking play in improving the lifestyles of the target group, according to the healthcare professionals?
4. Does the perceived / expected effectiveness of the solution focused approach in improving the lifestyles of the target group differ between different healthcare disciplines?

3. Methods

To answer the main research question "*How do healthcare professionals evaluate the use of a solution focused approach for improving lifestyles in new or prospective parents with a low socioeconomic status?*", semi-structured interviews were held among nine healthcare professionals, each in one of the following groups:

1. Healthcare professionals that already use a solution focused approach (n=3).
2. Healthcare professionals that do not yet use a solution focused approach, but plan to use it in the near future, i.e. they are enrolled in a course on the SFA (n=3).
3. Healthcare professionals that do not yet use a SFA and are not enrolled or planning to enrol in a course on the SFA in the near future (n=3).

This division was made to get different points of views on the topic. This specific division was chosen, because healthcare professionals that already use a SFA were expected to evaluate the actual use of a SFA; healthcare professionals enrolled in the course to mostly show their expectations; and healthcare professionals that did not yet use a SFA and were not enrolled or planning to enrol in a course, could provide insights on how they thought about the SFA without knowing much about the topic yet. Furthermore, since most respondents already worked with, or planned to work with a SFA, they were expected to be more positive about the SFA. To provide a more balanced and realistic view, respondents that did not use a SFA and were not enrolled in the course, were included. Questions on the negative or lacking aspects of the SFA were also included.

3.1 Setting

This research was executed in the context of project 'Gezondhuizen'. Project Gezondhuizen focuses on improving the lifestyles of new or prospective parents with a low SES and their children. This project is initialised by a general practitioner from healthcare centre Veldhuizen in Ede (the Netherlands), together with a foundation called Mura, which is a primary care supporting foundation (Mura, 2018). Three healthcare centres in Ede are part of this project, all located in a different district within Ede. Healthcare centre Veldhuizen in the district Veldhuizen, healthcare centre Beatrixpark in Ede-West, and Zuiderzorg in Ede-Zuid. Those districts were assumed to be comparable when looking at SES, since each district had about the same percentage of people with a low income (40-47%), at least 17% of people with a non-Dutch origin, whom often have a low SES (GGD, no date), 7-13% of people living below or at the social minimum, and 24-30% of people receiving some form of social assistance (basic state pension for those who reached retirement age, unemployment benefit, (work) disability benefit, or social assistance benefit; Centraal bureau voor de statistiek (CBS), no date).

The healthcare centres are also considered to be comparable. All three healthcare centres gathered several disciplines, most of which are represented in all three healthcare centres. Each healthcare centre has, for example, at least a general practitioner, a pharmacy, a physiotherapist, a dietician, home care and midwives (Gezondheidscentrum Veldhuizen, no date; Eerstelijnscentrum Beatrixpark, no date; Gezondheidscentrum Zuiderzorg, no date). See appendix A for tables with comparisons of the healthcare centres and the districts, as well as a map with the location of each district.

3.2 Respondents

Respondents from group one and two were identified in collaboration with the initiators of project Gezondhuizen. They are in contact with people who already work with the SFA (group one) and organised the courses; the entry list for one of those courses was used to find respondents for group two. Respondents for group one and two were recruited from the three healthcare centres in Ede that were part of project Gezondhuizen. Respondents for group three were gathered via personal contacts of the researcher. Respondents were only included if they worked with the target group of new or prospective parents with a low SES, spoke Dutch, were active healthcare professionals in primary healthcare and worked in the province of Gelderland. During the process of gathering respondents, an attempt was made to include different healthcare disciplines in each group, to answer questions on differences between the use of the SFA in different disciplines. An attempt was also made to include respondents of different ages in the study. Characteristics of the respondents are shown in table 1.

Table 1: Characteristics of the respondents.

Respondent number	**Group**	**Discipline**	**Estimated age group**	**Sex**
1	1: enrolled in course	Midwife	<35	Female
2	1: enrolled in course	Paediatrician	>50	Female
3	1: enrolled in course	Physiotherapist	>50	Female
4	2: already uses SFA	Youth nurse	<35	Female

5	2: already uses SFA	General practitioner	35<>50	Female
6	2: already uses SFA	Midwife	>50	Female
7	3: does not use SFA	Paediatrician	>50	Male
8	3: does not use SFA	Youth nurse	>50	Female
9	3: does not use SFA	Midwife	<35	Female

3.3 The interview

The interviews took about 35-50 minutes and were held at the healthcare centres or at the homes of the respondents. The interviews were held in Dutch, as this was the native language of each of the healthcare professionals and this was expected to give more natural responses. The interviews of group two took place in May and June of 2017, the interviews of group one in November and December of 2017 and of group three in February and March 2018.

Questions in the interview consisted of some general questions about the respondents' disciplines and whether they (wanted to) use the SFA; questions about the perceived or expected effectiveness of the use of a SFA in the target group concerning lifestyle changes; and some questions based on the solution focused inventory from Grant and colleagues (2012) to find possible relations between a solution focused way of thinking and the effectiveness of the solution focused approach. The interview guide (in Dutch) can be found in appendix B.

Before the interviews started, the respondents were asked to sign an informed consent form (see appendix C) and received information on the purpose of this research. Their rights to stop at any time were explained and it was mentioned that the data is used for this research only and that no names will be saved in the data or mentioned in this report. The respondents were also asked if they agreed to making voice records of the conversation. If they agreed on all this, the introduction to the interview started.

During this introduction, respondents were asked if they already knew enough about the SFA, or if they wanted to read two paragraphs of Bartelink (2013). The paragraphs presented were the introduction and paragraphs 1.1 and 1.3, which describe the basic principles of the SFA in Dutch, in a clear but short manner. This was done to make sure that everyone had the same basic understanding of what the SFA entails. Respondents in group three also received the paragraphs beforehand via e-mail, so they had a chance to thoroughly read the paragraphs. All nine respondents had read the paragraphs before starting the interview. During the interview, the concepts 'goal orientation', 'resource activation' and 'problem disengagement' were explained, to ensure that everyone understood the concepts and their corresponding questions. When respondents did not understand a question, or did not remember the meaning of concepts, these were explained as well.

3.4 Data analysis

All interviews were recorded and transcribed, to ensure no information was lost. After transcription, the interviews were inductively coded using the Atlas.ti program. After coding, the codes were sorted in different themes. To do this, a list of a-priori themes was used, based on the sub-questions, including: 'positive / negative experiences using SFA', 'positive / negative expectations using SFA', 'lifestyles', 'target group', 'SES', 'solution focused thinking', 'healthcare discipline'; and the code

'time', because during the interviews, the researcher noticed that this topic was raised multiple times. The possibility was kept to inductively add themes while sorting the codes. During the process of sorting the codes, two themes were added inductively, namely: 'conditions for using SFA' and 'connecting with the client'. This sorting took place in the form of a scheme, which is shown in table 2.

Table 2: organisation of codes and themes, with example.

