From problem-focused to solution-focused: A study about the intended shift in parenting support in youth healthcare

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"The answers you get depend upon the questions you ask"

Thomas Kuhn (1922-1987)
American physicist and philosopher of science

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Chapter 1

General introduction

Introduction

Historically, the parenting support provided by Dutch public health nurses (PHNs) within the field of youth healthcare (YH) could be characterized as problem-focused. Since the appearance of the new guidelines for parenting support for YH in 2013 (Oudhof et al., 2013), these PHNs have been expected to possess a set of basic skills that includes solution-focused parenting support. Moreover, they are expected to shift from problem-focused parenting support to solution-focused parenting support for parents who are experiencing mild parenting problems. Given the profound differences between these two approaches, this shift is complex for professionals. Little is known about the current state of solution-focused parenting support in YH and about effective mechanisms to facilitate the shift from problem-focused to solution-focused parenting support in the daily practice of PHNs.

Youth healthcare as public health system

YH is an essential component of the Dutch public healthcare system. Based on the Convention on the Rights of the Child (UNICEF, 2019), YH is offered free of charge, and it reaches approximately 95% of all children in the Netherlands. It is organized nationally and executed by 48 regional YH organizations (Jambroes et al., 2015). The main aim of YH is to promote physical and mental health in all children 0–18 years of age and to ensure that all children have an equal opportunity to thrive. The basic tasks and responsibilities of YH in the Netherlands are described in the Dutch Public Health Act. The YH system provides activities at the population and individual levels: provision of information (anticipatory and just-in-time), immunization, screening for health problems and care needs, and support for parents and children at an early stage of problem development (Nederlands Centrum Jeugdgezondheid, 2022; Public Health Act, 2008). To provide the best possible preventive healthcare, all activities relating to YH should be based on new scientific and practical insights and adapted to relevant societal issues (Vanneste et al., 2022).

Parenting support in Youth Healthcare

Parenting support for mild parenting problems is one of the core early interventions that PHNs deploy within the framework of YH. In previous decades, the Dutch government gradually created a system of parenting support aimed at child protection. One result was that vulnerable families with mild parenting problems were often prematurely referred to specialized forms of youth care, and their problems were taken out of their social and pedagogical context to solve these. In line with this trend, parenting support in YH increasingly came to focus on deficits: what was wrong in parenting and, consequently, what needed to be "fixed" by

the professional. In other words, parenting support was provided according to a problem-focused approach (Knijn & Hopman, 2015; Van Nijnatten et al., 2014).

The shift to a solution-focused approach

Since 2011, as part of a total-system reform, the Netherlands has been initiating solution-focused parenting support as a means of reversing the situation described above (Rijksoverheid, 2011a, 2011b). Fundamental principles underlying this system reform have included normalizing mild parenting problems and strengthening the self-direction of families. This implies that it should be generally accepted that all families occasionally experience mild parenting problems and that most mild problems will be solved by parents themselves, with support from their informal networks. Furthermore, professional support for mild parenting problems should be easily accessible, with minimal intervention that taps into and reinforces the available strengths and resources of parents to solve their problems within the context of their own lives (Knijn & Hopman, 2015; Raad Voor Maatschappelijke Ontwikkeling, 2012). As a professional intervention, solution-focused support was assumed to meet these reform objectives.

Evidence on solution-focused parenting support

Evidence on the positive outcomes of solution-focused support is promising. To date, solution-focused support has been found to be as effective as other support approaches are in solving typical problems, in addition to being more efficient (Bond et al., 2013; Gingerich & Peterson, 2013; Kim, 2008; Stams et al., 2006). In a broader sense, solution-focused support is positively associated with a goal approach, positive affect, and action planning. It has also been found to decrease negative affect (Grant, 2012; Neipp et al., 2016). Although specific knowledge about solution-focused parenting support is limited, it has been presumed that the more general positive effects of solution-focused support also apply to situations involving mild parenting support in YH.

Differences between solution-focused and problem-focused parenting support

Solution-focused parenting support differs fundamentally from problem-focused parenting support (Table 1, Appendix A). In general, solution-focused parenting support is a strength-based and future-oriented approach to support. It aims to empower parents, improve parenting skills, and increase the ability of parents to solve future problems independently (Rapp et al., 2005). In contrast to a problem-focused approach, solution-focused parenting support seeks to solve parenting problems by first identifying the preferred future of parents, situations in which the problem does not exist (i.e., exception times), and the strengths and resources available to parents. The next step in this approach is to tap into and reinforce the

available strengths, resources, and problem-solving competencies of parents. One fundamental assumption in the process of solution-focused parenting support is that parents are aware of their preferred future, current strengths, and resources, and that they have the abilities they need in order to achieve their desired goals in a systematic manner. The perspective of the parent thus plays a central role in all stages of solution-focused parenting support (De Jong & Berg, 2013; McAllister, 2003).

Table 1. Characteristics of problem-focused and solution-focused parenting support (De Jong & Berg, 2013; McAllister, 2003)

	Problem-focused parenting support	Solution-focused parenting support
Aim	To decrease the negative aspects of parents/parenting	To increase the positive aspects of parents/ parenting
Process	1. Problem introduction	1. Problem introduction
	2. Problem assessment	2. Assessment of the preferred future
	3. Problem definition	3. Assessment of exception times, available strengths and resources
	4. Intervention planning	4. Assessment of the first step toward the preferred future
	5. Intervention execution	5. Professional advice
	6. Process and outcome evaluation	6. Progress support
	7. Progress support	
Collaboration features	Professional leads the process	Professional leads the process "from one step behind"
	Professional as expert	Parents as expert
	Parents follow the professionals' perspective on the solution	Professional adopts a stance of 'not knowing'

Given the fundamental differences between the two approaches, it is assumed that the professional shift from problem-focused to solution-focused parenting support behavior will be complex for PHNs (Henderson, 2002).

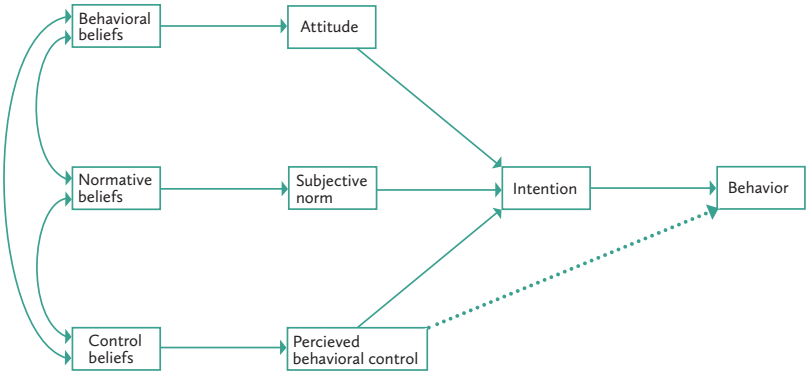
Theoretical perspective on behavior change

There are several theories on behavior change, each with its own perspective. Examples include the social cognitive theory (Bandura, 1986), the transtheoretical (stages of change) model of behavior change (Prochaska & Velicer, 1997), the self-determination theory (Ryan & Deci, 2017), and the theory of planned behavior (Ajzen, 1991). For the purposes of this thesis, the theory of planned behavior (TPB) was selected to predict and explain the solution-focused parenting support behavior of PHNs, for several reasons. First, convincing evidence is available that the TPB is applicable to the behavior of health professionals (Godin et al., 2008).

Second, this theory takes cognitive factors of behavior and behavior change into account. Third, it stresses the importance of subjective norms (i.e., the experienced social pressures to perform a given behavior) (Ajzen, 1991). Given that public health nursing is a team-based profession, and given that PHNs collaborate closely with children, parents, and other professionals, it is important to consider the social pressure that these significant others exert on the behavior of PHNs. Finally, the TPB highlights the role of perceived behavioral control. This construct considers self-efficacy, along with perceived barriers to and facilitators of performing a given behavior. Insight into the construct of perceived behavioral control could be especially helpful for developing interventions that enable the desired change (Ajzen, 1991).

According to the TPB, an individual's intention is the most proximal predictor of performing a given behavior. Moreover, this intention is substantially determined by the individual's own beliefs, attitude, subjective norm, and perceived behavioral control in terms of performing the behavior (Ajzen, 1991) (Figure 1). The TPB implies that the beliefs of PHNs should be aligned with the principles of solution-focused parenting support and that a positive intention to adopt this approach to support is a precondition for the actual shift.

Figure 1. *Theory of planned behavior (Ajzen, 1991)*



Professional shift toward solution-focused parenting support

Within the Dutch YH system, implementation activities aimed at facilitating the shift toward solution-focused parenting support have largely consisted of knowledge transfer, practical training, and additional peer supervision sessions (Hensen et al., 2016). The impact of these implementation activities has not been monitored in daily practice. Moreover, knowledge about beliefs, intention, and behavior is currently lacking. Given the differences between the two approaches and the known complexity of changing professional behavior, a strong

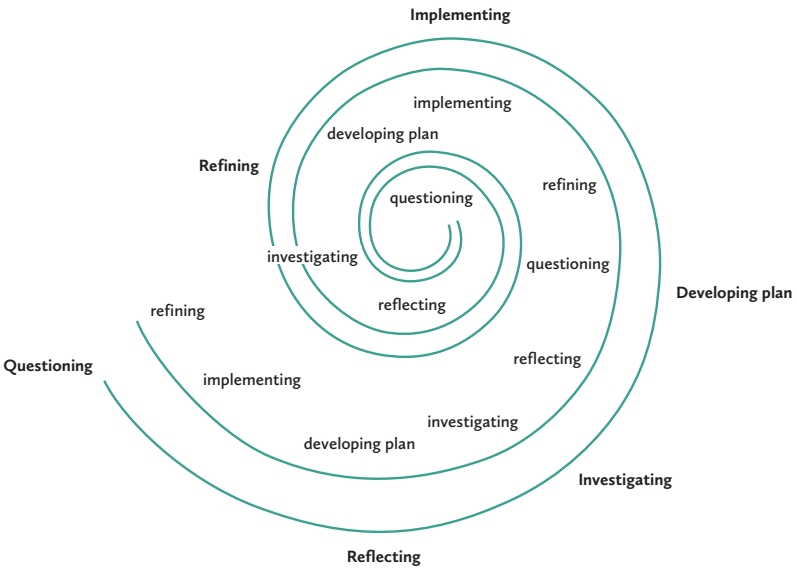
implementation effort, including an intensive learning process, is likely to be necessary in order to effect a substantial shift in PHNs toward the provision of more solution-focused parenting support (Grimshaw et al., 2012).

Transformative learning

A transformative learning process is known to facilitate more radical changes in the perspectives and behavior of professionals (Henderson, 2002). The concept of transformative learning draws on constructivist principles that knowledge, beliefs, and related behavior are created through new (and challenging) experiences and critical reflection on prior assumptions (McAllister, 2015; Merriam, 2018; Mezirow, 2000). Defined as "processes that result in significant and irreversible changes in the way a person experiences, conceptualizes, and interacts with the world," transformative learning describes such an intensive learning process (Hoggan, 2016, p. 71). It is therefore plausible that transformative learning by PHNs in the Netherlands could enable the shift toward solution-focused parenting support behavior.

Participatory action research (PAR) is a research approach that enables change through a process of co-constructive knowledge building and the encouragement of critical self- awareness. This form of research could be described as a stepwise iterative process that includes questioning a topic of interest, reflecting upon and exploring it, developing an action plan, and implementing and refining it (McIntyre, 2008) (Figure 2).

Figure 2. The process of PAR (McIntyre, 2008)



For the purposes of this thesis, appreciative inquiry (AI) has been chosen as a positive, strength-based approach to PAR, as it is known to enable transformative learning and related changes in nursing practice (Knibbs et al., 2012; Trajkovski et al., 2013; Watkins et al., 2016). Moreover, throughout the stages of AI, extensive attention is devoted to the sustainable implementation of a new professional practice (e.g., defining a topic of interest, discovering current strengths, dreaming and designing preferred practice, planning individual/collective action, reflecting critically).

Research aims

This thesis aims to contribute to the shift toward solution-focused parenting support in the Dutch YH system by first identifying the current state of solution-focused parenting support practice, as well as the beliefs and intentions of PHNs. It subsequently explores ways of further facilitating the shift toward solution-focused parenting support by PHNs. In the following sections, this aim is described in greater detail for each part of the thesis.

Part I: Solution-focused parenting support in YH

The first part of this thesis explores the state of solution-focused parenting support among PHNs in YH.

The research aims were:

1 To explore the problem-focused and solution-focused characteristics of parenting support provided by PHNs in the YH, three years after solution-focused parenting support was implemented.
2 To explore the behavioral, normative, and control beliefs of PHNs about solution-focused parenting support.
3 To explore and explain the intention of PHNs to provide solution-focused parenting support by the concepts of attitude, subjective norm, and perceived behavioral control.

Part II: Facilitation of transformative learning

The second part of this thesis explores the impact of an action research approach on transformative learning aimed at solution-focused parenting support among PHNs.

The research aim was:

4 To investigate whether and how appreciative inquiry could facilitate transformative learning and related changes toward solution-focused parenting support among PHNs.

Study designs and methods

A mix of qualitative, quantitative, and participatory action-research designs were used to achieve the various research goals (Figure 3).

Part I: Solution-focused parenting support in YH

The first step in this part of the research involved collecting qualitative data in cooperation with one YH organization in the south of the Netherlands. In all, live audio recordings were made of 15 parenting support sessions provided by 10 different PHNs. These recordings were subsequently analyzed to identify the problem-focused and solution-focused characteristics of parenting support.

In a second step, qualitative data were collected in two focus groups with PHNs (N = 18), in cooperation with two different YH organizations, in order to elicit beliefs surrounding solution-focused parenting support. These insights were used to develop a questionnaire to measure the beliefs, attitude, subjective norm, perceived behavioral control, and intention of PHNs. Subsequently, quantitative data were collected through an online survey conducted in cooperation with 12 different YH organizations throughout the Netherlands to explore beliefs of PHNs (N = 449) about solution-focused parenting support, and to identify and explain their intention to provide solution-focused parenting support.

Part II: Facilitation of transformative learning

Third, qualitative data were collected within a team of PHNs (N = 8) in one YH organization in the south of the Netherlands. Semi-structured interviews and multiple focus groups were conducted to identify whether and how AI could facilitate transformative learning among PHNs.

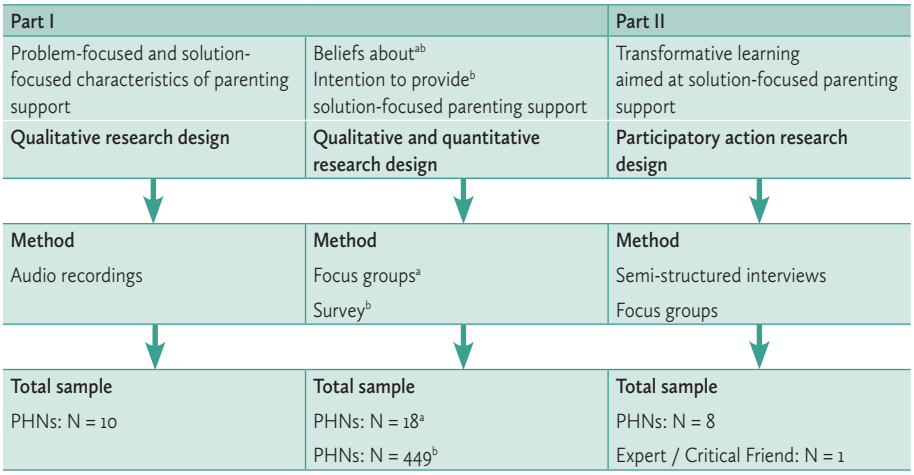
Outline of the thesis

The first part of this thesis presents the status of solution-focused parenting support by PHNs in the YH system in the Netherlands. *Chapter 2* describes the problem-focused and solution-focused characteristics of parenting support, as provided by PHNs. The beliefs of PHNs about solution-focused parenting support are presented in *Chapter 3*. The intention of PHNs to provide parenting support and how this intention can be explained by the attitudes, subjective norms, and perceived behavioral control of PHNs are reported in *Chapter 4*.

The second part of this thesis focuses on the impact of AI on transformative learning among PHNs. *Chapter 5* describes the mechanisms that facilitate

transformative learning and change among PHNs toward solution-focused parenting support. Finally, *Chapter 6* presents a summary and discussion of the main findings, in addition to addressing implications and recommendations for future research, policy, and practice.

Figure 3. *Flowchart of research designs, methods, and samples across the studies*



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Chapter 2

Problem- and solution-focused characteristics of parenting support, 3 years after implementation of the solution-focused approach: A qualitative content analysis

Theuns-Boumans, L., Mathijssen, J., Rots-de Vries, C., & van de Goor, I. (2021). Problem- and solution-focused characteristics of parenting support, 3 years after implementation of the solution-focused approach: A qualitative content analysis. *Child & Family Social Work, 26*(1), 163-172. https://doi.org/https://doi.org/10.1111/cfs.12800

Abstract

Objective: In recent years, solution-focused parenting support has been developed and implemented as a promising brief and strength-based approach. Given the fundamental differences between solution-focused and the historically more common problem-focused parenting support and the complexity of transforming professional practice, an actual shift towards solution-focused parenting support practice can be expected to be limited up to now. However, because research into the specific communication characteristics of professional parenting support is currently lacking, no conclusion can be drawn at present. Therefore, this study aims to explore the current problem- and solution-focused characteristics of parenting support in the Dutch youth healthcare (YH). ***Methods:*** In total, 15 support sessions performed by 10 public health nurses were audio recorded and transcribed verbatim. A detailed qualitative content analysis of professional communication was conducted to identify problem and solution-focused factual, expressive, relational, and appealing aspects of parenting support. ***Results:*** Problem-focused characteristics dominated all sessions of parenting support. ***Conclusion:*** This study is the first to thoroughly analyze the problem- and solution-focused communication characteristics of professional parenting support using a qualitative content analysis. Parenting support practice in the Dutch YH did not shift substantially to a solution-focused approach. More effort is required to stimulate and facilitate this professional transformation.