Theme	Codes	All phrases that belonged to this code
Target group	*Cultural differences*	*R2- I think if you have a parent in front of you who speaks a different language, or where you need the help of a translator, it does not work at all, I think. When I think of immigrants, immigrant parents here in the, in the neighbourhood, I think it is not so effective, their culture is so different that, I think, they would want more direct approach, or a different approach than the solution focused.*

After sorting the codes into themes, the researcher looked within each theme at what was said by whom, which things were mentioned multiple times, but also at contradictions, and what was unexpected. From these combined findings, the results section is written, subdivided per sub-question.

To answer the sub question "*How do healthcare professionals evaluate the effectiveness of a solution focused approach in changing lifestyles*?" (effectiveness), the themes 'positive / negative experiences use SFA', 'positive / negative expectations use SFA', 'conditions for the use of SFA', 'time', 'lifestyles' and 'solution focused thinking' were used. To answer the sub-question "*What role does a solution focused way of thinking play in improving the lifestyles of the target group*?" (lifestyle changes), the themes 'lifestyles' and 'solution focused thinking' were used. For the question "*How do healthcare professionals evaluate the effectiveness of a solution focused approach for the target group of new or prospective parents with a low SES?*" (target group), the themes 'target group', 'SES' and 'connecting with the client' were used to answer the question. Finally, to answer the sub-question "*Does the perceived / expected effectiveness of the solution focused approach differ between different healthcare disciplines in changing the lifestyles of the target group?*" (disciplines) the theme 'healthcare discipline' was used.

During the analysis and writing of the results, account was taken of the three respondent groups (already working with a SFA; does not yet work with a SFA, but is enrolled in a course; and does not work with a SFA). Where there was a difference between the respondent groups, this is mentioned, in order to show differences between people who had experienced the advantages or disadvantages and the people who expected this, but who had not experienced it from practice. All respondents and their opinions were included during the analysis. When the amount of respondents mentioned in the results section do not add up to nine, some respondents gave answers from which no clear answer could be extracted.

After the analysis, the researchers' interpretations were checked by a peer researcher, whom was not involved in the current research (as advised by O'Connor and Gibson, 2003). The peer researcher analysed one of the transcripts (randomly chosen) and divided it into the abovementioned themes, but was also asked to check whether they missed themes or thought

themes were superfluous. This test confirmed the way the researcher divided the information from that interview into themes.

4. Results

4.1 Effectiveness of the solution focused approach

On the effectiveness of the SFA, the respondents gave some positives, negatives and some conditions. A listing of all points can be found in table three.

What is good about it?

The respondents mentioned several advantages. Some advantages were mentioned by both healthcare professionals who already work with a SFA, and healthcare professionals that do not (yet) use a SFA, namely that clients are in control (n=3), and that they make their own choices (are their own directors) and are therefore more inclined and more motivated to do what is good for them (n=6). In addition, three respondents expected the client to gain self-confidence or self-esteem through the solution focused sessions. This quote shows how, if clients are in control, they are expected to be more motivated:

> "*I think people are more motivated then, if they have a plan for themselves, [...] think for themselves, well maybe I should talk to somebody, or I should use my phone less often, or things like that, if they came up with it themselves, I think they'll try harder for it, I guess, and if I say from now on you cannot do this or you cannot do that, you soon get resistance*" -R8.

Healthcare professionals who already work with a SFA added that people often only see the negative things and by using a SFA they will look more at the positive things (n=2); but also that the SFA is applicable to everyone and on every level (n=1); that clients feel heard (n=1); and that people are recognised in what they already do (n=1). Furthermore, one respondent noticed that the clients relax during sessions with a SFA and one respondent noticed that clients feel more respected:

> "*When you really value them and let them choose the answers themselves and let them name positive things themselves, they feel that they are much more respected*" -R6.

> The focus on the positive and acknowledgement for what clients already do are also portrayed in this quote from respondent 5: "*and they are therefore much more encouraged to do something themselves, to get started and also to be acknowledged in what they already do, so the positive things are approached instead of just you are too heavy or .. only the negative* " -R5.

Besides, respondents who did not (yet) work with a SFA expected that because clients make their own choices, they are less likely to put their heels in the sand (n=3), which might eventually save

time (n=1). Additionally they expected that it creates a better bond between client and professional (n=1), and that realising that the SFA is an instrument, might help in communicating information about the client with colleagues (n=1). But also that it helps people to put things into perspective by releasing the focus on the negative (n=1); and that the focus in a pregnancy is often on what is no longer allowed and that the SFA might help to look at what is still allowed and how you can get through the period in a pleasant way (n=1).

What is not so good about it?

Disadvantages that healthcare professionals who already work with a SFA mentioned, are that healthcare professionals should not overshoot in the SFA (n=2), it is important to be able to recognize medical problems or to educate, even if the client does not ask for it. They also said that it is difficult to use for people with a language barrier or intelligence or communication problems, since a certain level of reflection is expected from the clients (n=1). For example respondent four mentioned the importance of not overusing the SFA:

> "*I do see disadvantages, I think, if you would only use the solution focused approach, for everything, for example, if a child spits, if it really is a medical problem, then you sometimes also really just have to ask out in a problem focused way*" -R4.

In addition, there were a number of expected disadvantages among people who did not (yet) work with a SFA: First, if you do not supervise people properly, the clients can overshoot in the solution focused thinking (n=1). Second, the SFA is not a suitable approach for all problems (n=2). Third, people do not always see the possibilities (n=2), as shown in the quote below. Two respondents could not think of any disadvantages.

> "*And people [...] may not always have an idea of what is possible, maybe you should also offer them something, like we can do all of this, what suits you best?*" -R8.

Furthermore, five of the respondents indicated that time is an important factor, four of them felt that they did not have enough time in one appointment to use the SFA, these were respondents who would follow the course, who already work with SFA and people who do not work with SFA. One respondent at the same time also indicated that it might save time, given that fewer recommendations are given that do not sink in with people, this respondent said:

> "*if you start giving advice, it does not sink in, that is all wasted time*" -R7.

What conditions are attached to using a solution focused approach?

The healthcare professionals also mentioned a number of conditions, which they say should be met in order to make the approach effective:

First, the importance of having a personal connection or trust between professional and client was mentioned (n=5). This is seen in the following quote:

"*I notice that if you listen carefully to the client, if you let her speak, if you let her suggest the solution, that you have more connection and because you have more connection, people are more inclined to see things they did not see before; while if you have less connection, you see people putting their heels in the sand faster*" -R6.

Second, respondents found it important to remember that the SFA is a method and in many disciplines it is not the only method that you should use (n=5):

"*Sometimes things are just physical, I think you should always keep that in mind, if someone throws a hammer on his toe, you should not [treat that person with a solution focused approach], then you should just put a stitch in it, so to speak*" -R6.

Third, the SFA must fit in with the way of thinking of the professional (n=4), which can be seen in the following quotes, but during the interviews, the interviewer also noticed that the respondents that seemed more positive in general, also were more positive about using the SFA.