Introduction

In recent years, a growing body of evidence is encouraging the use of solution-focused parenting support over the historically more common problem-focused parenting support. First, solution-focused support was found to be as effective in solving typical problems as other support approaches (Kim, 2008). Second, solution-focused support was found to require less time than other support approaches (Bond et al., 2013; Gingerich & Peterson, 2013; Stams et al., 2006). Third, solution-focused support is positively associated with goal approach, positive affect and action planning, and was found to decrease negative affect in clients (Grant, 2012; Neipp et al., 2016). In general, the added value of solution-focused parenting support is described as enabling parent empowerment, which contributes to improved parenting and to parents' ability to independently solve future problems (Rapp et al., 2005). Given these effects and its time-efficient and strength-based nature, solution-focused parenting support is recommended as the preferred approach, especially when problems are still mild (Bond et al., 2013; Carr et al., 2017).

Despite the recent development of this preferred approach in parenting support (Carr et al., 2017; Polaschek & Polaschek, 2007; Wells et al., 2014), an actual shift from problem-focused to solution-focused parenting support is expected to be limited in current child welfare services (Lietz, 2011; Roose et al., 2014; Toros et al., 2018). This expectation is based on the combination of vital differences between both approaches (De Jong & Berg, 2013; De Shazer, 1988, 1997; McAllister, 2003) and current implementation strategies of these interventions. We will elaborate on these issues.

Differences between the two approaches are fundamental and become apparent in the factual (content), expressive (expression of professional role), relational (view on parents and parents' role) and appealing (what is expected of parents) aspects of professional communication during parenting support sessions (Schulz von Thun, 2010). Problem-focused parenting support originates in the tradition of the biomedical model (Engel, 1977). This support approach is past-oriented and focuses on identifying problems and their causes, and on solving or reducing problems by eliminating or intervening in those causes. In this approach, the professional has an expert role during the different support stages, that is, assessment, definition, implementation, and evaluation. Parents serve mainly as a source of information to enable the process of professional judgement and decision making. In addition, parents are expected to comply with the professional's actions and suggestions to problem solving (De Jong & Berg, 2013; McAllister, 2003; Wilkinson, 2012).
In contrast, solution-focused parenting support is a future-oriented and strength-based approach that concentrates on improving parents' motivation, confidence, competences, and problem-solving skills (De Jong & Berg, 2013; De Shazer, 1988, 1989; McAllister, 2003). The support process is divided into various stages (De Jong & Berg, 2013). First, the preferred future and current strengths and resources are assessed. Second, a first small step towards the preferred future is assessed. Third, professional feedback is provided. Finally, parents' progress is evaluated and their need for further support is determined. The parents' perspective is central in every stage of support. The professional, meanwhile, has a stance of 'not-knowing' and leads the support process explicitly from the parents' perspective (De Jong & Berg, 2013; De Shazer, 1988, 1989; McAllister, 2003).

Sustainable implementation of solution-focused professional parenting support behavior implies an alignment between this new approach and the professional's views, beliefs, values and identity. A combination of context specific implementation strategies in several stages of change is needed to facilitate this alignment and behavior change (Durlak & DuPre, 2008). For example, the implementation model of Grol and Wensing (2013) distinguishes five stages for sustainable implementation: orientation, insight and understanding, acceptance,

change and maintenance. Within each stage, different strategies are described that contribute to the goals of a specific stage. To the best of our knowledge, current implementation strategies of solution-focused and other parenting support interventions in child welfare services are limited to a standardized 2- to 5-day technical intervention training, the provision of intervention material and, possibly, a limited amount of additional peer supervision sessions. For example, Parents Plus provides a 3-day training including program materials. Post training peer supervision sessions are provided on additional request (ParentsPlus, 2017). The implementation of another positive parenting support intervention, Triple P, is stimulated by a 3-day training plus three peer support sessions (Triple P, 2019).

In 2014, the Dutch youth healthcare (YH) promoted the shift from problem-focused to solution-focused parenting support as part of a system reform of youth care in the Netherlands (Knijn & Hopman, 2015). The YH is a national public child and family welfare service that contributes to a healthy physical, psychological, social and functional child development by a set of preventive activities and early interventions. It is available for all families living in the Netherlands, free of charge and is governed by the Public Health Act (2008). Parenting support by the YH is provided as early social intervention by public health nurses to parents with mild parenting problems. Although these mild problems are generally viewed as normal parenting problems connected to the developmental stage of the child, parents can experience problems in handling these situations (e.g. regarding children's sleeping problems, aggressive behavior, disobedience, or fear of strangers). Therefore, the aim of this support is to empower parents and to prevent the development of more severe parenting problems and further negative consequences (Dutch center for youth healthcare, 2018). Public health nurses are educated as Bachelor of Nursing and as social nurses during a Post Bachelor education. They can offer one to three sessions of parenting support, on average. If more support is needed or if problems are more severe, parents are referred to other or more specialized professionals (e.g., social worker, psychologist and psychiatrist).
To facilitate the shift to solution-focused parenting support in the YH, different interventions were initiated. Training public health nurses in solution-focused support techniques and additional peer supervision sessions were the most commonly used methods to encourage the implementation of this new approach. However, given the profound nature of the shift (discussed above), it seemed questionable whether these methods would be sufficient to achieve the shift to solution-focused parenting support in daily practice of the Dutch YH.

The litmus test to determine whether solution-focused parenting support was implemented sustainably is to study the professionals' actual behavior in natural circumstances (Hulsman et al., 1999). To the best of our knowledge, good fidelity

measures in solution-focused parenting support research are currently lacking. Fidelity measures of Parent Plus interventions are limited to 'requiring facilitators to follow detailed guidelines in program manuals, complete integrity checklists after each session, and attend preprogram training and regular supervision with program developers' (Carr et al., 2017, p. 4). Furthermore, in reviews of solution-focused parenting support, fidelity measures were reported as lacking in general or were based on self-report (Bond et al., 2013; Gingerich & Peterson, 2013). Knowledge about current parenting support communication characteristics is needed to inform further implementation processes.
Therefore, the aim of this study is to explore the problem-focused and solution-focused characteristics of actual parenting support by public health nurses in the YH, three years after solution-focused parenting support was implemented.

Methods

Study design

A qualitative research design was used to identify the problem- and solution-focused characteristics of current parenting support in the YH. This approach enables the identification of factual, expressive, relational and appealing aspects of professional communication in naturally occurring parenting support sessions in the YH (Merriam & Tisdell, 2016; Schulz von Thun, 2010).

Setting

This study was performed at a YH organization in the south of the Netherlands, in a region comprising 18 municipalities which are served by nine self-organized teams. These teams consist of medical doctors, public health nurses, and health assistants.

Population and study sample

The research population of this study consisted of public health nurses, because they provide parenting support as early intervention. In total, 53 public health nurses were employed at this YH organization. The average age of these nurses was 48 years (range 24–63), and their mean work experience as a public health nurse was 19 years (range 1–37). In 2014, these public health nurses received a 3-day training and participated in two peer supervision sessions to consolidate the implementation of solution-focused parenting support.

For this study, a sample of 15 public health nurses was selected through a purposive selection procedure, based on the criterion of maximum variation (Palinkas et al., 2015). The selected nurses varied on the criteria of team (region), age, work

experience as a public health nurse, number of attended parenting support courses and self-reported experience with parenting support. Due to job change, pregnancy leave and sickness leave, the initial sample was changed to a final sample of 10 public health nurses (Table 1).

Table 1. Sample selection

Population characteristics	Total population	Initial sample	Final Sample
Number of public health nurses	53	15	10
Different teams (regions)	9	9	7
Age (years)			
20-30	5	2	1
30-40	11	3	3
40-50	7	5	3
50-60	24	4	3
60-67	6	1	0
Work experience as a public health nurse (years)			
1-10	15	5	3
10-20	13	4	4
20-30	10	4	2
30-40	15	2	1
Number of attended parenting support courses			
1-2	15	3	3
3-4	34	11	6
5-6	4	1	1
Self-reported experience with parenting support			
1: Little	6	1	1
2: Moderate	19	8	5
3: Extensive	28	6	4

Data collection

Data were collected through audio recordings of actual parenting support sessions between parents experiencing mild parenting problems and public health nurses. These recordings provide data about parenting support in their natural occurrence. Small recording devices were used and, no researcher was present during the support sessions. This procedure ensured unobtrusive data collection (Merriam & Tisdell, 2016).

Preceding data collection, the participants received a protocol for case selection, recording instructions and an informed consent form. In order to prevent professionals to act differently due to knowledge about research goals, our specific interest in solution-focused and problem-focused characteristics was not mentioned to participants. Rather, participants were informed that we were interested in their general way of working when providing parenting support. Case

selection was based on the criterion of a mild parenting problem in which the nurse professionally indicated that one to three sessions would be adequate to support the parents. Data collection started after the informed consent procedure with the nurse was completed. Prior to recording, parents were informed by the nurse about the aim and procedures of the research activities and were asked for permission to record the support sessions. The audio recordings were transcribed verbatim for analysis and anonymized. The procedures in this study were approved by the Ethical Review Board of Tilburg University (Reference number: EC-2017.05).

Data analysis

A qualitative content analysis procedure was conducted. This type of analysis enables the identification of factual aspects and the interpretation of expressive, relational and appealing aspects of parenting support provided by public health nurses as being either problem- or solution-focused (Krippendorff, 2012; Mayring, 2014; Schulz von Thun, 2010).

Coding protocol

An initial coding protocol was developed to identify problem- and solution-focused characteristics of parenting support. Problem- and solution-focused parenting support can both be divided into general support stages: (a) Problem description; (b) Assessment; (c) Definition; (d) Implementation; (e) Evaluation (De Jong & Berg, 2013; Wilkinson, 2012). The coding protocol included these stages of the parenting support combined with typical problem-focused and typical solution-focused factual, expressive, relational and appealing aspects of professional communication (De Jong & Berg, 2013; McAllister, 2003).

Factual, expressive, relational and appealing aspects of professional support

The factual aspect of a message refers to the content of a message. In problem-focused support, the content of support focuses on for example the 'problem' or 'cause'. In solution-focused support, on the other hand, 'the preferred future' or 'current strengths' are examples of the factual aspects of professional messages. The expressive aspect of a message refers to how the professional presents herself. In problem-focused support, the professional acts as an expert. By contrast, in solution-focused support, the professional operates from a stance of not knowing and leads the process from the parents' perspective.

The relational aspect of a message pertains to how the professional expresses her view on the role of the parents. In problem-focused support, the professional views the parents as an important source of information from whom to retrieve as much detailed information as possible about the problem and its causes to enable the process of professional reasoning and judgement. In solution-focused support, the professional views the parents as the expert in describing the problem, the

preferred future and the possibilities to grow towards this future.
The appealing aspect of the message refers to what the professional implicitly or explicitly expects from the parents. During problem-focused support, the professional expects parents to cooperate during the support process by, for example, answering the questions asked and by acting upon professional advice. In solution focused support, the professional expects the parents to create a solution based on their own possibilities and perspective, in a co-creative support process (De Jong & Berg, 2013; Schulz von Thun, 2010).
The initial coding protocol was used both deductively and inductively. It was used deductively, because the coding scheme was constructed from a theoretical knowledge base. It was used inductively, because flexibility during analysis was needed to ensure the codes would match the actual data (Mayring, 2014). An interrater agreement procedure was performed to test the clarity and completeness of these codes.

Interrater agreement

The interrater agreement procedure was based on the criterion of 80% agreement within 20% of all transcripts, and was completed in two stages (McHugh, 2012). In the first stage, three researchers (including the primary researcher) compared the results of their individual analysis. Their 80% agreement in 20% of all transcripts was confirmed. In the second stage, these results were compared with the results of the analysis of a fourth researcher. Again, the criterion of 80% agreement was reached and interrater agreement was confirmed.
The initial coding protocol was adapted throughout this procedure with a view to achieving clarity and completeness. Revisions were accepted if all researchers involved approved. Changes to the coding protocol included for example the deletion of the problem description stage. This stage is the first stage in both approaches, and was therefore not distinctive. Moreover, specific factual aspects were no longer assigned to either problem or solution-focused characteristics, because they could be found in both approaches (e.g., compliment and professional advice). Their problem-focused or solution-focused nature was found to be dependent on the expressive, relational and appealing aspects of that message.
The primary researcher proceeded with the analysis based on the final protocol for analysis, which is illustrated in Table 2. During this final analysis no additional changes were necessary. For a full description, the final protocol can be obtained from the primary researcher.

Table 2. Illustration final coding protocol

Stage of support process	Aspect of message	Solution-focused codes	Problem-focused codes
Definition stage	Factual aspect	Preferred future	Problem
		Compliment	Cause
		Professional advice	Compliment
		Professional reflection	Professional advice
			Professional reflection
	Expressive aspect	Professional attitude of 'not knowing'	Professional as an expert
		Grounding (i.e., establishing and expressing mutual understanding)	
	Relational aspect	Parent as the expert	Parent as source of information
	Appealing aspect	Cocreation	Cooperation

Stepped data analysis

The analysis was performed in three steps. In 'Step 1: Support stage', the transcripts of the parenting support sessions were divided into segments that indicated the different stages of parenting support. These stages were the assessment stage, definition stage, implementation stage and evaluation stage. In 'Step 2: Expressive, Relational and Appealing aspects', the expressive, relational and appealing aspects were interpreted within the context of each selected stage of parenting support. After all, the nature of these aspects is revealed in consecutive messages. For example, whether a question is asked to identify the parents' perspective or to enable professional judgement and decision making only becomes apparent in the consecutive reactions of the professional to the parents' answers. In 'Step 3: Factual aspects', all factual aspects were identified in each individual professional message in the transcripts. If a factual aspect could be identified in both approaches of parenting support, its nature was determined by the expressive, relational and appealing aspects in this stage of parenting support. An example of this stepped data analysis procedure based on the data is provided in Table 3.

Table 3. Example of stepped analysis

Excerpt from transcript Case R4	Step 1: Support stage	Step 2: Expressive, Relational and Appealing aspects	Step 3: Factual aspects
Nurse: And that does not work? Well, but does joining the battle like you do work?	Assessment stage	E: Professional as an expert	Previous attempt
Parent: No, it doesn't, not really.		R: Parent as source of information	
Nurse: No. It is not like she is suddenly finishing her meal properly?			Previous attempt
Parent: No.		A: Cooperation	
Nurse: For how long has this been a problem?			Problem
Parent: For some time, though.			
Nurse: Did it start before the rudeness problem?			Problem
Parent: Yes.			
Nurse: Well, to sum up, it's a three-year-old girl who plays well, is developing fine in several outcomes, is able to clearly express herself, is rarely sick and is growing well. Her obedience is, however, a challenge, especially at meal times.	Definition stage	E: Professional as an expert R: Parent as source of information	Problem
Parent: Yes		A: Cooperation	
Nurse: Now, we can do two different things. First, we could observe the behavior for some time to see if we can identify some specific causes. Second, we could hypothesize the cause and select interventions based on this hypothesis. What would you prefer?	Intervention stage	E: Professional as an expert R: Parent as source of information	Intervention
Parent: I would prefer the first option.		A: Cooperation	
Nurse: Ok, that is possible. That means that we will first have to explore what happens in advance of the problematic behavior and how you react to it. Moreover, I will give you a DVD with many examples of problematic parenting situations. You can use these examples to better describe the parenting behavior that you recognize as your own. In this session, I will not give any further advice if that is fine with you?			Intervention
Parent: Yes, that is fine			

Member check

After completing the analysis, a member check procedure was conducted with all participants individually for two aims. First, to determine whether the protocol reflected their view on the characteristics of problem and solution-focused parenting support. Second, to determine whether the results reflected their parenting support practices (Merriam & Tisdell, 2016). All participants supported the protocol for analysis, and they recognized and confirmed the results of the analysis. No changes were needed due to this member check procedure.

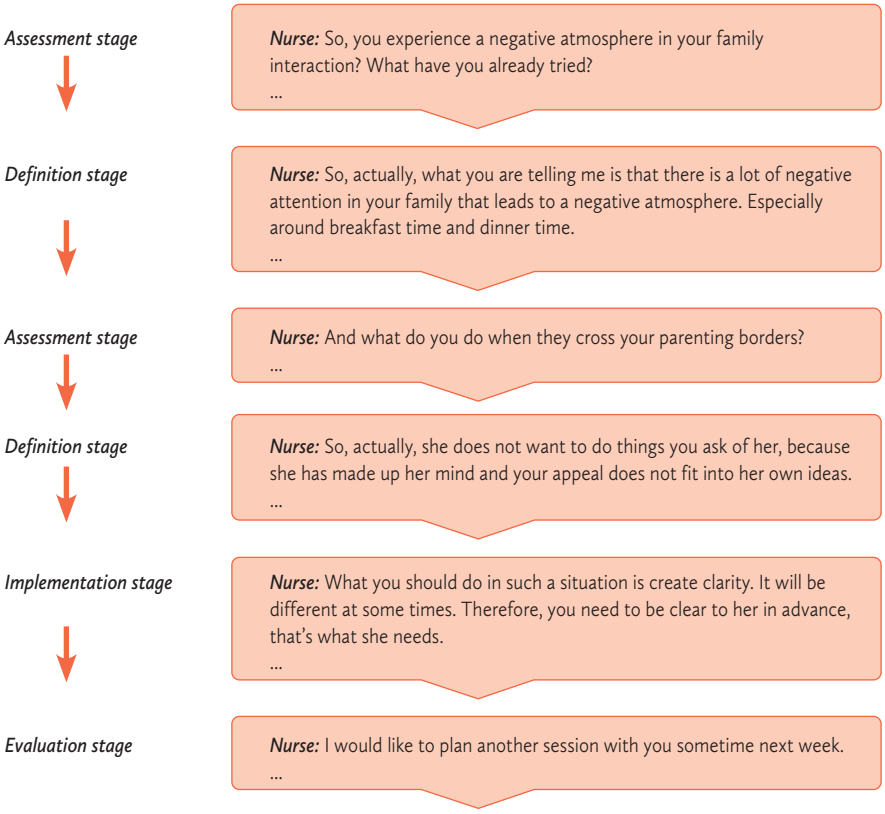
Results

Each participant contributed one case of parenting support. Thus, in total, 10 cases of parenting support were recorded. Within these cases, a wide range of parenting problems was supported by the public health nurses. Eating problems, sleeping problems and interaction problems were most common. The cases varied in terms of the number of support sessions, ranging from one to four sessions per case. Moreover, each session varied in length (range: 30–90 min) and in the number of professional messages that could be identified and analyzed (range: 29–181 messages). In sum, 1534 professional messages were suitable for analysis. The rigor of the results presented was established by the saturation of factual, expressive, relational and appealing aspects of parenting support within six cases of parenting support. This data saturation was confirmed by the analysis of four additional cases.

Stages in parenting support

All stages of parenting support process emerged from the transcripts (i.e., assessment, definition, implementation and evaluation stage). The public health nurses used the stages in an iterative way. Not every individual case exhibited all stages of the parenting support process. Overall, the assessment stage and the implementation stage dominated all parenting support sessions. The iterative application of the different stages in one session is illustrated in a case (R10) in which the parents described their parenting problem as their two children not getting along, which caused a lot of tension for all family members.

R10:



Problem-focused characteristics of parenting support

Within all cases and in all stages of the recorded parenting support cases, the factual, expressive, relational and appealing aspects of the professional messages were mainly characterized by problem-focused features (i.e., 1525 of in total 1534 messages). The most common problem-focused factual aspects coded were *problem* and *professional advice*. Both factual aspects were used in all stages of the support. The main expressive, relational and appealing problem-focused aspects coded in all stages of support were, respectively, *professional as an expert, parent as a source of information, and cooperation*. These problem-focused characteristics are illustrated by a case of a public health nurse (R4) supporting parents who perceived their child as being rude in family interaction. This nurse started the first session with an extensive problem assessment, assessing the problem, its causes, and the actions of parents to solve the problem. The questions were initiated from a professional perspective and parents were expected to cooperate, that is, to answer the questions to provide the professional with information to enable professional reasoning and judgement. The words in bold style refer to the problem-focused factual aspects of each message.

R4:

Nurse: So, what is **the problem**? Can you tell me more about **that**?
...
Nurse: Could you perhaps give **an example**?
...
Nurse: You mean **a reply**?
...
Nurse: It is about **obedience** then?
...
Nurse: And when did **this** start?
...
Nurse: And does **it** get worse or does **it** remain the same?
...
Nurse: Can you relate **it** to something? Does **it** relate to your behavior or to what has happened or not at all?
...
Nurse: Are there moments that **the situation** is different, for example when she returns from preschool? That ***it***'s worse or that it has improved?
...
Nurse: What have you already tried in order to solve **this problem**?

Solution-focused characteristics of parenting support

Of all 1534 analyzed professional messages, 11 messages were interpreted as solution-focused on one or more aspects of that message. For example, asking for goals in the assessment stage in terms of the *preferred future* was identified as a solution-focused factual aspect. The expressive, relational and appealing solution-focused characteristics that were identified were, respectively, *professional attitude of not knowing, grounding, parent as expert*, and *cocreation*. These characteristics are illustrated in a case in which the eating behavior of a child was presented as a huge problem by the parents (R6). This case started with a thorough assessment of the problem and the way parents had handled it so far. During this assessment, the parents began to realize that a lot had already changed for the better. They started to become more positive and hopeful. The stages presented are the definition and the implementation stage of this session. The sentences in bold style illustrate solution-focused support by a focus on *solution*, *grounding*, giving *compliments*, and a *professional attitude of not knowing* in consecutive messages.

R6:

Nurse: What do you think? To my opinion you're telling me that the situation is better than it ever was before.
Mother: Yes, it has never been this good!
Nurse: **What do you think should happen now? What do you think is necessary in your situation?**
Mother: Well, my ideal is that she eats what she needs as a 6-year old.
Nurse: **That's a good one. You emphasize 'as a 6-year-old'. Well, let's find out what a 6-year-old should eat.**
...

Interpreting factual aspects

Some factual aspects could be identified in both problem and solution-focused parenting support messages, for example, *compliment* and *professional advice*. Messages containing these factual aspects were interpreted as either problem-focused or solution-focused, depending on the nature of the associated expressive, relational and appealing aspects. The next session illustrates how a message containing the factual aspect *compliment* was interpreted as entirely problem-focused, because the *professional* presented herself *as an expert* providing a lot of *professional advice* without *grounding*. The case (R5) is about a child asking for maternal attention in a negative way. The compliments in this conversation are presented in bold style.

R5:

Nurse: So, you really would like to know where this negative behavior came from?
...
Nurse: Sometimes it is hard to find out. There could be multiple factors. His world is getting larger, he is at school now, he starts to develop certain feelings about how to cope with situations, his baby brother was born, and you've stayed in the hospital for a few days ... It could be that a combination of these factors have an impact on his feelings. With children it is often hard to determine a specific cause. What you can do, **and actually you are already practicing it**, is to really listen to your gut feeling. This is probably the best way of finding out what is happening and how you can help him.
...
[Mother gives an example of what she has tried.]
...
Nurse: **Super**!
...
[Mother gives another example of what she has tried.]
...
Nurse: **Very good, yes**! Children can ask for attention in two different ways. First, cute and positive. Then, you can give them a compliment. But children can also ask for attention in a negative way.
...
Nurse: I think he wants your full attention. So, having small conversations with him, **like you already do, is very good**. Possibly you can do that more often.

A combination of expressive, relational and appealing characteristics

Other text fragments presented combinations of problem-focused and solution-focused expressive, relational and appealing aspects. In the following example, which is from the case in which a child asked for maternal attention in a negative way (R5), the *progress of support* was coded as the factual aspect. The professional took a solution-focused *stance of not knowing* (expressive) and asked the parents how they would prefer to proceed (relational: *parent as expert*). These aspects were interpreted as solution-focused. Moreover, the professional made an explicit appeal to the parents to contact and inform her about their progress. This appealing aspect was interpreted as problem-focused. In the example, the underlined words

illustrate the problem-focused appealing aspect, and the words in bold style illustrate the solution-focused factual, expressive and relational aspects.

R5:

> ***Nurse:*** **How would you like to proceed?**
> ***Mother:*** Well, how long, yes... First, I have to put it into practice. I don't know how much time I will need...
> ***Nurse:*** Let's do it this way. What if you contact me in a few weeks, **whenever you are ready?** First, **you can practice as long as you need** and then you call me or email me...
> I would appreciate it if you could inform me about your progress.
> ...

Discussion

The aim of this study was to identify the problem-focused and solution-focused characteristics of parenting support provided by public health nurses in the Dutch YH, 3 years after solution-focused parenting support was implemented.
The literature indicates that problem-focused parenting support is equally effective on solving typical parenting problems but more time-consuming than a solution-focused approach (Bond et al., 2013; Gingerich & Peterson, 2013; Kim, 2008; Stams et al., 2006). According to a solution-focused point of view, knowledge about the problem and its causes does not provide knowledge about the solution. Moreover, putting the parents' perspective at the heart of the support process, as is typical for solution-focused support, adds to a problem-solving approach by increasing parents' motivation, confidence, and problem-solving competences (Rapp et al., 2005).
Our findings show that both problem-focused and solution-focused features are present in current professional parenting support in the YH. However, in all stages of support, problem-focused characteristics were found to dominate in the nature of professional messages. In particular, the performance of an extensive and time-intensive problem assessment and the offering of professional advice from the professional's perspective were notable in all cases. These characteristics are typical for a problem-focused support approach.

In this study, parenting support sessions were recorded by the public health nurse using a small unobtrusive audio recording device. These recordings were transcribed verbatim. This method of gathering and processing data adds to the internal validity of the results of this study. First, the data represented professional support in its most natural occurrence. Second, the detailed transcriptions enabled the assessment of the interrater reliability as performed by different researchers. Despite the fact that audio recordings are favorable for securing the natural setting

over video recording and specifically over the presence of an observer at the scene, the absence of these might also have limited the collection of relevant data. First, visual information would have made the researcher more familiar with the specific context of parenting support. Consequently, a more detailed description of this context could add to the external validity of this study (Merriam & Tisdell, 2016). However, the apparent differences between the contexts of the cases recorded that could be retrieved from the transcripts (i.e., location of support, family characteristics, and family composition) did not result in different problem-focused and solution-focused support characteristics. Therefore, it is assumed that these contextual differences do not influence the problem-focused or solution-focused nature of professional parenting support in the YH. Second, a consequence of audio recordings is that nonverbal aspects of communication could not be observed. Although verbal and nonverbal communication are theoretically inseparable in the meaning-making process, encoding nonverbal communication is by definition viewed as complex (Bavelas & Chovil, 2000). Moreover, distinctive descriptions of nonverbal aspects in both problem- and solution-focused approaches are lacking. Given these complexities, a reliable interpretation of nonverbal communication as problem or solution-focused could not be expected. That is why audio recording seemed the best data collection method for this study.

The stepped analysis procedure in this study was complex. Theoretical knowledge about both approaches was prerequisite for the application of the coding protocol, for the interpretation of expressive, relational and appealing aspects of support, and for equal contribution to discussions during interrater agreement procedures. The interrater agreement procedure was performed in two stages, involving four different researchers. Intense discussions contributed to an improved coding protocol. This thorough procedure added to the validity and reliability of the process and results of this study (Leung, 2015).

To the best of our knowledge, this is the first time that the problem-focused and solution-focused characteristics of professional parenting support communication were studied so thoroughly, using a qualitative content analysis. In current reviews on the effectiveness of solution-focused parenting support, the lack of fidelity measures is reported as a common limitation. Moreover, in cases where fidelity was measured, these claims primarily rested upon professional self-reports (Bond et al., 2013; Gingerich & Peterson, 2013). In this study, during the member check procedure, participants indicated that they had expected their parenting support to be more solution-focused. It is known that incompetent professionals tend to overestimate their competences (Hulsman et al., 1999; Kruger & Dunning, 1999).

Therefore, identifying problem-focused and solution-focused characteristics directly from the professional support communication adds to the fidelity claim of solution-focused parenting support (Hulsman et al., 1999; Mowbray et al., 2003).

Although no conclusive inferences can be made due to the design of this study, results indicate that the impact of training public health nurses, followed up by two additional peer supervision sessions, on applying solution-focused parenting support seems to be limited. While some professional messages contained solution-focused characteristics, overall the nature of parenting support remained problem-focused. This is in line with our expectations based on existing implementation and transformative learning theories. To facilitate a shift from problem-focused to solution-focused parenting support, policy makers should acknowledge that, besides system level changes, a long-term complex process of transformative professional learning during the different stages of implementation should be facilitated in order to change their perspectives, assumptions and, consequently, their support behavior (Cullinane et al., 2005; Grol et al., 2013; Henderson, 2002; Mezirow, 1997, 1998). Insight in, and deep understanding and acceptance of solution-focused parenting support are first steps for intrapersonal perspective change. Stage four of implementation 'Change' as distinguished in the model of Grol and Wensing seems crucial for subsequent actual behavior change and in-depth internal transformation of professionals. Experimenting with new behavior, critical reflection and continuous improvement are at the core of this stage. When professional experiences within this stage are positive, chances of sustainable implementation will improve (Grol et al., 2013; Henderson, 2002; Mezirow, 1997, 1998). Our further research will focus on how the transformation of public health nurses towards solution-focused parenting support can be stimulated, within each stage of implementation, using an action research methodology.

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Chapter 3

Beliefs of public health nurses about solution-focused parenting support - A questionnaire study

Theuns-Boumans, L., Mathijssen, J., Rots-de Vries, C., & van de Goor, I. (2022a). Beliefs of public health nurses about solution-focused parenting support – A questionnaire study. *Children and Youth Services Review, 143*, 106693. https://doi.org/https://doi.org/10.1016/j.childyouth.2022.106693

Abstract

Objective: Parenting support guidelines for public health nurses (PHNs) have shifted from a problem-focused to a solution-focused approach. Given the fundamental differences between these two approaches, implementation of solution-focused parenting support is assumed to be difficult. Since the way PHNs provide parenting support is largely guided by their beliefs, knowledge about their beliefs concerning solution-focused parenting support is important for its actual implementation. This study aims to explore the behavioral, normative, and control beliefs of PHNs about solution-focused parenting support for future design of implementation interventions and related research activities. ***Methods:*** A theory of planned behavior questionnaire was systematically developed and tested using focus groups. Thematic analysis and nominal group technique were used to analyze the data and to reach consensus. Next, this questionnaire was conducted among 449 PHNs in the Netherlands. Factor analysis and descriptive statistical analysis were performed. ***Results:*** Factor analysis resulted in three distinguishing subscales: behavioral beliefs ($\alpha = 0.79$), normative beliefs ($\alpha = 0.80$), and control beliefs ($\alpha = 0.64$). Beliefs of PHNs about solution-focused parenting support were moderately positive to positive (means varying from 4.24 to 5.54, on a 1–7 scale), and differences were statistically significant for various background variables. Control beliefs were less positive than behavioral and normative beliefs. PHNs trained in solution-focused parenting support reported more positive control beliefs ($M = 4.34$, $SD = 0.83$) as compared to untrained PHNs ($M = 4.00$, $SD = 0.82$). ***Conclusion:*** This study is the first to provide insight into PHNs' beliefs about solution-focused parenting support. The overall moderately positive to positive beliefs of PHNs about solution-focused parenting support suggests that PHNs tend to accept solution-focused parenting support as a viable approach. Compared to behavioral and normative beliefs, PHNs score the lowest on control beliefs.

Introduction

Parenting support can be described as any intervention to promote a healthy child development by improving the parenting approach, competencies, and resources (Daly, 2015; Moran et al., 2004), and has been found effective on many different outcomes (Mihelic et al., 2017; Mingebach et al., 2018; Moran et al., 2004; Rayce et al., 2017). In recent years, in connection with the international trend, parenting support guidelines for public health nurses (PHNs) in the Netherlands have shifted from a problem-focused to a solution-focused approach (Carr et al., 2017; De Jong & Berg, 2013; Knijn & Hopman, 2015; Oudhof et al., 2013; Polaschek & Polaschek, 2007; Wells et al., 2014).

Differences between problem-focused and solution-focused parenting support are fundamental. In problem-focused parenting support, the professional is the expert assessing the current problem and its main causes, selecting, and implementing evidence-based interventions to solve the current problem, and evaluating whether the problem is solved. This approach is in line with the traditional medical model (De Jong & Berg, 2013; McAllister, 2003). Solution-focused parenting support can be characterized by a future oriented, positive discourse. Here, parents are the experts on their problems and the solutions. Their perspective on the preferred future is central. Current strengths and resources are assessed and used to establish small goals of progress toward the preferred future. Solution-focused approaches solve problems as effectively as other approaches and are probably more time-efficient (Bond et al., 2013; Gingerich & Peterson, 2013; Kim, 2008; Stams et al., 2006). Moreover, they increase goal approach, positive affect, and action planning, and decrease negative affect (Grant, 2012; Neipp et al., 2016). Solution-focused parenting support aims at empowering parents by increasing their motivation, self-confidence, competencies, and problem-solving skills. This new approach in parenting support not only addresses current, but also future parenting problems (De Jong & Berg, 2013; McAllister, 2003).

PHNs play an important role in the delivery of parenting support (Hanson et al., 2019; Novilla et al., 2006). They provide parenting support as primary prevention to all parents (e.g., general, standardized oral and written parenting education) and as secondary prevention to parents with specific parenting questions or problems (e.g., indicated one-hour-support sessions, and indicated Video-Interaction-Guidance). The way PHNs provide parenting support is largely guided by their beliefs (Connors & Halligan, 2015; Fishbein & Ajzen, 2011; Gottlieb & Gottlieb, 2017; Henderson, 2002). Sustainable implementation of solution-focused parenting support in the daily practice of PHNs is challenging, given the fundamental differences of this approach with the traditionally more common problem-focused approach of parenting support in the youth healthcare (YH). Grol et al. (2013) developed a model to support sustainable implementation of the complex process of innovations in healthcare. They distinguish different stages in the process of change for professionals that include different aspects of effective implementation. These stages are orientation, insight, acceptance, change, and maintenance (Grol & Wensing, 2004, 2013). In the acceptance stage, after passing the stages of orientation and insight, the formation of beliefs around the innovation plays a central role according to Grol et al. (2013). Therefore, positive beliefs about solution-focused parenting support could be viewed as a prerequisite for PHNs to change their routine problem-focused parenting support practice to the empowering solution-focused approach (Fishbein & Ajzen, 2011).

According to the theory of planned behavior (TPB) beliefs are "subjective probabilities" and the most elementary explanation of behavior (Ajzen, 1991;

Fishbein & Ajzen, 2011). Within this theory, beliefs are assumed to be factors that causally influence a person's attitude, subjective norm, and perceived behavioral control, which subsequently affects a person's (intention toward a) given behavior (Ajzen, 1991).
The TPB distinguishes between three types of beliefs: behavioral, normative, and control beliefs. Behavioral beliefs are "the likely consequences or other attributes of the behavior" that "produce a favorable or unfavorable attitude toward the behavior." Normative beliefs are "beliefs about the normative expectations of other people" that "result in perceived social pressure or subjective norm." Control beliefs are "beliefs about the presence of factors that may further or hinder performance of the behavior" that "give rise to perceived behavioral control, the perceived ease or difficulty of performing the behavior" (Ajzen, 2002, p. 665).

Beliefs, thus, explicate the perspectives of PHNs on the importance and feasibility of solution-focused parenting support in their daily practice, and are viewed as antecedents of their professional behavior and behavior change (Ajzen, 2002; Ajzen & Fishbein, 2000; Fishbein & Ajzen, 2011; Grol et al., 2013; Parandeh et al., 2015; Squires et al., 2011). Therefore, knowledge of these beliefs is needed to align implementation strategies with the characteristics of this specific target group, i.e., PHNs (Fishbein & Ajzen, 2011; Godin et al., 2008; Grol et al., 2013). Unfortunately, to our knowledge, no study has been conducted yet to gain in-depth understanding of PHNs beliefs about solution-focused parenting support. Hence, this study aims to explore the behavioral, normative, and control beliefs of PHNs about solution-focused parenting support to contribute to a knowledge base for future design of implementation interventions and related research activities.