"*to what extent you can leave the [thinking up of a solution] to the client or that you are inclined to do it yourself*" -R1.

"*It will certainly make it more difficult if you think for yourself the whole time: I already see what you have to do, and then that patient still does not*" -R4.

Fourth, health care professionals need to know how they can raise any worries or problems they see in the clients, themselves (n=3):

"*because you keep it so positive, people sometimes really think that it is going fantastic [...] so if you want to mention that what you see or think for example [...] that still should change, then they get kind of disappointed*" -R4.

Fifth, for clients it is important that they are open to lifestyle changes (n=3):

"*people who are more interested in healthy living and in a healthy lifestyle [...] I think they are more open to this [the solution focused approach]" "So they also think more about what is good for me and what can I improve on and are therefore more concerned with solutions"; "someone must be very motivated to [get started with] this [= the solution focused approach], they should really want it, I think, otherwise it will not work"* -R3.

Furthermore, the need for repetition (n=2), recognition (n=2) and to continuously ask follow-up questions (n=1) were raised:

Respondent two about the need for repetition: "*you cannot do it in a single conversation, it also has to stick with them, that is with everything of course [...] so you have to give it maintenance*"- R2.

Respondent five about the need for recognition: "*You cannot go over it too quickly, so you have to recognize them first, in those problems, [...] to then see if you can then park them for a moment and look more into the future, to a solution* " -R5.

Respondent six about the need for follow-up questions: "*if you keep asking, things almost always come, but the slap on the hammer comes at number four [...] that is often the solution* " -R6.

Finally, one person was worried about whether clients would be able to recognise the problems themselves, which is important for the effectiveness of the SFA:

"*If you do not see it as a problem, then you're not going to do anything with it*" -R8.

Table 3. Advantages, disadvantages and conditions for the use of the SFA.

Advantages	**Disadvantages**	**Conditions**
Higher motivation client (n=6)	Being too positive (n=3)	Personal connection between client and professional (n=5)
Client is in control (n=6)	Not suitable for all problems (n=2)	Remember that SFA is one of many methods (n=5)
Focus on the positives (n=3)	Clients unable to see possibilities (n=2)	SFA should fit mindset of professional (n=4)
Client is more willing to cooperate (n=3)	Difficult to use in people with language barrier, intelligence- or communication problems (n=1)	Professionals need to know how to raise worries themselves (n=3)
Recognition for what the client does (n=2)	Not enough time in one session to use SFA (n=4)	Clients should be open to lifestyle changes (n=3)
Applicable to everyone (n=1)		Repetition (n=2)
Bond between professional and client (n=1)		Recognition for client (n=2)
More self-confidence client (n=1)		Follow-up questions (n=1)
Helps putting things in perspective (n=1)		
Takes clients out of the negative spiral (n=1)		

Coherence with solution focused thinking

All nine respondents felt that a SFA is better suited to people who already think in a solution focused way, reasons given for this are that it fits with the way of thinking that people already have (n=6), they do not have to acquire a new skill; they are often already on the right thinking-track (n=2) and often it is also easier because they can answer questions more quickly (n=1):

> "*if someone is already used to thinking in a certain way, and we then apply the solution focused approach, then of course it just fits in with what they already know, instead of if it [solution focused way of thinking] being totally new to them and they actually have to learn it as a skill first*" -R1.

One of the respondents indicated that this coherence could have to do with the clients character. One other respondents specifically mentioned the reflective capacity of people as possible influence:

> "[*what I] call the reflective capacity, to indeed place their own position in a somewhat broader perspective and so from there to come to a solution more easily*" -R9.

Two respondents thought that the SFA could also especially help people who do not yet think in a solution focused way, given that there is a bigger change for them if they start thinking in a more solution focused way through the solution focused sessions. One respondent thought that people who do not think in a solution focused way, might think that the SFA is nonsense.

> Respondent six on how the SFA could be beneficial for people who do not yet think in a solution focused way: "*[people who already think in a solution focused way] already figured it out beforehand, so it's just a small update that I still do through such a conversation, while people who do not have that [solution focused way of thinking] can have a total turnaround in their thinking* " -R6.

4.2 Solution focused approach and lifestyle changes

On the effectiveness of the SFA for lifestyle changes, seven of the respondents indicated that they expected or thought that the SFA was suitable for changing lifestyles; one respondent thought that lifestyle was associated with too many factors, making it difficult to adjust in any way; and one respondent thought that it was partly suitable, but that it is only a method, of which there are more.

Eight of the respondents indicated that the fact that clients have to think about solutions themselves, plays an important role in the effectiveness of a SFA to changing lifestyles, mainly because the respondents noticed that clients tend to put their heels in the sand when they give advice. As respondent five put it:

> "*I think it is more effective than telling someone what to do, I think that it is precisely for that kind of thing, for lifestyle, [...] that people must of course fully support the plan themselves and have a specific goal and want something themselves and then you can say that it has to go a certain way or you can say, well it is a problem that you are too*

heavy and that you [, the professional, say] all that, but of course I have done that before and it feels like pulling on a dead horse. And indeed I think with that solution focused approach that it connects much more to what people want and what they, their own strength, and that that works better for this type of thing " -R5.

Two respondents also indicated that people would be more motivated if they had their own say. In addition, "placing clients in their own strength" or "autonomy" were mentioned four times as important aspects for effectiveness.

One respondent indicated that it can be very difficult for people with chronic pain complaints or diseases that they have had their whole lives, since it is difficult to get out of a chronic pain syndrome.

4.3 Solution focused thinking and lifestyle changes

Coherence solution focused thinking and lifestyle

Concerning the question of whether solution focused thinking and a healthy lifestyle are connected, three respondents thought that there was a coherence, indicating that people with a more solution focused way of thinking also had a healthier lifestyle. This was hypothesised through interests or higher expectations of their health, which encouraged them to set goals. On the other hand, four respondents thought that there was no coherence, at least not in every situation. Two respondents did not know what to answer. In each group of respondents (already uses a SFA, does not use SFA and enrolled in course on SFA), there were respondents who saw a connection and respondents who did not. The two groups that do not (yet) work with a SFA both had one respondent who did not know.

Of the four respondents who saw no correlation, two respondents indicated that it depends more on the priorities that people set, if one does not place a priority on health, solution focused thinking does not help when it comes to having a good lifestyle:

"*It's just what you find important and where your goal lies, of course, so it is like what I just said, that man who does not want to quit smoking, can be very goal oriented on all kinds of fronts, but that is simply not his goal*" -R5.

Three respondents who did not see a direct connection, indicated that solution focused thinking might help in changing lifestyles (as opposed to having a healthy lifestyle already). One of these respondents thought that especially goal orientation was useful, the second thought letting go of a focus on problems was useful and the last thought finding and using resources was most important, so all three domains of solution focused thinking were covered.

Respondent nine about the role of a solution focused way of thinking in changing lifestyles: "*In the base [for having a healthy lifestyle] not really, but if you want to bring about something, so indeed wanted to bring about a change, than it would be good [if one has a more solution focused way of thinking]*" -R9.

Resource activation

Six respondents (two of each respondent group) indicated that they could recognise in their clients whether they were able to recognize and make use of resources. The respondents mainly recognised this ability in conversations when the client was asked about possibilities or when clients told the professionals what they had already tried.

Five of the respondents thought that there would be a correlation between recognizing resources and having a healthy lifestyle, four of them thought that lifestyle changes could be more easily triggered if people recognised the resources; and one respondent thought that a healthy lifestyle could help recognise resources.

> Respondent six about the ability to use resources: "*If they can use the resources, it's just a lot easier, and if you can't do that, then you get lost in thinking that it does not work anyway, you can't do it and it does not work*" -R6.

Five respondents thought that a solution focused session could help clients in recognising resources, even after the session was over. Two respondents expected that they then would have to repeatedly have clients think about possible resources, in order to have an effect outside of the sessions or subject considered in the sessions.

One respondent was sceptical about recognising resources:

> "*If you have a goal and know that something has to change to get a little closer to the goal, then I still think that not everyone can find those resources, or see them, or know that they exist*" - R8.

Problem disengagement

Seven respondents answered the question of whether they recognised if their clients mainly thought in terms of problems, or if they could easily let those problem thoughts go.

Five of them indicated that they quickly recognise whether clients get stuck in thoughts about problems, usually from how they respond in conversations, if they tell them what is wrong, or what has gone well / what they have already tried; two respondents had never really thought about whether they recognised this in their clients and could not provide a clear answer.

> Respondent nine about recognising whether clients get stuck in problem thinking or not: "*that is often quite clear, you know with some people, if you just ask a simple question like how that person is doing or how they think something is going, then you notice quite easily if someone indeed answers in terms of things they run into or instead mention things like this goes well or I am planning to try this the coming weeks, so yes that is very recognisable"* - R9.

Two respondents indicated that people who are more focused on problems, more often have the attitude that the professional has to solve it, compared to people who are less focused on problems. One respondent indicated that for the target group of pregnant women, it is also important to pay

attention to possible pregnancy depressions, which can make them more focused on problems than usual.

Seven respondents answered the question of whether clients would be better able to let go of problem thinking after a solution focused session. Six of them thought that clients would be better in letting go of the problem after a solution focused session, one respondent hoped for it, but still had some doubts. Three of these respondents indicated that this would not be after just one session, but should be repeated more often. Two of the respondents also indicated that the effect would differ per person. One respondent thought that once clients had raised their problems with the professional, they would not stick to the problem thinking, since they would know that the professional would help them with the problem.

Goal orientation

Eight of the respondents indicated that they could recognise in their clients to what extent they are goal oriented. Two of the respondents knew that mainly by their gut feeling and how the conversation went, four respondents saw that clients clearly stated what they wanted to achieve. Two of the respondents indicated that they thought that goal orientation and a higher SES were linearly related.

Five respondents, divided over the three respondent groups, expected that the goal orientation of clients would be increased after a solution focused session. One respondent indicated that they found it difficult to estimate. Three respondents indicated that the effect after a session could vary greatly per person, due to personality or habits.

4.4 Suitability of the SFA for the target group

Here the respondents' answers about how well they thought the SFA would fit with the target group of new or prospective parents with a low SES are laid out. The answers given on the questions about the target group are divided into 'new or prospective parents', 'SES', 'cultural differences' and 'clients in general', because responses differed between these components of the target group.

New or prospective parents

On the topic of new or prospective parents, two respondents indicated that it is good to focus on lifestyle changes during pregnancy or shortly after birth, because the results can last a lifetime. One respondent indicated that the subject of lifestyle changes lends itself well to a SFA, regardless of which target group it should reach. One respondent indicated that she expected SES to play a lesser role in new or prospective parents and how they handle issues, because everything surrounding having a baby is still new to all new or prospective parents.

One respondent indicated that many women become more aware of their lifestyle as soon as they get pregnant:

> "*when they get pregnant, many women become more aware of what they eat and how they organise their day, that they sleep well, and are more attentive to a healthy lifestyle and very practical in education of course smoking and alcohol and medicine use*" -R9.

Socioeconomic status

Five of the respondents, including all respondents who already use a SFA, thought that SES did not necessarily have to influence how well a SFA connects with clients. However, they indicated that there were certain specific groups, where it would be more difficult, such as people with a language barrier, dementia, autism or (intellectual) disability, given that clients are asked to think for themselves and reflect. One respondent said:

> "*For example, people with autism, for them it is difficult to visualise something so if you ask them to visualise the desired future, they can't, so you know... then you can of course ask it in a different way, but that is more difficult I think*" -R5.

One of the respondents indicated that when you change your use of words, the SFA can be used for everyone. Another respondent indicated that it is also a matter of gaining experience, so that you know how to apply it to these specific groups. One of these respondents noticed that there were more problems among people in a neighbourhood with low SES, but she expected that the SFA could help all clients by getting more responsibility.

The other four respondents did not so much think that the SFA was not usable for persons with a high or low SES, but expected some differences that would make it easier or more difficult. Three of these respondents indicated that highly educated people often have more insight into their problems and possible solutions than the lower educated, this was also indicated by a respondent who thought that SES did not influence the effectiveness of the SFA.

> Respondent eight about the relation between SES and the effectiveness of the SFA: "*I think that if you are highly educated, you are also more capable of.. that you have better insight into possible solutions, you know what is for sale, what is there for exercises, what kind of websites for example, what is reliable and what is not*" -R8.

One respondent expected that he would use the SFA less for higher educated people, because in general they are more confident in his experience; he could, however, see a SFA being used in highly educated people that are insecure. Furthermore, one respondent thought that higher educated people might be more aware of the solution focused questions and would prefer to just be told what they should do.

One respondent indicated that it could be a prejudice that higher educated people have more insight in their situation and that some lower educated people surprise her with their insights. She also indicated that life experience might help to pick up a solution focused way of thinking. One respondent on the other hand expected young people to be more open to a SFA.

Two respondents indicated that people with lower SES and immigrants more often assume that the healthcare professional should solve the problem for them, compared to others:

> "*Sometimes you see someone with a lower economic status, and certainly with people who do not have a Dutch origin, they sometimes come here with a problem, with an attitude like: here is my problem, give me the solution*" -R8.

Furthermore, one respondent also mentioned that the SFA connects well with people with a low SES, because it has a more positive way of looking at their lives:

> "*[people with a lot of problems] also have a past, a negative past, they already come from a low social family, economically they just have more problems, [...] so that already are some more negative things in their lives, and this really gives a positive twist to it, so you also give them a piece of self-worth, that you are really going to look 'what are you good at and what is going well and what are you good at, what fits with you?' So I certainly notice that it really connects to them*" -R4.