Methods

In this study, we used a two-stage exploratory study design (Creswell, 2009). The first phase aimed at the development of a solution-focused parenting support beliefs questionnaire (SFBQ). The second phase aimed at assessing the behavioral, normative, and control beliefs of PHNs by applying the SFBQ.
Prior to each stage of data collection, participants were informed about the study aim and procedures, and gave their consent to participate on a voluntary basis.
All procedures in this study were approved by the Ethics Review Board of Tilburg University.

Phase 1: Development of the SFBQ

The SFBQ was developed following the steps as recommended by Francis et al. (2004): 1) Define the population of interest; 2) Define the behavior of interest; 3) Determine salient behavioral, normative, and control beliefs, and include items in the first draft of the questionnaire; 4) Test the first draft of the questionnaire regarding clarity, comprehensibility, convenience, and size, and adjust if necessary.

1 Define the population of interest

The population of interest in this study consisted of PHNs occupied at YH organizations in the Netherlands. The Dutch YH is a public health service executed at regional level. The general aim of YH is to promote child health and to prevent or reduce physical, psychological, social, and functional child development problems. YH is available for all families in the Netherlands with children aged 0-18 years old, free of charge. Parenting support as early intervention is at the core of the work of PHNs to prevent more severe problems (Bakker-Camu & van Kuppevelt, 2014). At the time of this study, approximately 3,000 PHNs were employed at 48 different YH organizations in the Netherlands (Jambroes et al., 2015).

2 Define the behavior of interest

A clear definition of solution-focused parenting support appropriate for the aim of content validity in the survey was missing (De Jong & Berg, 2013; Del Greco et al., 1987). Therefore, to reach a consensus definition, two meetings with a jury of solution-focused experts were conducted (McKenzie et al., 1999). In total, six experts in solution-focused support originating from different perspectives (researchers and practitioners) participated in both meetings.

During the first meeting, the main characteristics of solution-focused parenting support were elicited from the experts individually and shared with other group members. After the meeting, the elicited characteristics were clustered into themes by the primary researcher, using the first three steps of a thematic analysis procedure (Table 1) (Braun & Clarke, 2006). This analysis was discussed with two other researchers (J.M. & P.V.) until consensus was reached.

***Table 1**. Thematic analysis (Braun & Clarke, 2006)*

Phase	Description of the process
1. Familiarizing yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

During the second meeting, step four and five of thematic analysis were executed collaboratively. The initial themes were discussed with all participants, and consensus was reached about an appropriate name for each theme (Braun & Clarke, 2006). Finally, during the second meeting, a nominal group technique was used to create consensus about the final definition of solution-focused parenting support based on the identified themes. This nominal group technique included five consecutive stages: 1) Introduction and explanation, 2) Silent generation of ideas, 3) Sharing ideas, 4) Group discussion/clarifying, and 5) Voting and ranking (Harvey & Holmes, 2012).

The final definition, presented below, was used during all further data collection procedures in this study.

Solution-focused parenting support implies for public health nurses a cooperation with parents based on an attitude of appreciation, genuine interest, and without prejudice. The public health nurse is confident that parents can achieve their preferred changes with help of their social network.

Solution-focused parenting support aims at the best wishes of parents and at discovering, activating, and strengthening parents' ability to grow toward their preferred future. The public health nurse uses specific language to invite parents:

1. *to tell their current story*
2. *to express their preferred future*
3. *to discover their current positive exceptions to the problem*
4. *to boost their available strengths and resources through one first step toward their preferred future*

3 Determine salient behavioral, normative, and control beliefs

Two focus groups with PHNs were held to elicit the most common behavioral, normative, and control beliefs about solution-focused parenting support (Francis et al., 2004). A convenience sampling method was used to recruit eighteen PHNs from two YH organizations in different large regions of the Netherlands (South and South-West, each comprising >350.000 inhabitants) (Daniel, 2012). The sample consisted of females who were all educated as registered nurse (RN). Their mean age was 41.8 years old (Min = 24, Max = 61), and their mean work experience as PHN was 14.25 years (Min = 1, Max = 32).

During the focus group meetings, open-ended questions were used to elicit the beliefs about solution-focused parenting support (Table 2). Next, all expressed beliefs were analyzed by the primary researcher using a thematic content analysis (Braun & Clarke, 2006). Six belief categories were used as a framework for the analysis: positive behavioral beliefs, negative behavioral beliefs, positive normative beliefs, negative normative beliefs, positive control beliefs, and negative control beliefs. In the first step of the analysis, the beliefs mentioned were assigned to one of the belief categories. Next, beliefs within one category were grouped based on their similar content. A theme that covered their content was assigned to each group of beliefs. Finally, the 75% most mentioned behavioral, normative, and control beliefs were determined as the most salient beliefs. These salient beliefs were converted into belief statements and included in the first draft of the SFBQ (Francis et al., 2004). This analysis was discussed with all co-authors until consensus was reached.

4 Testing the questionnaire

The first draft of the SFBQ included an introduction with an informed consent procedure and the definition of solution-focused parenting support, questions on background characteristics, and behavioral, normative, and control belief questions. Beliefs were measured using a 7-point Likert scale (1 = totally disagree/difficult; 7 = totally agree/easy), which is recommended as preferred rating scale in TPB research (Francis et al., 2004). The SFBQ was developed as an online questionnaire using Qualtrics® XM software (2019).

A convenience sampling method was used to solicit PHNs to test the questionnaire for its clarity, comprehensibility, convenience, and size (Daniel, 2012). First, two YH organizations were purposefully selected based on their location (i.e., relative near to the principal researcher's location). Next, all PHNs in these organization were invited by email to test the questionnaire.
In total, eleven PHNs responded positive to the invitation. Five of them were occupied at one of the YH organizations, and six were occupied at the other.

Due to sickness and heavy workload, finally five PHNs tested the questionnaire, two from one YH organization and three from the other. After completing the questionnaire, the participants were interviewed individually for information about the clarity, comprehensibility, convenience, and size of the online questionnaire.

Table 2. *Beliefs eliciting questions (Francis et al., 2004)*

Behavioral beliefs
When parents share their mild parenting problems with you ...
1. What would you like or enjoy about providing solution-focused parenting support?
2. What would you dislike or hate about providing solution-focused parenting support?
3. What do you believe are the advantages of solution-focused parenting support?
4. What do you believe are the disadvantages of solution-focused parenting support?
5. Is there anything else you associate with providing solution-focused parenting support?
Normative beliefs
When parents share their mild parenting problems with you...
1. Are there any individuals or groups who would approve of you providing solution-focused parenting support?
2. Are there any individuals or groups who would disapprove of you providing solution-focused parenting support?
Control beliefs
When parents share their mild parenting problems with you ...
1. What factors or circumstances enable you to provide solution-focused parenting support?
2. What factors or circumstances make it difficult or impossible for you provide solution-focused parenting support?
Final question
Are there any other issues that come to mind when you think about providing solution-focused parenting support to parents with mild parenting problems?

Phase 2: Survey SFBQ

Study sample

For the survey, 20 out of the 48 Dutch YH organizations were randomly selected using the function "random sample of cases" in SPSS Statistics for Windows (Version 24.0) and invited to participate in the survey. In total, twelve organizations agreed to participate, four organizations declined to participate due to work pressure issues, and four organizations did not respond to multiple invitations. The participating organizations together employed 809 PHNs in various regions around the Netherlands (Table 3).

Table 3. Characteristics participating YH organizations

YH organization	Region in the Netherlands	Number of municipalities	Number of inhabitants
1	South	16	696.356
2	South	24	1.000.000
3	South-West	13	385.459
4	South-East	1	122.723
5	South-East	8	245.000
6	Central	13	439.755
7	Central	17	490.486
8	South-East	13	577.372
9	South	6	249.303
10	North-West	8	320.000
11	East	14	554.124
12	North	16	658.000

Data collection

The SFBQ was distributed digitally to 809 PHNs, using Qualtrics XM software (2019). PHNs first received an email in which the study, its aim, and the procedure were introduced. In direct response to this email, 28 automatic replies from PHNs reported long-term absence due to various reasons (e.g., maternity leave, sick leave), which made participation in this study impossible. One week later, a second email was sent to the remaining PHNs (n = 781), which included an invitation to participate and a link to the questionnaire. Data were collected using three reminders in a six-week-period, which was carefully selected to promote the possibility of responding (e.g., no public holidays). The data collection period was extended from November 2018 to May 2019.

Data analysis

Preliminary analysis

Data were analyzed using SPSS Statistics. Initially, the data were screened for missing data. In total, twelve cases were eliminated from the dataset, because 20% or less of all questionnaire items were completed. Moreover, three cases in the dataset each missed one item. In these cases, mean imputations were performed for the missing values (Polit & Beck, 2008). All other cases were complete. Furthermore, items were recoded, if necessary, to assure all higher scores to associate with positive beliefs. Our data are hierarchical, as PHNs (level 1) are nested within twelve different YH organizations (level 2). Therefore, we tested whether it was necessary to control for organization effect in the analyses (Shek & Ma, 2011). We calculated the intraclass correlation coefficient (ICC), which is the proportion of the total variation in beliefs of PHNs that is due to differences between YH organizations. Multilevel modeling for the YH organization effect would be needed if the proportion of explained variance is 25% or higher (Heinrich & Lynn, 2001). The result of the ICC of beliefs ranged between 0.5% and 7.6%. Thus, multilevel modeling was proved to be not necessary.

Main analysis

Factor analysis using principal component analysis (PCA) with 26 items and direct oblimin rotation was performed to verify the discriminant validity of the three beliefs constructs from the TPB. The Kaiser-Meyer-Olkin test revealed sample adequacy for PCA, KMO = 0.85 (which is "great" according to Hutcheson and Sofroniou (1999)). Furthermore, Bartlett's test of sphericity was statistically significant, indicating factorability based on the correlations between variables. Factors associated with eigenvalues >1 were retained based on Kaiser's criterion. Furthermore, within each factor, items with loadings >0.3 were selected as initially suitable for this specific factor (Beavers et al., 2013; Williams et al., 2010). Next, the first and second author compared the retained factors to the beliefs constructs within the TPB by the content of the associated items. Based on substantial assessment of the content of each item, factors were established as subscales within the overall belief scale. Finally, Cronbach's alpha, mean, and standard deviation were calculated for each subscale, and statistically significant differences related to the background variables "age," "work experience," and "trained in solution-focused parenting support (or not)" were explored by performing an independent T-test or ANOVA.

Results

Phase 1: Development of SFBQ

1 Definition population of interest

As mentioned in more detail in the method section, approximately 3,000 PHNs employed at 48 different Dutch YH organizations were identified as study population.

2 Definition behavior of interest

The definition of solution-focused parenting support as result of the expert meetings is presented in section 2.1.1.2.

3 Salient behavioral, normative, and control beliefs

In total, 515 beliefs were expressed during the two focus groups. The analysis resulted in eleven positive behavioral belief themes, seven negative behavioral belief themes, six positive normative belief themes, three negative normative belief themes, eight positive control belief themes, and five negative control belief themes (Table 4). Beliefs that could not be grouped with other statements were clustered per category in the theme "other." In Table 4, the themes presented in Italic represent the selection of the 75% most mentioned beliefs per category that were included in the first draft of the questionnaire.

Table 4. *Behavioral, normative, and control beliefs of PHNs about solution-focused parenting support*

Positive behavioral beliefs (n=133)	Negative behavioral beliefs (n=91)	Positive normative beliefs (n=74)	Negative normative beliefs (n=19)	Positive control beliefs (n=121)	Negative control beliefs (n=77)
Themes:	Themes:	Themes:	Themes:	Themes:	Themes:
Parents become more active (n=23)	*Not corresponding to parents' expectations (n=24)*	*Colleagues would support (n=17)*	*Parents would not support (n=13)*	*Enough time (n=21)*	*Lack of time (n=31)*
Parents' perspective central in support process (n=13)	*Not suitable in every case of parenting support (n=14)*	*Stakeholders would support (n=16)*	*Colleagues would not support (n=2)*	*Training in solution-focused support (n=19)*	*Lack of experience with approach (n=11)*
Adopting a positive support approach (n=13)	*Time-inefficient support approach (n=13)*	*Management would support (n=11)*	*Social network would not support (n=2)*	*Peer supervision sessions (n=17)*	*Knowledge gap (n=6)*
Same result is achieved in less time (n=13)	*Difficult to ask correct questions (n=11)*	*Nurseries/ Preschools/ Schools would support (n=11)*	Other	*Having an appreciative attitude (n=16)*	*Unsuitable workspaces in organization (n=5)*
Confirming available strengths in parents (n=12)	*Unable to deploy professional knowledge (n=9)*	*Parents would support (n=9)*		*Experience with approach (n=15)*	*Unmotivated parents (n=3)*
Working according to a concrete methodology (n=11)	*No flexibility in methodology (n=6)*	Counsel would support (n=5)		*Suitable workspaces in organization (n=8)*	Other
Stimulates motivation in parents (n=9)	Does not fit in current organization of care (n=6)	Other		Parents that will be open to solution-focused parenting support (n=7)	
Stimulates good contact with parents (n=8)	Other			Same method used by all colleagues/ stakeholders (n=4)	
Active listening (n=7)				Other	
Better problem clarification (n=7)					
Appreciative attitude (n=6)					
Other					

4 Results from testing the questionnaire

As a result of testing the questionnaire, some adjustments to the first draft of the SFBQ were made. Specific textual amendments were made; for example, the introduction text was adapted to be more appealing to PHNs. Furthermore, word order was changed in two questions for clarity purposes. If the same topic was included as both a positive and a negative belief about solution-focused parenting support (e.g., control beliefs "time" and "experience"), these two questions were merged into one question. Questionnaire size and the time needed to fill out the questionnaire were positively evaluated. Table 5 presents the items included in the final questionnaire.

Table 5. Demographic and beliefs questions SFBQ

Demographic questions	
A1 What is your gender?	o Female o Male
A2 What is your age?	o 20–30 o 31–40 o 41–50 o 51–60 o 61–67
A3 At which organization are you employed?	▼
A4 Have you been trained in solution-focused parenting support?	o Yes o No
A5 How many years have you been working as a public health nurse?	o 0–5 o 6–10 o 11–15 o 16–20 o 21–25 o 26–30 o 31–35 o 36–40 o > 40
Behavioral beliefs questions	
If I provide or would provide solution-focused parenting support to parents with mild parenting problems ...	
B1 ... I work according to a concrete methodology.	Totally disagree 1-2-3-4-5-6-7 Totally agree
B2 ... the same result is achieved in less time.	Totally disagree 1-2-3-4-5-6-7 Totally agree
B3 ... the motivation of parents is stimulated.	Totally disagree 1-2-3-4-5-6-7 Totally agree
B4 ... it does not correspond to the parents' expectations.	Totally disagree 1-2-3-4-5-6-7 Totally agree
B5 ... it stimulates a good contact with parents.	Totally disagree 1-2-3-4-5-6-7 Totally agree
B6 ... the parents' perspective is central in the support process.	Totally disagree 1-2-3-4-5-6-7 Totally agree
B7 ... I find it difficult to ask correct solution-focused questions.	Totally disagree 1-2-3-4-5-6-7 Totally agree
B8 ... I adopt a positive approach.	Totally disagree 1-2-3-4-5-6-7 Totally agree
B9 ... the support process is less time-efficient than other support approaches.	Totally disagree 1-2-3-4-5-6-7 Totally agree
B10 ... parents become more active in finding a suitable solution.	Totally disagree 1-2-3-4-5-6-7 Totally agree
B11 ... I cannot deploy my professional knowledge.	Totally disagree 1-2-3-4-5-6-7 Totally agree

Behavioral beliefs questions	
B12 ... the strengths of parents are being confirmed.	Totally disagree 1-2-3-4-5-6-7 Totally agree
B13 Solution-focused parenting support is suitable in all cases of parenting support.	Totally disagree 1-2-3-4-5-6-7 Totally agree
Normative beliefs questions	
B14 Stakeholders think I should provide solution-focused parenting support to parents with mild parenting problems.	Totally disagree 1-2-3-4-5-6-7 Totally agree
B15 I think parents with mild parenting problems would agree with solution-focused parenting support.	Totally disagree 1-2-3-4-5-6-7 Totally agree
B16 The management of my organization wants me to provide solution-focused parenting support to parents with mild parenting problems.	Totally disagree 1-2-3-4-5-6-7 Totally agree
B17 I assume my colleagues think I should provide solution-focused parenting support to parents with mild parenting problems.	Totally disagree 1-2-3-4-5-6-7 Totally agree
B18 Nurseries, preschools, and schools expect me to provide solution-focused parenting support to parents with mild parenting problems.	Totally disagree 1-2-3-4-5-6-7 Totally agree
Control beliefs questions	
B19 The time available in youth healthcare to provide solution-focused parenting support to parents with mild parenting problems is insufficient.	Totally disagree 1-2-3-4-5-6-7 Totally agree
B20 The training "solution-focused parenting support" as offered by the youth healthcare is sufficient.	Totally disagree 1-2-3-4-5-6-7 Totally agree
B21 For me, having an appreciative attitude toward parents with mild parenting problems is ...	Difficult 1-2-3-4-5-6-7 Easy
B22 For me, carrying out peer supervision sessions into solution-focused parenting support is ...	Difficult 1-2-3-4-5-6-7 Easy
B23 For me, providing solution-focused parenting support to unmotivated parents is ...	Difficult 1-2-3-4-5-6-7 Easy
B24 For me, gaining experience in solution-focused parenting support in daily practice is ...	Difficult 1-2-3-4-5-6-7 Easy
B25 I have insufficient knowledge about solution-focused parenting support to parents with mild parenting problems.	Totally disagree 1-2-3-4-5-6-7 Totally agree
B26 The workspaces within my organization are inappropriate for providing solution-focused parenting support	Totally disagree 1-2-3-4-5-6-7 Totally agree

3.2 Phase 2: Survey SFBQ

Sample characteristics

In total, 57.5% (n = 449) of the PHNs who received a link to the SFBQ completed the questionnaire. All twelve YH organizations were represented in the response. Response percentages per organization fluctuated, with a minimum of 43.6% per organization. The participants were predominantly female (97.8%), and 70.8% of the participants have been trained in solution-focused parenting support. Other characteristics of the participants are presented with the results of differences in beliefs in Table 7.