Cultural differences

Five of the respondents mentioned that cultural differences could influence the effectiveness of the SFA. Reasons mentioned for this are the language barrier and that they are used to other environmental factors, a different way of health care, but also to different nutritional habits, etc. This is for example visible in these two quotes:

> "*Middle-aged immigrants, somewhat older, are often people like ouch ouch ouch, pain pain pain, oh massage massage, and for them you have to do everything, while people who just are a bit more full of life and look further ahead, that also work and have a bigger world so to say, [...] they do want to be involved themselves*"-R3.

> "*They are used [...] that everyone above them tells them what to do, and then I say: listen, the children got seriously overweight in the three months they have been in the Netherlands, so you can no longer buy coke, you can no longer buy sweets and that works [...] that is language they understand and they will not do that anymore, and then for the rest [talking about what goes well, etc.], that will come later on*" -R7.

Connecting to client in general

During the interviews, the respondents repeatedly mentioned the importance of a connection to the client (n=8). Examples of connection with the client are:

> "*to get more on their level, I do not mean IQ or so, but maybe match their way of thinking more, so that the distance between professional and the target group lessens*" -R2.

> "*[with new clients] I always ask: what is your request for help, what do you expect, what do you really want and what do you expect from me?*" -R3.

Two respondents indicated that they noticed that clients are not yet used to working with a SFA:

"*There are people who are very inclined to get stuck in thinking about problems and that mention time and time again everything that is not going well or all the problems they have, and I think a lot of people think that that's why you come to the doctors', there are a lot of people who might not normally think that way, but you go to the doctor and there you are supposed to tell all your problems, that is what people have learned*" -R5.

"*Maybe they're not used to it either, maybe they're used to the local council and social helpers -sometimes there are a lot of people involved- who all come to do their thing in your family, maybe it's very nice for those people to sit here and be asked: what do you think and have you already thought about it yourself?* " -R8.

4.5 Different disciplines

On the differences in effectiveness of the SFA between healthcare disciplines, all respondents thought that there would be a difference between the different healthcare disciplines, with the difference being whether mostly clients with medical issues came, or with mostly psychological, social or preventive issues, would consult that specific discipline. The respondents indicated that they expected the SFA to be better suited for non-acute physical or medical problems. Three respondents, all working with a SFA, specifically indicated that they thought SFA could be used in all disciplines, despite all the differences:

"I *think that you could use it everywhere, but that it obviously is a lot more useful in a setting, in a preventive setting or in one concerning more psychological problems, and for a general practitioner it is a bit more of a mix, there are a lot of things, where I really do not have to try and use a solution focused approach, that adds nothing*" -R5.

Secondly, the duration of sessions and how often people came by were mentioned five times as an important factor, for which the respondents thought that longer sessions and more frequent recurrence were more suitable for SFA, given that there was more time for conversations and that a sense of trust could be built.

To clarify abovementioned expectations, respondents gave several different examples. One respondent indicated that the GP was suitable for using a SFA, since they were generalists or could schedule their own time. Contrarily, three other respondents indicated that GPs were less suitable because they had to solve mostly medical problems and had little time in one session. Another respondent indicated that the general practitioner might be suitable, given that people often trust their general practitioner.

Furthermore, one respondent indicated that she expected that the use of a SFA to improve lifestyles in new or prospective parents would be more effective in healthcare disciplines where people specifically come for information about the health of their children and a healthy pregnancy, such as midwives, as opposed to for example a physiotherapist.

5. Discussion

This research investigated how healthcare professionals evaluate the use of a SFA for improving lifestyles of new or prospective parents with a low SES. To do this, semi-structured interviews were held among primary healthcare professionals who already used a SFA, who planned to use a SFA and who did not use -or plan to use- a SFA. The aim of this study was to get the professionals' opinion on the effectiveness of the SFA, to get a first idea of the employability of the SFA in primary healthcare for improving lifestyles of the target group.

In this section, the results will be combined with and compared to previous research. The findings are organised by the sub-research questions. Afterwards, this research will be evaluated on strengths and weaknesses and some recommendations for future research will be given.

5.1 Findings

How do healthcare professionals evaluate the effectiveness of a solution focused approach in improving lifestyles?

Most respondents thought or expected that the SFA was effective in changing lifestyles. The working element in this, according to the respondents, was that clients have to think about the solutions themselves and were therefore less likely to be resistant of the lifestyle changes, which was a common problem when giving advice. From the interviews, it seemed that there were several positives to the use of a SFA in improving lifestyles of new or prospective parents with a low SES. There were, however, also some negatives and some conditions that should be met in order for the SFA to be effective.

Two main positives were reported, the first being that the clients are in control and make their own decisions, and are therefore more motivated to perform an action. Which may be explained by how autonomy is linked to intrinsic motivation: if one is free to choose an action, they are more appreciative of the reasons for performing the action as well (Boniwell, 2012). The second main positive is that the SFA may take people out of the negative spiral and problem focus, and instead help them to look positively to the future. Grant et al. (2012) also mentioned the negative effects of focusing on problems and that these could be prevented by using a SFA.

The main negative mentioned, was that the SFA takes more time, both within a session when compared to a problem focused approach, and to learn a new approach. Contrarily, research showed that the SFA is relatively easy to learn and that one needs less sessions to achieve a goal (Bannink, 2013), which might reduce the total amount of time needed.

Some conditions mentioned for the effectiveness of the SFA, were: First, that one should not overshoot in using the SFA. The respondents indicated that some problems just need a problem focused approach and that a healthcare professional should still be able to recognise health problems or to educate people. Second, a personal bond between professional and client. This corresponds to the research by Wampold and Bhati (2004, in: Bannink, 2013), which showed that the bond with the professional explains 60% of the effectiveness of a method. Third, that the SFA should fit with the mindset of the professional. And last, that clients should be open to lifestyle changes. Therefore it is important that clients are in a customer type relationship, where they take responsibility for the problem and are willing to take action to change their lifestyle.

How do healthcare professionals evaluate the effectiveness of a solution focused approach for the target group of new or prospective parents with a low SES?

The respondents expected the use of a SFA to be more effective in prospective parents, since they would be more motivated to obtain a healthy lifestyle. This was also mentioned by O'Keeffe et al. (2016).

On the topic of SES, most respondents thought that having a low SES did not negatively influence the effectiveness of a SFA, this corresponds to the articles of Bannink (2013) and Bartelink (2011), which state that the SFA can be used in both people with high and low SES. Some respondents expected higher educated people to have more insight in their problems and possible solutions. Although one respondent indicated that this might also be a prejudice.

The respondents did mention that it might be more difficult to use the SFA with people with a language, intelligence or communication problem, which was also mentioned by Bannink (2013). Roeden (2012) has investigated the use of the SFA in people with an intellectual disability and found that the SFA has some advantages for them, among which the focus on skills instead of inabilities, empowerment and self-efficacy, and the tailored interventions. Roeden also found some suggestions for the use of a SFA in people with an intellectual disability, like the use of simple, short and clear language, a focus on engagement and using different questions to find someone's goal (Roeden, 2012).