Beliefs scales resulting from factor analysis

The three factors that resulted from the principal component analysis accounted for 38.6% of the variance. Factor loadings after rotation are presented in Table 6.

Table 6. Factor loadings after rotation

Rotated component matrix			
Questionnaire item	1	2	3
B3 ... the motivation of parents is stimulated.	**0.778**	−0.028	−0.046
B6 ... the parents' perspective is central in the support process.	**0.773**	−0.030	−0.063
B5 ... it stimulates a good contact with parents.	**0.765**	0.054	−0.056
B12 ... the strengths of parents are being confirmed.	**0.764**	0.039	−0.100
B10 ... parents become more active in finding a suitable solution.	**0.740**	0.029	−0.077
B15 I think parents with mild parenting problems would agree with solution-focused parenting support.	**0.622**	0.242	−0.070
B8 ... I adopt a positive approach.	**0.620**	0.128	−0.009
B21 For me, having an appreciative attitude toward parents with mild parenting problems is ...	**0.506**	0.019	0.073
B11 ... I cannot deploy my professional knowledge.	**0.488**	−0.119	0.060
B13 Solution-focused parenting support is suitable in all cases of parenting support.	**0.328**	0.276	0.128
B2 ... the same result is achieved in less time.	**0.318**	−0.023	0.214
B9 ... the support process is less time-efficient than other support approaches.	**0.306**	−0.179	0.303
B4 ... it does not correspond to the parents' expectations.	0.294	0.028	0.006
B26 The workspaces within my organization are inappropriate for providing solution-focused parenting support.	0.178	−0.033	0.101
B17 I assume my colleagues think I should provide solution-focused parenting support to parents with mild parenting problems.	0.147	**0.805**	−0.068
B18 Nurseries, preschools, and schools expect me to provide solution-focused parenting support to parents with mild parenting problems.	−0.053	**0.755**	0.111
B14 Stakeholders think I should provide solution-focused parenting support to parents with mild parenting problems.	0.014	**0.747**	0.032
B16 The management of my organization wants me to provide solution-focused parenting support to parents with mild parenting problems.	0.112	**0.726**	0.042
B7 ... I find it difficult to ask correct solution-focused questions.	−0.004	−0.095	**0.629**
B24 For me, gaining experience in solution-focused parenting support in daily practice is ...	0.218	0.110	**0.597**
B23 For me, providing solution-focused parenting to unmotivated parents is ...	−0.001	−0.011	**0.561**
B22 For me, carrying out peer supervision sessions into solution-focused parenting support is ...	−0.129	0.187	**0.510**
B25 I have insufficient knowledge about solution-focused parenting support to parents with mild parenting problems.		0.164	**0.074**
B20 The training "solution-focused parenting support" as offered by the youth healthcare is sufficient.	−0.101	0.218	**0.491**
B19 The time available in youth healthcare to provide solution-focused parenting support to parents with mild parenting problems is insufficient.	−0.030	−0.119	**0.371**
B1 ... I work according to a concrete methodology.	0.133	0.101	**0.370**
Extraction Method: Principal Component Analysis. Rotation Method: Oblimin with Kaiser Normalization.			

Based on the loadings and on the content of each item, the factors "behavioral beliefs" (factor 1), "normative beliefs" (factor 2) and "control beliefs" (factor 3) from the TPB were distinguished.

Factors were finally determined by specific choices of the first and second author after substantial assessments of the items. First, item B15 (*I think parents with mild parenting problems would agree with solution-focused parenting support*) with a factor loading > 0.3 was excluded from factor 1 "behavioral beliefs." During the focus groups, this item was mentioned as "normative belief." Since this item loaded high on "behavioral beliefs" in the analysis, but could not be interpreted as such, this item was excluded from further analysis. Second, item B21 (*Having an appreciative attitude toward parents is difficult/easy for me*) loaded high on factor 1 "behavioral beliefs." However, this item was mentioned as a "control belief" during the focus groups. Since this item could not be interpreted as a "behavioral belief," it was excluded from further analysis. Third, item B9 (*... the support process is less time-efficient than other support approaches*) exceeded a factor loading of 0.3 on "behavioral beliefs" and "control beliefs." Since this item loaded highest on "behavioral beliefs" and was mentioned as a "behavioral belief" during focus groups, it was included in factor 1 "behavioral beliefs." Fourth, item B7 (*... I find it difficult to ask solution-focused questions*) was mentioned as a behavioral belief during focus groups, but loaded high on control beliefs. Since this item reflects a difficulty of performance as a negative evaluation of the behavior, it could be interpreted as a control belief, and was assigned as such. Finally, item B1 (*... I work according to a concrete methodology*) was mentioned as a "behavioral belief" during focus group sessions. However, it loaded high on factor 3 "control beliefs" in the analysis and could also be interpreted as such. This item was therefore assigned to factor 3 "control beliefs" for further analysis. The analysis resulted in three subscales of salient beliefs of PHNs about solution-focused parenting support: subscale 1 "behavioral beliefs" (including items B2, B3, B5, B6, B8, B9, B10, B11, B12, and B13), subscale 2 "normative beliefs" (including items B14, B16, B17, and B18), and subscale 3 "control beliefs" (including items B1, B7, B19, B20, B22, B23, B24, and B25).

Reliability and descriptive analysis

Cronbach's alpha was determined for each established subscale. Cronbach's alpha for "behavioral beliefs" was 0.79, Cronbach's alpha for "normative beliefs" was 0.80, and Cronbach's alpha for "control beliefs" was 0.64. Overall, PHNs had positive behavioral beliefs (M = 5.54; SD = 0.65), and moderately positive normative (M = 4.92; SD = 1.08) and control beliefs (M = 4.24; SD = 0.84) about solution-focused parenting support. Paired samples T-tests showed that the means of the subscales differed statistically significantly from each other. Behavioral beliefs were higher than control beliefs ($t(448) = 33.0$, $p \leq 0.01$) and normative beliefs ($t(448) = 12.0$, $p \leq 0.01$), and normative beliefs were higher than control beliefs ($t(448) = 12.5$, $p \leq 0.01$).

Differences in beliefs regarding background characteristics

Differences were found between trained and untrained PHNs for control beliefs ($t(447) = 4.01$; $p \leq 0.01$), indicating that trained nurses scored higher ($M = 4.34$; $SD = 0.83$) than untrained nurses ($M = 4.00$; $SD = 0.82$). Furthermore, differences between age groups were found for behavioral beliefs ($F(4) = 5.98$; $p \leq 0.01$) and control beliefs ($F(4) = 7.39$; $p \leq 0.01$). Finally, differences between the work experience groups were found for behavioral beliefs ($F(8) = 3.30$; $p \leq 0.01$) and control beliefs ($F(8) = 3.80$; $p \leq 0.01$).

Post hoc analyses, using the Bonferroni correction, were performed for in-depth analyses of differences in beliefs between age groups and work experience groups. These analyses showed that the age group 20–30 scored significantly lower on behavioral beliefs than the age groups 41–50 and 51–60 and scored significantly lower on control beliefs than the age groups 41–50, 51–60, and 61–67. Regarding work experience, we found that the mean on behavioral beliefs of group 0–10 was significantly lower than the mean of group 11–20 and 21–30, and the mean on control beliefs of group 0–10 was significantly lower than the mean of group 21–30. The post hoc analyses revealed no further statistically significant differences. The means and SD of beliefs for different training groups, age groups, and work experience groups, and significant mean differences, are presented in Table 7.

Table 7. *Mean and standard deviation behavioral, normative, and control beliefs related to background variables*

				Behavioral beliefs		Normative beliefs		Control beliefs	
		n (449)	%	Mean	SD	Mean	SD	Mean	SD
Training	Yes	318	70.8	5.55	0.66	4.97	1.07	4.34*	0.83
	No	131	29.2	5.51	0.63	4.81	1.10	4.00	0.82
Age (years)	a 20–30	64	14.2	5.24[c d]	0.53	4.70	1.05	3.81[c d e]	0.84
	b 31–40	93	20.7	5.45	0.57	4.82	1.07	4.11	0.84
	c 41–50	97	21.6	5.58[a]	0.61	4.96	0.95	4.30[a]	0.82
	d 51–60	148	33	5.68[a]	0.69	5.05	1.14	4.40[a]	0.78
	e 61–67	47	10.5	5.56	0.74	4.97	1.16	4.42[a]	0.81
Work experience (years)	a 0-10	163	36.3	5.19 [b c]	0.56	4.83	1.06	4.29 [c]	0.75
	b 11-20	145	32.3	5.41 [a]	0.58	4.97	1.07	4.52	0.74
	c 21-30	89	19.8	5.57 [a]	0.68	5.04	1.13	4.67 [a]	0.83
	d 31-40	48	10.7	5.34	0.64	4.89	1.11	4.55	0.73
	e >40	4	0.9	5.44	0.41	5.00	0.79	4.63	0.94

** Statistically significant mean difference ($p \leq 0.01$)*
The subscript letters indicate which categories differ statistically significantly from each other at the 0.01 level

Discussion

This study is the first to provide more insight into PHNs' beliefs about solution-focused parenting support. This paper reports on the salient behavioral, normative, and control beliefs of PHNs about solution-focused parenting support, and on the differences in these beliefs regarding some background characteristics. The results of this study contribute to a knowledge base for future design of implementation interventions and related research activities.

Behavioral beliefs were evaluated as the most positive, compared to normative and control beliefs. The salient behavioral beliefs of PHNs about solution-focused parenting support included increased parental motivation, parent-centeredness, a positive nurse–parent relationship, a positive approach, confirmation of parental strength, suitability for all cases of mild parenting problems, increased parental problem-solving activities, being able to use professional knowledge, and a time-efficient approach. These beliefs are in line with the basic principles of solution-focused theory, indicating a certain knowledge base of solution-focused parenting support in the PHNs' profession (De Jong & Berg, 2013; Grol & Wensing, 2004). A possible explanation for the positive evaluation of behavioral beliefs is that characteristics of solution-focused parenting support resemble the core values of health promotion within nursing and thus will appeal to PHNs (Wand, 2010). Stressing these beliefs as current strengths of PHNs in future implementation interventions should be motivating to proceed to the next step in the implementation process: i.e., change (Bartholomew Eldredge et al., 2016; Cooperrider et al., 2008; Grol et al., 2013). Lastly, on average, a younger age and little work experience are associated with less positive behavioral beliefs. This indicates that the development of positive behavioral beliefs of PHNs who are young and have little work experience needs special attention in designing implementation strategies. No differences in behavioral beliefs were found between trained and untrained PHNs.

Normative beliefs were evaluated moderately positive, and were related to the management of the organization, colleagues, nurseries/preschools/schools, and stakeholders. It is likely that PHNs expect their management and colleagues to be positive about them performing solution-focused parenting support, since they are all part of the Dutch YH, with its specific mission and goals of parenting support. Furthermore, since strength-based practices are generally promoted in the domain of youth health, welfare, and education, with a focus on interprofessional collaboration, PHNs might also expect their external partners, such as teachers and social workers, to be positive about them providing solution-focused parenting support. No differences between normative beliefs were found based on age, work

experience, and training in solution-focused parenting support, which means that it is unnecessary to differentiate with respect to normative beliefs as a motivational factor in implementation strategies to specific age, work experience, and trained-or-not groups.

The control beliefs of PHNs were also evaluated moderately positive. Control beliefs were linked to both internal and external factors. Internal control factors included knowledge, experience, and skills. External control factors mentioned were peer supervision sessions, training, time available, the concrete character of methodology, and situations with unmotivated parents.
Furthermore, trained PHNs scored significantly higher on control beliefs than untrained PHNs. This result corresponds with the outcome of the study of Bowles et al. (2001) in the context of mental health nursing. They found that solution-focused support training resulted in increased levels of confidence in nurses to talk to troubled people. Training in solution-focused parenting support thus seems to contribute to self-confidence. Additionally, control beliefs are positively related to age and work experience. A possible explanation of this finding is that experience and self-knowledge are factors known to increase with age. Besides, more experience and self-knowledge are associated with more accurate and stable views of behavioral control (Notani, 1998). Therefore, older PHNs, and PHNs with more work experience, are more likely to express more positive control beliefs on solution-focused parenting support.

Our study has several strengths and limitations. Some of which relate to the different steps in the development process of our tool. The expert panel and the resulting definition of solution-focused parenting support is a strength in this study. The different perspectives and the level of expertise of the participating experts on solution-focused support resulted in a general definition of solution-focused parenting support, and thus contributed to the content validity of the SFBQ. The in-depth interviewing during focus groups and subsequent thematic analysis to elicit the most salient beliefs of PHNs about solution-focused parenting support was another strength in this study. It could be discussed whether two different organizations and eighteen PHNs, selected using a convenience sampling method, provided sufficient variance in the results. However, the similarity in themes resulting from each focus group analysis indicated data saturation. Moreover, we assume that including more PHNs from other organizations would not have resulted in very different outcomes, given the relatively low ICCs found in the questionnaire study. Testing the first draft of the SFBQ could be viewed as a strength of our study, since we involved the target population in improving the clarity, comprehensibility, convenience, and size of the SFBQ.
Furthermore, our study has shown it is possible to distinguish between the

three beliefs categories in a questionnaire study, and that they are not merely theoretical constructs. Finally, the large number of participants is a strength of our study. The resemblance of characteristics of our sample with those of the total YH workforce in the Netherlands (including doctors and health assistants) adds to the assumption of generalizability of results to the PHNs population in the Netherlands (Jambroes et al., 2015). However, since specific characteristics of PHNs are lacking, no firm claims can be done. A limitation of this study was that we did not have access to details on the content and scope of the training received. This restricts the possibility of within group analysis to assert the influence of training. Furthermore, no claims about the effectiveness of training on beliefs can be done since beliefs were not measured in advance of solution-focused training activities. Generalizability of the results to other countries than the Netherlands and to parenting support provided by other organizations than YH cannot be assumed. The way YH is organized in the Netherlands cannot be compared to other countries. Moreover, YH has a broader scope on health promotion compared to other organizations in the Netherlands providing parenting support as social intervention. Since this is the first study assessing the validity and internal consistency of the SFBQ, and first results are promising, it would be a valuable follow-up to test the SFBQ in different – national and international – contexts of parenting support. Furthermore, the SFBQ could, for example, be used as pre- and post-measure to test whether activities to implement solution-focused parenting support changes PHNs' behavioral, normative, and control beliefs. In turn, in line with the Medina and Beyebach (2014) study, these changes in behavioral, normative and control beliefs could be used as predictors of the actual implementation of solution-focused parenting support by PHNs.

Consistent with transformative learning theories, engaging PHNs in action-oriented research strategies is recommended for radical changes in salient professional beliefs, since beliefs could be changed and new (salient) beliefs could be created by experimenting with new behaviors (Cooperrider et al., 2008; Henderson, 2002; Mezirow, 2003). Given the relatively low scores on control beliefs compared to behavioral and normative beliefs, the likelihood of improvement is greatest for control beliefs. Specific methods to increase control beliefs are, for example, guided practice, goal setting, and planning coping responses (Bartholomew Eldredge et al., 2016; Kelder et al., 2015; Latham & Locke, 2007; Marlatt & Donovan, 2005).

Conclusion

The SFBQ measures the three distinguishing types of beliefs from the TPB. The overall moderately positive to positive beliefs of PHNs about solution-focused parenting support suggests that PHNs tend to accept solution-focused parenting support as a viable approach. Compared to behavioral and normative beliefs, PHNs score the lowest on control beliefs.

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Chapter 4

Survey of intention among public health nurses in providing solution-focused parenting support

Theuns-Boumans, L., Mathijssen, J., Rots-de Vries, C., & van de Goor, I. (2022b). Survey of intention among public health nurses in providing solution-focused parenting support. *Public Health Nursing, 39*(3), 643-651. https://doi.org/https://doi.org/10.1111/phn.13032

Abstract

Objective: Parenting support has shifted from a problem-focused to a strengths-based solution-focused approach. This study surveyed public health nurses to explain their intention to provide solution-focused parenting support in their practice. ***Methods:*** The design of this study was cross-sectional. The initial sample included 781 public health nurses who were employed with various youth healthcare organizations in the Netherlands. Based on the Theory of Planned Behavior, a questionnaire was developed and administered to measure (a) behavioral, normative, and control beliefs, (b) attitudes, subjective norm, and perceived behavioral control, and (c) intention. The data were subjected to structural equation modeling. ***Results:*** A total of 449 (57.5%) public health nurses completed questionnaires. Associations as indicated by the Theory of Planned Behavior were confirmed with the exception of that between perceived behavioral control and intention. Statistically significant paths and correlations were added. The final model accounted for 53% of the variance in the intention to perform solution-focused parenting support. ***Conclusion:*** In this study, public health nurses strongly intended to provide solution-focused parenting support, thus indicating their acceptance of the approach. Their intention was predominantly associated with subjective norm.

Introduction

In recent years, the guidelines and interventions for parenting support have shifted from a problem-focused approach to a solution-focused approach (Carr et al., 2017; Polaschek & Polaschek, 2007; Wells et al., 2014). More specifically, solution-focused parenting support is a strengths-based approach in which positive, future-oriented goals are established. In this context, practitioners must assess parents to determine their current strengths and available resources, thus identifying the first steps parents should take in moving toward their objectives. The parental perspective is positioned at the center during each stage of this support process, with professionals leading the parents from behind (De Jong & Berg, 2013; Shazer et al., 1986). Meanwhile, scholarly evidence continues to show the promising effects of this approach (Bond et al., 2013; Gingerich & Peterson, 2013; Stams et al., 2006). When compared to problem-focused parenting support, the solution-focused approach adds value through its specific focus on sustainably increasing motivation, self-confidence, and problem-solving capacity among the parents (De Jong & Berg, 2013).

In healthcare practice, it takes a complex process to actually change and sustainably implement new guidelines (Grol & Buchan, 2006; Grol et al., 2013). Previous

investigators have described this as "a planned process and systematic introduction of innovations and/or changes of proven value; the aim being that these are given a structural place in professional practice, in the functioning of organizations or in the healthcare structure" (ZorgOnderzoek Nederland, 1997).
According to Grol et al. (2013), the implementation process can be divided into the five following stages:

- Orientation — the target group develops awareness, involvement, and interest in the presented topic.
- Insight — the target group gains a factual understanding of the innovation, thus raising their insights into their own practices.
- Acceptance — focus is placed on the development of positive attitudes, the motivation for change, and the positive intention to change.
- Change — an actual shift occurs in practice; meanwhile the benefits and values of the innovation are validated.
- Maintenance — the target group integrates new routines into daily practice and organizes financial and structural support.

In 2014, the youth healthcare (YH) initiated the implementation of solution-focused parenting support in the Netherlands, with relevant activities rooted in the orientation and insight stages. At that time, organizational policies and parenting support guidelines were altered to reflect the new approach. Through various channels, public health nurses (PHNs) were informed about the intended shift in parenting support to facilitate their orientation to the subject, and the content of the solution-focused guideline of parenting support was implemented through various activities (e.g., informative team sessions, training in solution-focused parenting support, and participation in peer supervision sessions). In this regard, PHNs are now expected to have progressed through stage two of implementation (insight). As a result, they are supposed to accept solution-focused parenting support as a valuable new approach, which in turn is supposed to change their actual support behavior (Grol et al., 2013). However, it is currently unclear whether these PHNs have truly accepted solution-focused parenting support.

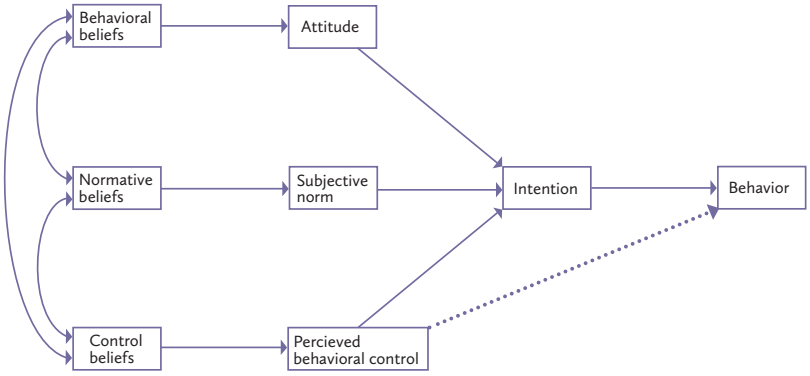
One way to determine if the stage of acceptance of solution-focused parenting support was established is to examine PHNs' intention to provide it in practice. Indeed, Grol and Wensing (2004), and Grol et al. (2013) assert that a key element of the acceptance stage is the intention to actually change one's behavior. Here, intention can be defined as "how hard people are willing to try, or how much of an effort they are planning to exert, in order to perform the behavior" (Ajzen, 1991, p. 181).

As shown in Figure 1, the Theory of planned behavior (TPB) posits that intention is the most proximal antecedent of behavior and behavioral change; it specifically indicates an individual's intention for a given behavior based on their attitude, subjective norm, and perceived behavioral control (PBC) (Ajzen, 1991). Attitude refers to the positive or negative evaluation of a given behavior by a specific individual, while subjective norm refers to experienced social pressures to perform the behavior of interest, and PBC includes both the concept of capability and controllability, referring to whether an individual views a given behavior as easy or difficult to perform. In the theoretical context, PBC is related to both intention and behavior (Ajzen, 1991).
TPB entails that the respective antecedents of attitude, subjective norm, and PBC are behavioral, normative, and control beliefs. Behavioral beliefs refer to an individual's expectations or the subjective probability that performing a given behavior will lead to a certain outcome, while normative beliefs refer to the expected approval (or disapproval) by significant others to provide a given behavior, and control beliefs refer to the subjective probability of the presence of specific impeding and facilitating factors to perform the given behavior (Ajzen, 1991, 2002).

Previous studies have shown that TPB is useful for predicting and explaining the intention of nurses in various areas of their professional behavior (Godin et al., 2008). For example, TPB concepts have explained 34% of the intention to use clinical guidelines in the hospital setting (Kortteisto et al., 2010), 50% of the intention to use filter needles when preparing parenteral medications (Gagnon et al., 2015), and 56% of the intention to adhere to hand hygiene guidelines in intensive care and post-intensive care units (O'Boyle et al., 2001). These nursing behaviors are more medically oriented, while solution-focused parenting support behaviors are more socially oriented. Nevertheless, the use of clinical guidelines in the hospital can be viewed as a more general nursing behavior that is comparable to solution-focused parenting support behaviors, albeit in a different setting. As such, the explained variance of the intention to provide solution-focused parenting support is expected to be at least 34% among PHNs.

There is currently insufficient evidence on whether PHNs in the Netherlands actually intend to provide solution-focused parenting support. This knowledge is important for determining whether they have progressed through the acceptance stage in regard to implementing this support approach. As such, this study used the TPB framework to explore and explain the intention of PHNs in the Netherlands to provide solution-focused parenting support. We developed the following research question: To what extent can the intention of PHNs to provide solution-focused parenting support be explained via the TPB concepts of attitude, subjective norm, and PBC?

Figure 1 *Theory of planned behavior (Ajzen, 1991, 2002)*



Methods

Study design

The design of this study was cross-sectional. An internet-based survey was developed and administered among a sample of PHNs employed at YH organizations throughout the Netherlands between November 2017 and May 2018.

Setting

YH is a regionally organized Dutch preventive public health service for all children aged 0–18 and their families. It is free of charge. Its contents are defined in the Dutch Public Health Act (Public Health Act, 2008). The main goal is to monitor and promote the health and wellbeing of all children living in the Netherlands. During different standardized consultations, medical doctors and PHNs screen and monitor the physical, psychosocial, and cognitive health of children; for example, assessments include nutrition and weight, motor development, language development, and behavioral competence. These professionals also provide parents and their children with health education to promote healthy child development. If risks or mild problems are detected (e.g., developmental gaps or behavioral problems), then YH professionals can intervene (i.e., early intervention). If more severe problems are noticed, then YH professionals can direct the parents and their children to more specialized professionals such as pediatricians, psychologists, or physiotherapists. In cases of mild parenting problems, PHNs provide parenting support as an early intervention.

Population and study sample

The 48 regional YH organizations employ approximately 3000 PHNs (Jambroes et al., 2015). In this study, 20 of those organizations were randomly selected and asked to recruit participants among PHNs from their respective staffs. However, four

organizations did not react despite multiple requests, while four others declined due to heavy workloads. Ultimately, 12 organizations agreed to participate, resulting in a final sample of 781 PHNs. All provided their consent to participate.

Data collection

Instrument

Francis et al. (2004) composed guidelines for the development of a TPB questionnaire. In this study, we used those guidelines to develop the Intention to Provide Solution-Focused Parenting Support questionnaire (I-SFPS), which includes scales for (a) behavioral, normative, and control beliefs; (b) attitude, subjective norm, and PBC; and (c) intention. In a previous study, we analyzed the most salient behavioral, normative, and control beliefs of PHNs using a factor analysis procedure, then measured the internal consistency of the obtained factors. That analysis revealed three internal consistent beliefs scales that equated to the behavioral (10 items; $\alpha = 0.79$), normative (four items; $\alpha = 0.80$) and control beliefs (eight items; $\alpha = 0.64$) from the TPB (Theuns-Boumans et al., 2022).

The first draft of the I-SFPS was developed using the Qualtrics® XM software (2019), and included an introductory text with an informed consent procedure. It included 37 measures related to the TPB constructs, with items answered on a 7-point Likert scale (1 = totally disagree/difficult; 7 = totally agree/easy), as recommended in TPB research (Ajzen, 1991; Francis et al., 2004). We tested the clarity, comprehensibility, size, convenience, and acceptability of the I-SFPS. Interviews with five PHNs were accomplished to document their opinions. Following this advice, the introductory text was adapted and the word order was changed for two questions to improve clarity. The I-SFPS can be viewed in Appendix B.

Procedure

The sample of PHNs was invited through emails that also contained links to the digital I-SFPS, and informed consent procedure. They were informed of the study aim, data anonymization, data storage procedure, voluntary nature of participation, and possibility to withdraw at any time. Three reminders were sent over the six-week collection period. All study methods were approved by the Ethics Review Board of Tilburg University.

Data analysis

First, missing items were dealt with by either excluding the case from further analysis ($n = 12$) or via mean substitution ($n = 4$) (Tabachnick & Fidell, 2007). Second, internal consistency and reliability (Cronbach's alpha) were individually determined for attitude (four items; $\alpha = 0.93$), subjective norm (three items; $\alpha = 0.80$), PBC (two items; $\alpha = 0.86$), and intention (three items; $\alpha = 0.87$). Items were deleted if they significantly inflated the internal consistency and reliability (items C10, C12, and

C15 were deleted). Third, since the participants (level 1) were nested within their organizations (level 2), the data were hierarchically organized. We calculated the intraclass correlation coefficient (ICC) to test whether it was necessary to control for the organizational effect (Shek & Ma, 2011). The ICC (proportion of total variation in variables, which is attributable to differences between organizations) indicates that multilevel modeling is necessary if the proportion of explained variance is 25% or higher (Heinrich & Lynn, 2001). In this study, the ICCs of the variable scales ranged between 0.5% and 4.5%, in which case multilevel modeling was not needed. Lastly, we used IBM SPSS AMOS (version 24.0) to conduct structural equation modeling (SEM). The variable scales were included as observed variables, while the TPB model (Figure 1) was estimated, evaluated, and improved through a modification approach toward a theoretical defensible fit of the model to the data. Improvements in model fit were evaluated using the Chi-square difference test (Tabachnick & Fidell, 2007), with final model fit determined based on both the Chi-square statistic ($p > 0.05$ indicating good model fit) and RMSEA test statistic ($p < 0.06$ indicating good model fit) (Schreiber et al., 2006; Ullman & Bentler, 2013).

Results

This study surveyed the TPB concepts to explain the intention among PHNs to provide solution-focused parenting support. A total of 449 participants (57.5%) completed the I-SFPS questionnaire. All 12 organizations were represented in this sample, with response percentages at each organization reaching at least 43.6%. Table 1 shows the participant characteristics.

Table 1. Characteristics of the surveyed public health nurses

	Characteristics	N (449)
Gender	Female	439 (97.8%)
	Male	10 (2.2%)
Age (years)	20–30	64 (14.2%)
	31–40	93 (20.7%)
	41–50	97 (21.6%)
	51–60	148 (33%)
	61–67	47 (10.5%)
Work experience (years)	0–5	98 (21.8%)
	6–10	65 (14.5%)
	11–15	64 (14.3%)
	16–20	81 (18%)
	21–25	34 (7.6%)
	26–30	55 (12.2%)
	31–35	34 (7.6%)
	36–40	14 (3.1%)
	>40	4 (0.9%)

Table 2 shows the means (M) and standard deviations (SD) for all variables and their correlations. Overall, the participants returned positive scores for the TPB variables. Further, all variables were correlated. On a scale ranging from 1 to 7, the mean intention to provide solution-focused parenting support was 6 (SD = 0.92).

Table 2. *Descriptions of variables used in the model*

	Intention	Attitude	Subjective norm	PBC	Normative beliefs	Behavioral beliefs	Control beliefs
Intention (M=6.0; SD=.92)	1						
Attitude (M=6.11; SD=.85)	.587**	1					
Subjective norm (M=5.42; SD=1.06)	.652**	.459**	1				
PBC (M=5.45; SD=1.05)	.350**	.410**	.309**	1			
Normative beliefs (M=4.92; SD=1.08)	.461**	.367**	.654**	.246**	1		
Behavioral beliefs (M=5.54; SD=.65)	.475**	.624**	.347**	.478**	.296**	1	
Control beliefs (M=4.24; SD=.84)	.221**	.269**	.218**	.575**	.277**	.391**	1

*** Correlation is significant at the 0.01 level (2-tailed); PBC = perceived behavioral control*

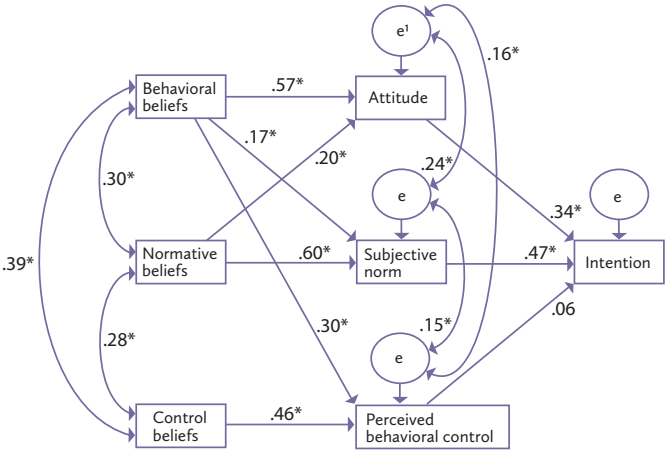
Model fit was achieved in six steps (Table 3). Each modification step improved the model significantly. The final model (model 7; Figure 2) had a non-significant Chi-square statistic and RMSEA <0.05, both of which indicated a good model fit (Schreiber et al., 2006).

Table 3. *Model fit modifications*

Model	Modification	Chi square	df	P-value	RMSEA	Differences between models	
						Chi-square (df)	P-value
1		155.378	12	.000	.163		
2	NB → A	127.741	11	.000	.154	27.637 (1)	<.05
3	BB → PBC	74.243	10	.000	.120	53.498 (1)	<.05
4	eSN ← → eA	48.626	9	.000	.099	25.617 (1)	<.05
5	BB → SN	27.978	8	.000	.075	20.648 (1)	<.05
6	eSN ← → ePBC	21.502	7	.003	.068	6.476 (1)	<.05
7	eA ← → ePBC	9.558	6	.145	.036	11.944 (1)	<.05

NB = normative beliefs; BB = behavioral beliefs; A = Attitude; SN = subjective norm; e = error term

Figure 2. Final model explaining the intention of participants to provide solution-focused parenting support



**statistically significant at p <0.01 level. 1 = error term/residual variable*

The analysis revealed statistically significant associations between behavioral beliefs and attitude, between normative beliefs and subjective norm, and between control beliefs and PBC. Moreover, associations between attitude and intention, and between subjective norm and intention were found. Furthermore, statistically significant correlations were found between behavioral beliefs and normative beliefs, between behavioral beliefs and control beliefs, and between normative beliefs and control beliefs. The association between PBC and intention was non-significant.

Statistically significant paths were also added to the original paths in the TPB. These paths connected behavioral beliefs to subjective norm, behavioral beliefs to PBC, and normative beliefs to attitude. Finally, correlations were added between the error terms of attitude and subjective norm, the error terms of subjective norm and PBC, and the error terms of attitude and PBC. Together, this final model accounted for 53% of the variance in the intention to perform solution-focused parenting support.

Discussion

While the solution-focused approach to parenting support is now the preferred method, it is unclear whether PHNs intend to provide solution-focused parenting support into their professional practice. This study investigated to what extent the intention of PHNs to provide solution-focused parenting support could be explained via the TPB concepts of attitude, subjective norm, and PBC. The findings

demonstrate that the TPB concepts subjective norm and attitude explained the intention of PHNs to provide solution-focused parenting support. Overall, the results showed a strong intention to provide solution-focused parenting support. Based on the TPB concepts of attitude, subjective norm, and PBC, the explained variance of this intention was high when compared to the general intention to follow clinical guidelines (Kortteisto et al., 2010). The explained variance of intention was congruent with previous studies that examined more specific nursing behaviors, such as the adherence to hand hygiene protocols and the use of filter needles when preparing medications for parenteral injections (Gagnon et al., 2015; O'Boyle et al., 2001). However, such comparisons are limited due to differences in the target behaviors and nursing contexts. Other studies among nurses have reported explained variances in behavioral intention up to 70% (Côté et al., 2012; Godin et al., 2008; Lee & Kang, 2020). However, comparison of results is not possible since these studies included other predicting concepts in addition to the TPB model (e.g., moral norm and past behaviors) whereas our study did not.

Of particular note, the model used in this study showed strong effects for behavioral beliefs, which were positively related to attitude, subjective norm, and PBC. While TPB entails a strong association between behavioral beliefs and attitude, the associations between behavioral beliefs and both subjective norm/PBC were surprising. Given that this study employed a cross-sectional design, it may be hypothesized that behavioral beliefs changed due to perceived subjective norm and PBC among the participants. For example, they may have perceived solution-focused parenting support behaviors as socially desirable following the organizational implementation of related policies and guidelines. This may imply that participants experienced social pressure, thus influencing their view that solution-focused parenting support was both positive and beneficial. In this regard, behavioral beliefs may change due to experiences in which strong subjective norm is applied. Further, PHNs who perceive strong behavioral control in the context of performing solution-focused parenting support may also be more likely to think positively about the associated benefits and characteristics. However, these hypotheses contrast with the original directions of the associations as modeled via TPB (Figure 1). Additional research is therefore needed to clarify any such relationships.

We also found that subjective norm was most strongly associated with the intention to provide solution-focused parenting support, thus supporting previous studies showing this association among other nurses (Kortteisto et al., 2010; O'Boyle et al., 2001). Meanwhile, attitude was also positively related to the intention to provide solution-focused parenting support, which similarly supports previous research showing the same type of association for various nursing

behaviors under the TPB framework (Gagnon et al., 2015; Kortteisto et al., 2010; Lee & Kang, 2020). Thus, the current results imply that evaluating the benefits of solution-focused parenting support and/or being influenced by positive subjective norms to provide this approach are associated with PHNs strong intentions to provide this support.
For YH organizations in the Netherlands, the implementation of solution-focused parenting support can be enhanced in two ways. The first involves persuasive interventions aimed at increasing positive attitudes about the method among PHNs, while the second involves interventions aimed at increasing the experienced positive norm exhibited by colleagues. Since attitude and subjective norm are correlated, these interventions should have complementary effects. Following said interventions, longitudinal research will be needed to measure the actual effects at different timepoints (i.e., at baseline, during, and after).