Some differences were noted between high and low SES or between cultures as the people with lower SES or non-Dutch origin more often assumed that the healthcare professional would just solve the problem, without them needing to do much for it. This corresponds to the complainer type relationship. Some of the respondents expected this to be related to differences in what the client is used to in different situations or other countries. Respondents also noticed that clients in general were not yet used to the SFA.

What role does a solution focused way of thinking play in improving the lifestyles of the target group?

Some respondents expected a positive correlation between a solution focused way of thinking and a healthy lifestyle. Some however, rather expected a relationship between a solution focused way of thinking and obtaining a healthier lifestyle, as opposed to already having a healthy lifestyle.

Most respondents were able to recognise the three domains of solution focused thinking (Grant, 2011) in their clients: resource activation, problem disengagement and goal orientation. Most of them also expected clients to have an increase in these domains after a session with the SFA. This might indicate that clients learn to think more in a solution focused way, through a use of the SFA by their healthcare professionals. Which, according to Grant et al. (2012), can positively influence well-being.

No research was found on the direct relation between solution focused thinking and improving lifestyles, but research shows that goal orientation is related to a healthy weight in pregnant women (Brown et al., 2012), that the mothers strengths, resilience and social network (resources) are related to child health (Black and Ford-Gilboe, 2004) and in general that optimism is related to better mental and physical health (Conversano et al., 2010).

All respondents thought that the SFA would fit better with and thus be more effective in people that already think in a solution focused way, but some respondents expected to be able to make a bigger change in the way of thinking if people did not yet think in a solution focused way.

Does the perceived / expected effectiveness of the solution focused approach differ between different healthcare disciplines in improving the lifestyles of the target group?

All respondents indicated that the SFA would be more effective in disciplines that deal more with social or psychological issues, and would be less suited for acute, medical issues. But, as one respondent put it:

> *"[the SFA] is about a solution focused conversation, the solution focused action can sometimes be to just stitch a wound"* - R5.

Interesting was that all respondents that already used a SFA, thought that it could be used in all disciplines, despite the differences. In her courses, Bannink also states that the SFA can be used in all healthcare disciplines (from personal conversation with Bannink, 2017).

5.2 Previous research in the context of project Gezondhuizen

Two master students previously investigated the use of a SFA in primary healthcare, specifically in the context of project Gezondhuizen. Van Gemert (2016) researched how the SFA compares to motivational interviewing, self-management and positive psychology via literature study and expert interviews, she also looked at how healthcare professionals in project Gezondhuizen view and use the SFA. Aeneae Venema (2016) investigated the perceptions of healthcare professionals towards the use of a SFA in health promotion.

Some important findings by van Gemert (2016) are that the SFA can be useful in improving lifestyles by healthcare professionals, but that the professionals view it as one of several methods. These results are confirmed by the current research. Van Gemert also found that experts noticed that other factors than the method itself were important for the effectiveness of the SFA, namely the relationship between professional and client, being enthusiastic about the SFA and how well it fits with the professional. The current research found literature that confirmed the importance of other factors. The relationship and connection to the professional's way of thinking were also mentioned by respondents in the current research.

Aeneae Venema (2016) found that the problem in changing lifestyle lies in motivating clients for change. Respondents in the current research mentioned that they thought that the SFA would be more effective in clients with a motivation for changing lifestyles. She found that the SFA was new to the professionals she interviewed and that they intended to start using the SFA. Aeneae Venema also investigated positive and negative attitudes towards the use of a SFA, with the positives being: the positive tone of the conversations, receiving positive reactions when clients bring up their own solution, a pleasant way of working, adding to health promotion and collaborating with the client. Negative attitudes were that the SFA could be too positive, not useful in all situations, and not a panacea (Aeneae Venema, 2016). The negative attitudes were also reflected in the current research.

Both found that the healthcare professionals experienced a lower workload, but van Gemert found that the professionals would need more experience in using the SFA to prevent relapsing into problem focused approaches. Aeneae Venema also found that professionals found it difficult to not give advice. According to differences in disciplines, van Gemert found differences in opinions on for whom and what situation the SFA would be most useful. Respondents in the current research were more like-minded about the use of the SFA, since they thought it would be useful in psychological and social problems and less in acute medical problems. Aeneae Venema found literature that stated that the SFA was more useful for psychological problems. She also found that, although there were no differences in attitudes between different disciplines, midwives had a lower intention to use a SFA and general practitioners displayed a lower self-efficacy. These differences were not observed in the current research.

Although the current research has some similarities to the research by van Gemert and Aeneae Venema in both methods and findings, there are some differences in focus and questions, which make the researches additive and not repetitive. Van Gemert mostly investigated what was known about the SFA and how it compares to other methods. Aeneae Venema investigated the attitudes towards using the SFA, focussing on the professionals and their work. Where the current research focused more on how professionals expected or experienced the SFA, with a focus on target group and goal, and on solution focused thinking.

5.3 Strengths and limitations

This research has some limitations, like the small number of respondents and the lack of experience in interviewing of the interviewer. Which caused some questions to not be answered as clearly or elaborately as liked. Also a mistake was made in the writing of the interview guide, where the examples of goal orientation and problem disengagement were switched. This was realised after some interviews were already done, but most respondents used the examples to answer the questions and the researcher was able to divide the answers between the aspects based on the examples. Another limitation might be the amount of time between the first and last interviews, it is not known whether this time influenced the thoughts respondents had about the SFA or how well-known (parts of) the SFA were to people.

This research also has some strengths, like the use of both respondents that did and did not use a SFA, to gather both expectations and experiences. Besides that, it was also expected that the respondents that were enrolled in the course on SFA would have mainly positive expectations. To make sure not only positive expectations would be found, respondents that did not know much about the SFA were included. For the same reason, questions about the negative sides of the SFA were included in the interviews. It also appeared that most findings from the current research, were consistent with findings from previous research. In addition, this research investigated and connected theory and practice (through the interviews). Another strength of this research is that it took researcher effects into account, by checking the researchers' interpretations of the transcripts. This confirmed the way the researcher divided information from the interviews into themes.

5.4 Recommendations

Based on the findings of this research, it is advised to investigate the use of a SFA in acute or physical medical problems. Since most respondents expected the SFA to be less useful, but no definitive research was found on this topic. It is also interesting to investigate the perceived effectiveness of a SFA in primary healthcare from the perspective of other persons, like the clients, their surroundings / caregivers, and maybe health insurers. Additionally, it would be interesting to follow clients over time, to see the lasting effects of the SFA on both solving a problem / improving a situation and on solution focused thinking in general. Besides, the relation between solution focused thinking and having or obtaining a healthy lifestyle appeared not proven, but is interesting since this relation might be utilised in lifestyle interventions, through for example focusing on both improving lifestyles directly, as well as increasing the amount in which a person thinks in a solution focused way, to enhance the results.

The results of this research can also be used to improve courses on the use of a SFA in regular healthcare. Especially a focus on creating a good relationship between healthcare professional and client, improving the motivation of the client, and on the abilities to use the SFA next to other methods, is advised. Additionally, it is advised to educate healthcare professionals on using the SFA in people with an intellectual disability.

6. Conclusion

This research investigated how healthcare professionals evaluate the use of a SFA for improving lifestyles in new or prospective parents with a low SES. To do so, interviews were held among healthcare professionals that already worked with a SFA, that planned to work with a SFA and who did not use or plan to use a SFA. From the interviews, it became clear that respondents saw positives in the SFA, but also some conditions that need to be met, for the SFA to be effective in improving the lifestyles of new or prospective parents with a low SES. The positives, negatives and conditions can be found in table three. Most respondents expected the SFA to be useful in both lifestyle changes and in the target group.

These findings are important since the confidence that a healthcare professional has in the methods he or she uses, determines an important part of the effectiveness of the method. Additionally, the healthcare professionals are the first in line to see how a method affects their work and their clients. An effective method in improving lifestyles in new or prospective parents may influence their health as well as their children's health, which may last over the life-course. Health is also closely related to SES, so improving health or using a method that is better suited to people with a low SES, might have double effects as it increases health and might increase SES. An approach that fits better with people with a low SES is important since health interventions tend to be more effective for people who already have a higher SES and thus a higher (healthy) life expectancy, which increases the health gap between different SES. So improving lifestyles in new or prospective parents with a low SES might decrease the health inequalities between different SES groups.

The respondents also expected improvements in the three factors of solution focused thinking: goal orientation, resource activation and problem disengagement, after a session with the SFA. In addition, the respondents expected the SFA to be more useful in clients with a more solution

focused way of thinking. Furthermore, respondents expected a difference in effectiveness between disciplines, mostly based on the type of problems they treat: they expected the SFA to be more useful in psychological or social problems and less in acute, physical or medical problems.

All in all, the SFA seems a promising method for improving the lifestyles of new or prospective parents with a low SES, as long as attention is paid to the conditions found in this research.

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Appendix

Appendix A: Comparing districts and healthcare centres

Table 1: comparing Veldhuizen, Ede-west and Ede-zuid. (Source: CBSinuwbuurt, no date)

	Veldhuizen	**Ede-west (Beatrixpark)**	**Ede-zuid (Zuiderzorg)**
Number of inhabitants	14010	15075	9260
Inhabitants 25-65	51%	52%	52%
Non-western immigrants	17%	9%	20%
Western immigrants	9%	8%	8%
Under or at social minimum	9%	7%	13%
Receiving social assistance benefit (Bijstandsuitkering)	3.6%	1.6%	4.4%
Receiving (work) disability benefit (Arbeidsongeschiktheid)	5.2%	4.5%	5.8%
Receiving unemployment benefit (WW)	3.3%	1.8%	2.5%
Receiving a basic state pension for those who reached retirement age (AOW)	17.7%	16.5%	10.7%
Average income per income recipient	27000 euro	29000	24100 euro
Persons with a low income	40%	41%	47%
Persons with a high income	17%	18%	13%
Rental houses owned by a housing corporation	29%	28%	49%
Vacant homes	4%	3%	7%

Table 2: Comparison of healthcare centres Veldhuizen, Zuiderzorg and Beatrixpark. (Sources: gcveldhuizen.nl, elcbeatrixpark.nl, gczuiderzorg.nl, 2017)

Veldhuizen	**Zuiderzorg**	**Beatrixpark**
Pharmacy	Pharmacy	Pharmacy
General practitioners	General practitioners	General practitioners
Physiotherapy	Physiotherapy	Physiotherapy
Occupational therapy		Occupational therapy
Podiatrist	Podiatrist	Podiatrist
Speech therapy		Speech therapy
Dieticians	Dieticians	Dieticians
Home care	Home care	Home care
Midwives	Midwives	Midwives
Youth healthcare		
Mental care	Psychologists	
Manual therapy		
	Thrombosis service	Thrombosis service
	Exercise therapy	
		Municipal health service

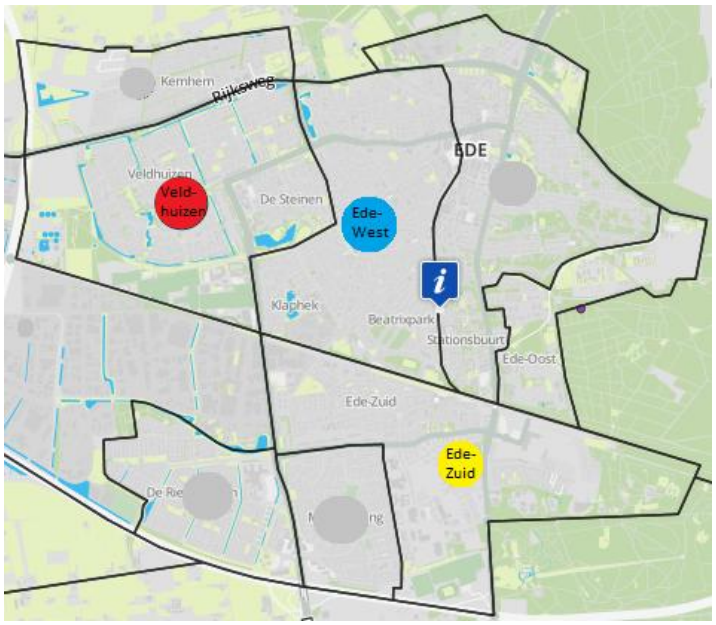

Figure 1: Location of districts on a map (source: CBSinuwbuurt, no date)

Appendix B: Interview guide

Inleiding

Korte inleiding over wie ik ben en wat ik onderzoek. Hier wordt ook benoemd waar de gegevens voor worden gebruikt, dat men geen antwoord hoeft te geven wanneer zij dit niet willen en dat ze op elk moment kunnen stoppen met het interview. Daarnaast zal gevraagd worden of zij alles begrijpen en wordt hen gevraagd om een toestemmingsverklaring te ondertekenen en of zij akkoord gaan met het opnemen van het interview.
In deze inleiding zal ook gevraagd worden of de respondent al wat afweet van de oplossingsgerichte aanpak. Wanneer dit niet het geval is of ze een opfrissing wensen, zullen zij paragrafen 1.1 en 1.3 voorgelegd worden uit Bartelink, 2013.

Algemeen

- Wat is uw beroep/taak binnen dit gezondheidscentrum?
- Komt u in uw werk in aanraking met leefstijlveranderingen van jonge of aanstaande ouders?
- Komt u in uw werk in aanraking met mensen met een lage sociaaleconomische status?
- Gebruikt u weleens een oplossingsgerichte aanpak in het behandelen van jonge of aanstaande ouders, wanneer u de leefstijl van deze doelgroep wilt verbeteren?
    - Ja: hoe denkt u hierover?
        - Hoe vaak past u deze methode toe?
    - Nee: had u wel al eens gehoord van een oplossingsgerichte aanpak?
        - Bent u van plan deze aanpak te gaan gebruiken?
        - Wat verwacht u van deze aanpak voor dit doeleinde?