In this study, PBC was not related to intention, which is remarkable. Indeed, this finding contrasts with previous studies (Gagnon et al., 2015; Kortteisto et al., 2010). This may be because PBC in the I-SFPS was restricted to measuring perceived capability. According to TPB, the PBC construct is comprised of two components, including perceived capability and actual control. In this study, the actual control component of PBC was excluded from analysis due to internal consistency and reliability issues. It is therefore difficult to compare the current results with the outcomes of studies that included the actual control component of PBC. Further, the lack of a statistically significant association between PBC and intention in this study may be explained due to the fact that our analysis controlled for correlations between both PBC and attitude (0.41) and PBC and subjective norm (0.31) when calculating the unique contribution of PBC to the explained variance of intention (Tabachnick & Fidell, 2007). Additional research is needed to further develop and test the PBC construct in the I-SFPS and assess the associations between PBC and intention. This study had several strengths. First, there were 449 participants, which is generally accepted as sufficient for obtaining reliable results from SEM (Schumacker & Lomax, 2004). Moreover, the rigorous development and testing of the I-SFPS and adequate handling of missing data increased the internal validity of the results. On the other hand, there were also some limitations. One was the cross-sectional design, which confines conclusions about the direction of the relationships in the model. In future research, a longitudinal design should be implemented to provide more detailed insights into the associations between TPB concepts. In addition, participants with the tendency to give more socially desirable answers may have positively biased the results. This also highlights the need to consider the self-reported nature of the questionnaire data when making interpretations. Finally, we did not ask participants for their specific background characteristics. Despite the large sample size, this further limits generalizability.

In sum, the PHNs in this study expressed a strong intention to provide solution-focused parenting support, thus indicating their readiness for change. This is promising, since such a strong intention should help ensure the successful and sustainable implementation of solution-focused parenting support among PHNs employed with YH organizations. Moreover, the intention to provide the method was predominantly determined by perceived subjective norm. As such, future implementation activities should be geared toward increasing perceived positive subjective norm. One way to accomplish this is to solicit the help of close colleagues during implementation activities. Meanwhile, we did not measure actual parenting support behaviors. For that reason, behavioral intention remained a mental state in the context of this study, and was thus an uncertain predictor of actual behavior. Here, a strong intention does not necessarily indicate that support behaviors had already been altered toward the solution-focused approach in daily practice. According to Grol et al. (2013), behavioral intention indicates the acceptance of an innovative intervention. The next step should be to increase actual behaviors aimed at solution-focused parenting support; for example, PHNs can be included in participatory action research as part of their daily practice, with a focus on detecting what works for them when changing toward solution-focused parenting support, and by simultaneously changing their practice in compliance with this support approach (Cooperrider et al., 2008; Cusack et al., 2018; Kemmis et al., 2014).

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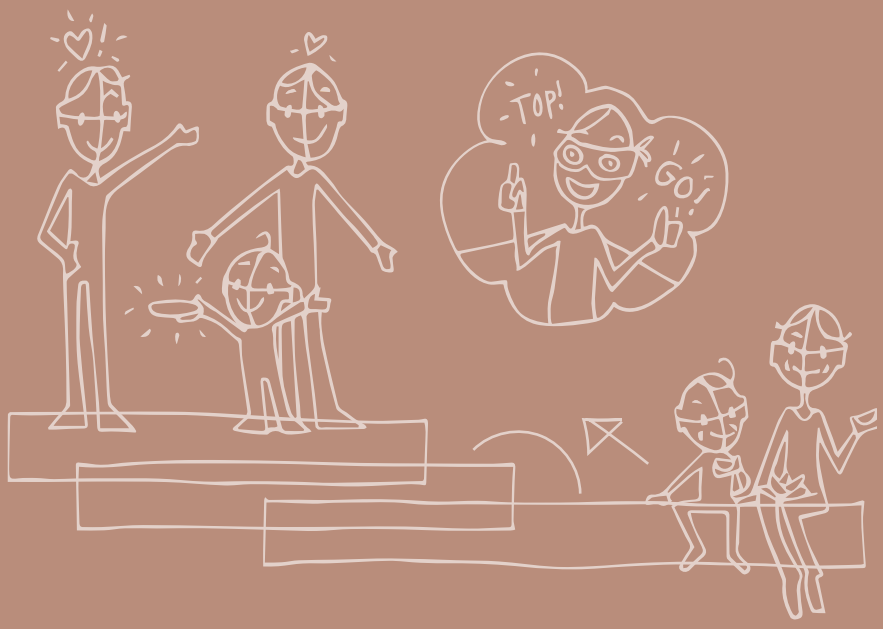
Chapter 5

Appreciative inquiry to facilitate transformative learning in public health nurses toward solution-focused parenting support



Abstract

Objective: To investigate whether and how Appreciative inquiry (AI) could facilitate transformative learning and related changes toward solution-focused parenting support among public health nurses (PHNs). ***Methods:*** A case study design was used in this study. AI, a participatory action research approach, was applied in a team of eight PHNs from January to December 2019. Data were collected through individual interviews and focus group meetings. Data were analyzed using a consensus method and thematic analysis. ***Results:*** In the first stages of the AI, PHNs reported increased knowledge and changes in motivation and self-confidence toward solution-focused parenting support. In subsequent stages, changes in knowledge, motivation, and self-confidence continued. Moreover, PHNs provided more solution-focused parenting support in their daily practice. Six mechanisms of AI that facilitated these changes were identified: organizational preconditions, theory on solution-focused parenting support as the backbone of the entire process, preconditions of group meetings, characteristics of AI, collaborative analysis, and ownership. ***Conclusion:*** AI can be a promising way to facilitate transformative learning and related changes among PHNs through six mechanisms.

Introduction

In recent years, parenting support practices in many Western countries have shifted from problem-focused to solution-focused approaches (Carr et al., 2017; Polaschek & Polaschek, 2007; Wells et al., 2014). In problem-focused approaches, professionals identify a problem and its causes and select an (evidence¬-based) intervention to solve the problem. The role of parents in this type of approach can be characterized as that of a problem owner and provider of relevant information. Moreover, parents are expected to follow the advice of professionals in each step of the process. In contrast, solution-focused parenting support solves problems by identifying parents' perspective on their preferred future, current available strengths and resources, and the first possible step toward the preferred future. Professionals lead this support process with an attitude of "not knowing", and the parents' perspective is central. The main goals of solution-focused parenting support are to increase parents' motivation, self-confidence, and problem-solving competencies (De Jong & Berg, 2013; McAllister, 2003).

Given the fundamental differences between these two approaches, the shift toward solution-focused parenting support can be viewed as complex, requiring a transformative learning process for professionals (Henderson, 2002). Transformative learning can be defined as "processes that result in significant and irreversible

changes in the way a person experiences, conceptualizes, and interacts with the world" (Hoggan, 2016, p. 71). Whether these changes can truly be qualified as a result of transformative learning depends on the extent of the changes, that is, whether the changes are noticeable in multiple contexts, applied to different learning outcomes (e.g., a person's worldview and sense of self), and sustainable (Hoggan, 2016).

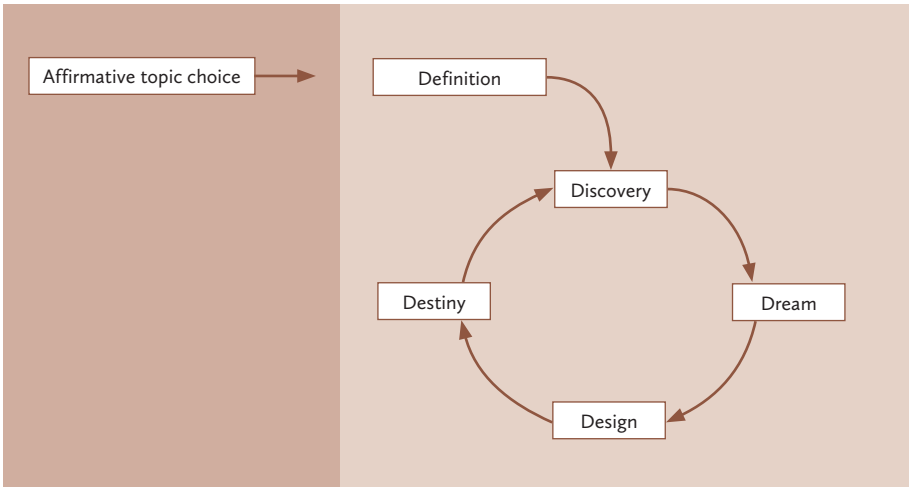
In Dutch youth healthcare (YH), the transformation process toward solution-focused parenting support began in 2014 with changes in parenting support policies and protocols. Moreover, several implementation activities, such as workshops and courses for public health nurses (PHNs) in solution-focused support techniques and peer supervision sessions, were conducted to support the shift in daily practice. Previous research has shown that problem-focused characteristics of parenting support still dominated the parenting support practices of PHNs three years after the implementation of solution-focused parenting support (Theuns-Boumans et al., 2021). Although a real shift was not yet visible in the daily parenting support practices of PHNs, their intentions to provide solution-focused parenting support were positive, indicating their acceptance of this approach, their readiness for change, and an opportunity for actual transformation (Theuns-Boumans et al., 2022). The present article reports the results of a case study using a participatory action research approach to transform the intentions of PHNs to provide solution-focused parenting support into active implementation.

Background

Appreciative Inquiry (AI) is a promising participatory stepwise action research approach that enables transformative learning and changes in nursing practice (Knibbs et al., 2012; Trajkovski et al., 2013; Watkins et al., 2016). AI starts with appreciating what gives meaning to professionals and organizations and valuing their current strengths. Next, a change is created stepwise and collaboratively from this positive core to the desired future. Throughout AI, compelling, positive, and provocative questioning is used to trigger positive images of people about how the future should be. This questioning is thought to liberate people, increase their positive expectations and inspiration, aid in the collaborative construction of new applicable knowledge, and promote experimentation, learning and change (Cooperrider et al., 2008).

AI includes an affirmative topic choice stage as a precondition, followed by a 5D-cycle containing consecutive stages of Definition, Discovery, Dream, Design, and Destiny (Figure 1).

Figure 1. Appreciative Inquiry (adapted from Appreciative Inquiry Commons, 2018)



Affirmative topic choice involves establishing the commitment of participants to the purpose and main topic of inquiry. In the Definition stage, the main topic of interest is collectively defined. The Discovery stage explores and appreciates what is already happening and available to professionals and the organization with respect to the defined topic of interest. In the Dream stage, the current situation is extended to the envisioned future. The Design stage involves in-depth inquiry into what is needed to achieve the envisioned future. At this stage, the envisioned future is concretized. In the Destiny stage, inquiry into how the designed future can be implemented sustainably in daily practice is the central focus (Appreciative Inquiry Commons, 2018; Cooperrider et al., 2008).

Although studies on the outcomes of AI in nursing are limited, a general meta-analysis by Bushe and Kassam (2005) reported transformative changes from seven different AIs. Furthermore, AI used in a nursing context has resulted in new ways of looking at old problems, positive expectations and determination to change, and actual changes in practices (Dewar & MacBride, 2017; Trajkovski et al., 2015).

This study aimed to investigate whether and how AI could facilitate transformative learning and related changes toward solution-focused parenting support among PHNs.

Methods

Study design

A case study design was used by applying a participatory action research approach (Godden, 2017; Yin, 2014). The AI conceptual framework guided different stages of data collection and analysis (Cooperrider et al., 2008), which lasted from January to December 2019.

Setting

This study was conducted at a regional location within the Dutch YH in the south of the Netherlands, comprising 680,000 inhabitants in 18 municipalities. At this YH location, 53 PHNs worked in nine different teams.

The Dutch YH is a national public health service that aims to promote healthy physical, psychological, social, and functional development of all children living in the Netherlands, aged 0–18 years (Nederlands Centrum Jeugdgezondheid, 2018). In YH, PHNs provide parenting support as a general health education activity and, in the case of mild parenting problems, as an early intervention during one or more consultations. If parenting problems are more complex, parents are referred to specialized professionals (e.g., psychologists and pediatricians).

Study sample

In this study, one of nine teams of PHNs was purposefully selected as a critical case (Yin, 2014). The inclusion criteria were as follows.

1. A team in which each PHN provided parenting support as an early intervention on a weekly basis
2. A team in which all members affirmed the research topic and study aim (affirmative topic choice as a precondition)

The selected team included eight PHNs working in two municipalities comprising 66,000 inhabitants. This team was invited to a meeting in which the principal researcher presented and discussed the research topic, the study aim, and the study design. At the end of this meeting, team members unanimously consented to participate in the study. Table 1 presents the characteristics of the PHNs participating in this study.

Table 1. Participant characteristics

Respondent	Sex	Age	Work experience (years)
R1	Female	31	8
R2	Female	56	30
R3	Female	41	16
R4	Female	53	28
R5	Female	29	1.5
R6	Female	58	25
R7	Female	50	26
R8	Female	45	19

Data collection and data analysis

Informed consent was obtained from all participants. All procedures in this study were approved by the Ethics Review Board of Tilburg University.
AI implies that both the researcher and PHNs fulfilled several roles in the data collection and analysis activities. Therefore, in the following section these roles are first explained. Then, the methods used to collect and analyze the data are explained in detail.

Roles of researcher and participants

During AI, the principal researcher fulfilled four roles: 1) researcher, 2) facilitator, 3) expert, and 4) critical friend. As ***researcher***, the principal researcher played a main role in designing the study and collecting and analyzing data according to scientific standards. As ***facilitator***, the principal researcher facilitated changes in the PHNs by structuring the process and content of the meetings according to the plan. The principal researcher participated as an ***expert*** on solution-focused parenting support in the Definition, Discovery, Dream, and Design stages. The principal researcher also participated as a ***critical friend*** (Foulger, 2010) in the Destiny stage.
The PHNs in this study fulfilled three roles: 1) professional expert, 2) co-researcher, and 3) subject to change. As ***professional experts***, PHNs used their theoretical and practical knowledge in all stages to define, discover, dream about, design, and reflect on solution-focused parenting support in their daily practice. As ***co-researchers***, PHNs participated in data analysis activities during group meetings and in establishing the results in the different stages of AI (Godden, 2017). As ***subjects to change***, PHNs were those who underwent the transformative learning process during AI.

Data collection and analysis methods per stage

Table 2 presents the data collection and analysis activities in the different stages of AI.

Table 2. Overview of data-collection and analysis methods per Appreciative Inquiry stage

Stage	Data collection and -analysis	Focus
Stage 1 Definition-1	Semi-structured interviews Thematic analysis	➤ Characteristics of solution-focused parenting support
Definition-2	Focus group 1: - *Respondent validation* - *Nominal group technique* Thematic analysis	➤ Characteristics of solution-focused parenting support
Stage 2 Discovery	Focus group 2: - *Respondent validation stage 1* - *Nominal group technique* Thematic analysis	➤ Current solution-focused parenting support strengths of PHNs and YH
Stage 3 Dream	Focus group 3: - *Respondent validation stage 2* - *Nominal group technique* Thematic analysis	➤ Envisioned future of solution-focused parenting support in YH
Stage 4 Design	Focus group 4: - *Respondent validation stage 3* - *Nominal group technique* Thematic analysis	➤ Design of solution-focused parenting support in YH context
Stage 5 Destiny-1	Focus group 5: - *Respondent validation stage 4* - *Co-creative workshop 1*	➤ Action plan 1
Destiny-2	Focus group 6: - *Realist evaluation 1* - *Co-creative workshop 2* Thematic analysis	➤ Actual change toward solution-focused parenting support ➤ Effective mechanisms of change in a specific context ➤ Action plan 2
Destiny-3	Focus group 7: - *Respondent validation realist evaluation 1* - *Realist evaluation 2* - *Co-creative workshop 3* Thematic analysis	➤ Actual change toward solution-focused parenting support ➤ Effective mechanisms of change in a specific context ➤ Action plan 3
Destiny-4	Focus group 8: - *Respondent validation realist evaluation 2* - *Realist evaluation 3* - *Co-creative workshop 4* Thematic analysis	➤ Actual change toward solution-focused parenting support ➤ Effective mechanisms of change in a specific context ➤ Action plan 4
Destiny-5	Focus group 9: - *Respondent validation realist evaluation 2* - *Realist evaluation 3* - *Co-creative workshop 4* Thematic analysis	➤ Actual change toward solution-focused parenting support ➤ Effective mechanisms of change in a specific context ➤ Action plan 5
Destiny-6	Email: - *Respondent validation realist evaluation 3*	➤ Actual change toward solution-focused parenting support ➤ Effective mechanisms of change in a specific context

Stage 1 Definition-1: Semi-structured interviews

Individual semi-structured interviews were developed by sensitizing questions about solution-focused support characteristics retrieved from the literature (e.g., professional attitude, support process, and expected attitude of parents) (De Jong & Berg, 2013). The PHNs' answers were further explored with the use of active listening techniques (listening, in-depth and open questioning, and paraphrasing). The full interview scheme is presented in Table 3. Semi-structured interviews were conducted by the principal researcher and analyzed by the principal researcher (Author 1) and one co-researcher (Author 3) using a thematic analysis procedure (Braun & Clarke, 2006).

Table 3. *Sensitizing interview questions*

1	What do you think is the general aim of solution-focused parenting support?
2	When providing solution-focused parenting support, which support stages would you follow?
3	What is the aim of each stage of solution-focused parenting support, according to you?
4	How do you view your role as a professional in the solution-focused parenting support process?
5	How do you view the role of parents experiencing mild parenting problems in the solution-focused parenting support process?
6	When providing solution-focused parenting support, which attitude do you adopt in the support relationship with parents?
7	Which attitude do you expect of parents experiencing mild parenting problems during the solution-focused parenting support process?
8	What characterizes the collaboration between you and parents experiencing mild parenting problems during the solution-focused parenting support process?
9	According to you, which communication techniques are essential in solution-focused parenting support?
10	Are there any other characteristics of solution-focused parenting support you would like to add?

Stages 1–4: Focus groups "from definition to design"

Next, four focus group meetings (3.5 hours each) were conducted. Each focus group started with the respondents' validation of the results of the previous analysis. At the end of this validation procedure, the results were collaboratively established by the researcher and PHNs.

During the first focus group (Definition-2), steps three and four of the nominal group technique (see Table 4) were used as participatory data analysis methods to reach a consensus on the definition of solution-focused parenting support by its characteristics (Harvey & Holmes, 2012). In focus groups 2–4, the full process of the nominal group technique was executed as a participatory data collection and analysis method to reach a consensus on the discovery, dream, and design of solution-focused parenting support as provided by PHNs.

Table 4. Nominal Group Technique (Harvey & Holmes, 2012)

Introduction of research question(s)	
Step 1	Participants generate ideas individually and silently.
Step 2	Participants share their individual ideas with the group. No discussion is allowed.
Step 3	Group discussion: solely questions to clarify the shared ideas. As value-free as possible.
Step 4	Participants collaboratively prioritize, organize, and label the (clustered) ideas as an answer to the research question(s).

Stage 5 Destiny: Focus groups "from theory to action"

During the focus groups in this fifth stage (Destiny 1–5), the strengths and resources identified in stage 2 Discovery were elaborated on in four complete plan-act-reflect cycles.

In co-creative workshops, the status of strengths and resources was identified as a starting point for future goal setting and action planning, and PHNs set goals and developed action plans to improve their solution-focused parenting support in daily practice. During these workshops, the researcher facilitated critical reflection by asking (critical) questions about goal setting and action planning. The questions were, for example, "How is this goal related to the designed and preferred future?" "Do you think this goal is realistic for the next month? Explain why you think that?" "How do you think this action will help you achieve your goal?" "Is it sufficient for goal achievement?" "Please explain why you think that action is attainable?" "What more is needed?" "What helped you in the past in comparable situations? How did that help? What makes you think it will help you again?" In the context of the Destiny stage, these action plans can be viewed as program theories to be tested. Subsequently, PHNs incorporated their planned goals and action plans into their parenting support practices and started acting upon them (or not).

In each reflection, a realist evaluation approach was used to reflect on the experiences of the PHNs (Nielsen & Miraglia, 2017; Pawson & Tilley, 1997). Realist evaluation is a method used to explain and understand what works in social interventions for whom, under what circumstances, and how. Since every organizational context differs and people differ, realist evaluation aims to evaluate the effective mechanisms of the actions and the related outcomes in their specific context, resulting in context-mechanism-outcome-configurations. During the focus groups in the Destiny stage, PHNs responded individually to standardized realist evaluation questions. Then, all answers were shared with the other PHNs and the researcher. The principal researcher participated as a critical friend by persistently asking questions to verify the claims made by PHNs.

Based on the results of these reflections, adapted goals and related action plans were created at the beginning of the new plan-act-reflect cycle.

All focus groups were video recorded. After each focus group, the principal researcher verified the accuracy and completeness of the results of the

(participatory) process by reviewing the video recording of the meeting and performing thematic analysis of all data collected. The results of this verification provided the input for respondent validation at the start of the next meeting. The respondent validation of the results from the final thematic analysis was done by email (Destiny-6).

Methods to evaluate AI as a facilitator of transformative learning and related changes

Data collection regarding how AI facilitated transformative learning and related changes among PHNs toward solution-focused parenting support was a central thread throughout the inquiry. First, it was evaluated at the end of each stage of AI using a standardized questionnaire designed by Knibbs et al. (2012) (Table 5). Each PHN completed the questionnaire individually. Second, in the final meeting, a questionnaire was administered to evaluate the complete AI (Table 6). Finally, notes were taken by the principal researcher during all research activities, during which participants occasionally mentioned their experiences with AI as a facilitating process for change. All questionnaire data and notes were included in the final data set, thematically analyzed (Braun & Clarke, 2006) by two different researchers (Author 1 and Author 2), and peer-reviewed by the other co-authors (Author 3 and Author 4). Respondent validation of the results was performed via email.

***Table 5**. Evaluation per meeting of how AI facilitates transformative learning and related changes (adapted from Knibbs et al., 2012)*

4-item Likert scale: 1: totally disagree, 7: totally agree	
1	Until now, meetings have been successful in the following:
	a Collaboratively defining solution-focused parenting support by its characteristics
	b Discovering the current strengths of PHNs regarding solution-focused parenting support
	c Specifying the dream "solution-focused parenting support by PHNs."
	d Designing solution-focused parenting support provided by PHNs in their context of YH.
	e Planning concrete actions to strengthen solution-focused parenting support by PHNs.
	f Evaluating the actions aimed at strengthening solution-focused parenting support by PHNs.
	g Planning and developing the AI process to support the professional development sustainably.
2	In my experience, my ideas were heard and understood by the facilitator.
3	In my experience, appreciative inquiry is a useful approach for professional transformative learning.
4	I would recommend the appreciative inquiry process to others.

Table 6. Overall evaluation of how AI facilitates transformative learning and related changes

1	On a scale from 1–10 (1=least, 10=most), how would you evaluate the AI as supporting transformative learning and related changes toward solution-focused parenting support?
2	Which elements from the inquiry contributed to this change?
3	How did these elements contribute to your personal change toward solution-focused parenting support?
4	Please rank these elements according to importance.
5	How did your parenting support change because of the inquiry?
6	How did you change because of the inquiry?
7	On a scale from 1–10 (1=least, 10=most), to what extent has your solution-focused parenting support improved?
8	What recommendations do you have for the facilitator and/or for a future appreciative inquiry?

Ethical considerations

In line with what Foulger (2010) states, a peer researcher (Author 2) functioned as a critical friend for the principal researcher to avoid ethical issues and secure research quality and integrity in participative action research.

To monitor the power distribution in the participatory process between the principal researcher and team of PHNs, several interventions were included in the research design (Long & Johnson, 2000). First, the principal researcher reflected on her own beliefs, values, and expectations with respect to solution-focused parenting support and AI as a research methodology in a self-description evaluated by the peer researcher. Risks for positive bias were explicated so that both the principal researcher and the peer researcher could reflect on these aspects after each research activity. Adjustments were made if necessary. Second, the ethical principles and practices of participatory action research were used as standards in the design of this study (Centre for Social Justice and Community Action [CSJCA], 2012). After each research activity, the principal researcher reflected on the criteria in a reflective journal. Moreover, the peer researcher audited the study by watching video recordings, reading the reflective journal, and assessing the results of the research activities (Long & Johnson, 2000).

Results

This study investigated whether and how AI could facilitate transformative learning and the related changes among PHNs toward solution-focused parenting support. Below, both the changes experienced by PHNs, and the way AI contributed to these changes are presented.

Experienced changes toward solution-focused parenting support

Throughout the AI trajectory, the PHNs experienced many changes in solution-focused parenting support. Overall, the content of these changes evolved over the subsequent stages and plan-act-reflect-cycles, from more cognitive to more practical changes.

In the Definition, Discovery, Dream, and Design stages of the AI, all PHNs mentioned their theoretical knowledge and insights into the possible application of solution-focused parenting support in their daily practice increased. The mechanisms that influenced these changes were the collaborative nature of defining the approach and the participation of an expert during these stages. Moreover, the continuous repetition of the solution-focused definition and theory in these and subsequent stages contributed to this knowledge gain and insights.

> ***R1:*** *Deepening the theory of solution-focused parenting support collaboratively with my colleagues and an expert increased my knowledge significantly.*
> ***R5:*** *The continuous repetition of theory increased my knowledge and insights about it.*

In the first cycle of the Destiny stage, six PHNs (R1, R3, R4, R5, R7, and R8) emphasized cognitive changes, such as an increase in their positive attitude toward solution-focused parenting support and in their motivation and self-confidence to initiate actual change. Mechanisms that triggered these changes included theoretical knowledge about solution-focused parenting support from previous stages, insights into their personal possibilities for growth from the discovery stage, attainable goals and actions, and reminders.

> ***R5:*** *I start the conversation more confidently because of the concrete preparation of actions.*
> ***R1:*** *Since I realize that one first step is good enough, I feel a lot of space for practice. Moreover, due to my knowledge gain about solution-focused parenting support in previous meetings, I feel more confident to practice.*

For two PHNs (R2 and R6), the first plan-act-reflect cycle resulted in social pressure, insecurity of own abilities, and blocking. They considered discontinuing their participation in the study. These PHNs mentioned reminders by the principal researcher and non-attainable action planning as the mechanisms leading to these outcomes.

> ***R6:*** *If you, as facilitator. sent me a reminder email, then I think: "Oh, I need to do this or that. I want to do it all perfectly, but then I realize I cannot do it at all. In the end I think: "what am I doing here."*

In the final cycles of the Destiny stage, six PHNs (R1, R3, R4, R5, R7, and R8) stressed more behavioral changes, such as experimenting more with solution-focused techniques in daily practice and more sustainable use of some solution-focused techniques (e.g., the so-called "miracle question" to assess the desired future). These changes were triggered by their continuously increasing knowledge, self-confidence, motivation, confirmative experiences with solution-focused parenting support in daily practice (it works, I can do it), and enhanced insights into their personal possibilities for growth. Furthermore, some basic assumptions of PHNs about providing solution-focused parenting support to parents changed because of their positive experiences with solution-focused parenting support in their daily practice. These new assumptions were the driving forces for further experiments with solution-focused parenting support.

> ***R3:*** *I used to think that parents expected professional advice and would not be satisfied if I approached them as solution-experts. However, during the experiments I experienced that treating parents as experts was perceived as a major compliment, and parents became more active in building their own solution. These experiences changed my view on the role of parents and myself in parenting support.*

In the final cycles of the Destiny stage, two PHNs (R2 and R6) emphasized cognitive changes, such as an increase in their positive attitude, motivation, and self-confidence to initiate actual change. The mechanisms that triggered these outcomes were attainable goal setting, action planning, and peer support.

> ***R2:*** *Sharing my insecurities with colleagues and practicing with them helps to increase my self-confidence to try solution-focused parenting support in my daily practice.*
> ***R6:*** *I am really convinced it works. However, I lack experience. I do use sample questions, I practice with my colleagues, and I consciously plan to ask solution-focused questions. I want to start working with it.*

Appreciative inquiry as facilitating transformative learning and related changes

Table 7 presents an overview of all themes and subthemes that emerged from the analysis of AI in facilitating transformative learning and the related changes among PHNs toward solution-focused parenting support. These themes and subthemes are described in more detail below.

Table 7. Results of "How AI facilitated transformative learning and related changes among PHNs"

Main themes	Sub-themes
Organizational preconditions	• Organization arranges time for PHNs to participate in the AI • Appreciative Inquiry at a location that is not work-related • Monthly, preplanned meetings
Theory on solution-focused parenting support as the backbone of the entire process	• Increase of theoretical knowledge through the participation of a solution-focused parenting support expert • Continuous repetition of (parts of) solution-focused parenting support theory • Theoretical tools for integrity of solution-focused parenting support in daily practice
Preconditions of group meetings	• A safe learning environment • Structured meetings (process and content) • Visual presentation of results • Facilitation of critical reflection
Characteristics of appreciative inquiry	• Topic is about the core of the profession • Process approach (step-by-step) • Positive and future oriented dialogue • Action-focused approach
Collaborative analysis	• Collaboration peers • Peer support
Ownership	No subthemes

Organizational preconditions

The PHNs mentioned three main organizational factors that enabled transformative learning and related changes. First, the fact that the study was organized as part of the daily practice of PHNs and did not involve extra time was mentioned as the most important factor in their enduring commitment. Second, PHNs reported that conducting group meetings in a non-work-related location supported their focus on the AI process. Finally, the preplanned structure of AI was experienced as positive for continued engagement and effort.

R7: *Good organization and facilitation of AI is essential. We can work and grow in serenity.*

R2: *The continuous overview created by the facilitator was helpful. Furthermore, AI outside of our working context creates space to focus on changing toward solution-focused parenting support.*

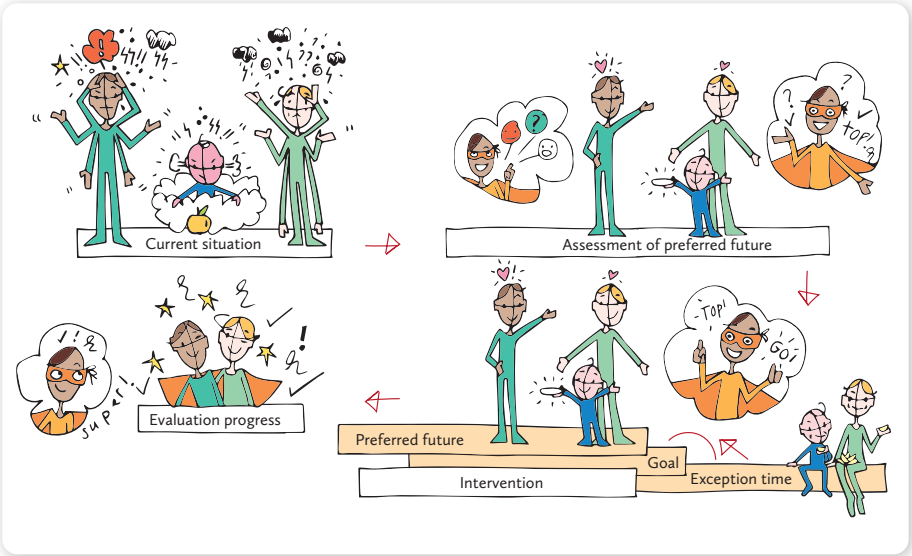
R3: *Continuity. Monthly, preplanned meetings give a sense of tranquility. This is how we are going to do it!*

Theory on solution-focused parenting support as the backbone of the entire process

The collaboratively constructed definition of solution-focused parenting support (Stage 1) profoundly guided the change process of PHNs. This definition was used during all stages of AI to discover, dream, design, and plan, act, and critically reflect on claims about (change toward) solution-focused parenting support. The participation of an expert and the constant repetition of the theory at each step in the AI process gradually expanded the insights of PHNs into the theory and practice of solution-focused parenting support. Furthermore, the design and use of theoretical solution-focused tools (e.g., Figure 2) promoted the integrity of PHNs' experiments with solution-focused parenting support in daily practice.

R1: *We collaboratively deepened our theoretical knowledge about solution-focused parenting support and created knowledge that was directly applicable in our daily practice.*

Figure 2. *Theoretical tool (placemat)*

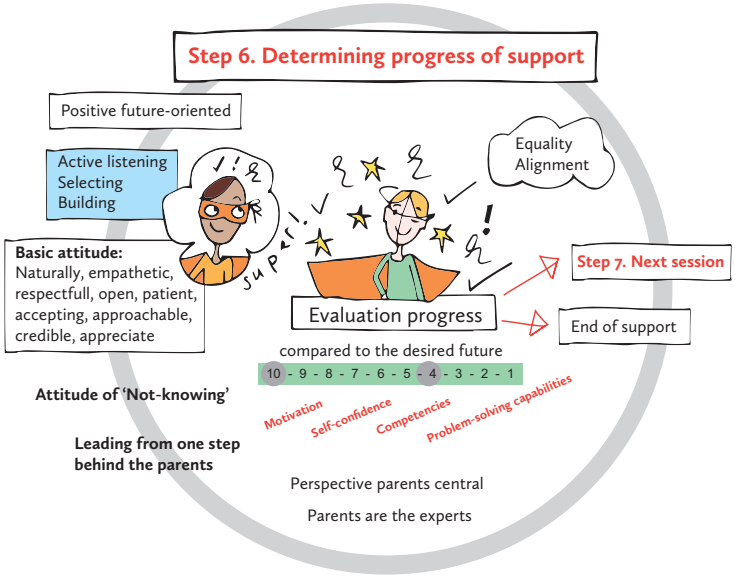


Preconditions of group meetings

The way the researcher facilitated a safe and structured learning environment, facilitated critical reflection, and provided visual overviews of all evolving intermediate results (e.g., Figure 3) was experienced as supportive for enabling change toward solution-focused parenting support.

> ***R1:*** *I felt safe, but also because you (facilitator) questioned me objectively and without any judgement. It made me feel I could be vulnerable when I did not know the answer or did not understand something. I did not feel any pressure to achieve; I could show the best of myself at that time. I like that since change is a process.*

Figure 3. *Visual presentation of defined step 6 in the solution-focused process*



Characteristics of appreciative inquiry

Some specific characteristics of AI were identified by the PHNs as facilitating the change process. First, the fact that the research topic was about the core of their profession (i.e., providing parenting support) motivated them to put effort into change activities. Second, PHNs expressed the step-by-step process approach as helpful for their change. Each step of the process was experienced as clear and attainable. This increased their feelings of self-confidence in achieving their intended goal per step. Third, the positive and future-oriented dialogue of AI increased PHNs' self-confidence and motivation to change. Moreover, this dialogue influenced PHNs to think more positively about the possibilities of solution-focused parenting support in their daily practice and their own possibilities for change toward solution-focused parenting support. Finally, PHNs reported that they felt

encouraged in their personal actions in every step of the research process (i.e., knowledge building, planning, acting, and reflecting). According to PHNs, the action-focused approach of AI stimulated the performance of (practical) change activities.

> ***R8:*** *Our profession as a PHN is manifest in the AI process. It really concerns the core of our profession, the profession we chose!*
> ***R4:*** *Realizing that one first step is good enough felt liberating.*
> ***R2:*** *Although you are only at the beginning of developing a new way of working, you can always do something to start the change process.*

Collaborative analysis

AI facilitated transformative learning and related changes by stimulating participants to share their available knowledge about solution-focused parenting support and to combine the best of this collective knowledge into the concrete outcomes of each stage (e.g., definition, dream, and design).

> ***R6:*** *Each participant has her personal experience and knowledge about the subject. This is used in the meetings to advance the development of solution-focused parenting support in our practice.*
> ***R5:*** *I really appreciate the collaborative development of solution-focused parenting support for our practice. We adapt theory to fit into our practice, we make it something of our own, and we implement it in concrete terms in our daily practice.*

Furthermore. PHNs experienced intensive collaboration during the AI, empowering their personal change toward solution-focused parenting support. Teamwork with peers and the solution-focused expert during the first four stages of the AI (Definition, Discovery, Dream, and Design) made the hard work feel easier. Moreover, peer support in the plan, act, and reflect phases of the Destiny stage increased motivation and self-confidence to sustain the change process.

> ***R1:*** *Experiences of my peers' success is helpful. It provides more insights in possibilities for my next step in the change process.*
> ***R7:*** *It is a lot, but