Leefstijl

- Heeft u het idee dat/verwacht u dat het gebruik van een oplossingsgerichte aanpak in het verbeteren van een leefstijl effectief is?
    - Waar baseert u dit op?
    - Denkt u dat het effectiever zou zijn dan andere aanpakken?
    - Denkt u dat cliënten dit hetzelfde (zouden) zien?
- Wat zijn volgens u de voordelen van het gebruik van een oplossingsgerichte aanpak in het verbeteren van een leefstijl?
- Wat zijn volgens u de nadelen van het gebruik van een oplossingsgerichte aanpak in het verbeteren van een leefstijl?

Doelgroep

- Denkt u dat de effectiviteit van een oplossingsgerichte aanpak in het verbeteren van de leefstijl verschillend is bij verschillende doelgroepen?
    - Denkt u bijvoorbeeld dat er een verschil is in hoe ouderen en jongeren reageren op een oplossingsgerichte aanpak? Of zwangere mensen tegenover niet-zwangere?
    - Waarom denkt u dit?

- Denkt u dat een oplossingsgerichte aanpak aansluit bij de doelgroep van aanstaande of jonge ouders met een lage SES?
    - Waarom denkt u dit?
    - Wat denkt u dat ervoor zorgt dat dit wel/niet het geval is?
    - Hoe zou dit (nog) beter kunnen?
- Krijgt u weleens reacties van de doelgroep over behandelingen waarin u de oplossingsgerichte aanpak toepaste?
    - Wat zijn deze reacties?
    - Wat doet u met deze reacties?
- Wat zijn volgens u de voordelen van het gebruik van een oplossingsgerichte aanpak voor deze doelgroep?
- Wat zijn volgens u de nadelen van het gebruik van een oplossingsgerichte aanpak voor deze doelgroep?

Oplossingsgericht denken

De volgende vragen zullen dieper ingaan op oplossingsgericht denken, hiermee wordt een denkwijze bedoeld waarbij men zich minder richt op problemen en meer op oplossingen en resources. Resources zijn hulpmiddelen of hulpbronnen, die mensen helpen om hun doel te bereiken. Voorbeelden hiervan zijn geld, opleidingsniveau of een bepaalde persoonseigenschap.

- Denkt u dat de effectiviteit van een oplossingsgerichte behandeling samenhangt met de mate waarin cliënten zelf al oplossingsgericht denken?
    - Waarom denkt u dit?
- Denkt u dat de mate waarin mensen oplossingsgericht denken samenhangt met hun leefstijl?
    - Op welke manier?
    - Waar denkt u dat dit door komt/ wat is het onderliggende mechanisme?
- Denkt u dat de mate waarin mensen oplossingsgericht denken samenhangt met hun SES?
    - Waarom denkt u dit?

Oplossingsgericht denken is onderverdeeld in drie domeinen: Goal orientation (doelgerichtheid), resource activation (het gebruik van resources) en problem disengagement (loslaten van probleem denken).

Goal orientation: doelgerichtheid, in hoeverre mensen zich richten op het creëren van een oplossing door middel van het stellen van doelen en zelfregulering. Stellingen hierover zijn bijvoorbeeld: ‘ik stel me mijn doelen voor en werk er dan naar toe’ en ‘ik ben goed in het ontwikkelen van een plan van aanpak’.

- Herkent u de eigenschap ‘**goal orientation**’ in uw cliënten?
    - Waaraan herkent u dit? Kunt u een voorbeeld geven?
- Heeft u het idee dat deze eigenschap samenhangt met een gezonde leefstijl?
    - Waarom denkt u dat?
- Ziet/verwacht u een verschil in deze eigenschap na een behandeling?
    - Waarom verwacht u dit/waaraan zit u dit?

Resource activation: gebruik van resources, in hoeverre mensen resources herkennen en deze gebruiken om hun doelen te bereiken. Stellingen hierover zijn bijvoorbeeld: ‘tegenvallers geven je

een kans om falen te veranderen in succes' en 'er zijn altijd genoeg resources om een probleem op te lossen, als je weet waar je moet kijken'.

- Herkent u de eigenschap '**Resource activation'** in uw cliënten?
    - Waaraan herkent u dit? Kunt u een voorbeeld geven?
- Heeft u het idee dat deze eigenschap samenhangt met een gezonde leefstijl?
    - Waarom denkt u dat?
- Ziet/verwacht u een verschil in deze eigenschap na een behandeling?
    - Waarom verwacht u dit/waaraan zit u dit?

Problem disengagement: loslaten van een focus op problemen en in plaats daarvan focussen op oplossingen. Stellingen hierover zijn bijvoorbeeld: 'er is altijd een oplossing voor elk probleem', en 'ik heb de neiging om te blijven hangen in het nadenken over problemen'.

- Herkent u de eigenschap '**problem disengagement'** in uw cliënten?
    - Waaraan herkent u dit? Kunt u een voorbeeld geven?
- Heeft u het idee dat deze eigenschap samenhangt met een gezonde leefstijl?
    - Waarom denkt u dat?
- Ziet/verwacht u een verschil in deze eigenschap na een behandeling?
    - Waarom verwacht u dit/waaraan zit u dit?

Afsluitend

- Verwacht u verschillen in de effectiviteit van een oplossingsgerichte aanpak tussen verschillende zorgdisciplines?
    - Waar denkt u dat dit mee te maken heeft?
- Heeft u verder nog opmerkingen over het gebruik van een oplossingsgerichte aanpak in het verbeteren van de leefstijl van jonge of aanstaande ouders?
- Heeft u nog toevoegingen aan deze vragen/het verhaal dat u zojuist verteld heeft?

Hartelijk bedankt voor uw tijd en informatie.

Appendix C: Informed consent

Informatie over dit onderzoek

Dit onderzoek betreft een interview over het gebruik van een oplossingsgerichte aanpak in de eerstelijns zorg, specifiek voor het verbeteren van de leefstijl van jonge of aanstaande ouders met een lage sociaaleconomische status. In totaal kost het interview ongeveer 30-45 minuten. Van het interview wordt een geluidsopname gemaakt.

Deelname is geheel vrijwillig. De antwoorden worden anoniem verwerkt en alleen voor onderzoeksdoeleinden gebruikt. U mag zich op elk moment van deelname aan het onderzoek terugtrekken zonder dat dit enige consequenties voor u heeft.

Mocht u vragen hebben over dit onderzoek dan kunt u contact opnemen met Amber van Hoof: Amber.vanhoof@wur.nl.

Ik verklaar hiermee akkoord te gaan met deelname aan dit onderzoek:

Naam:

Handtekening:

Datum: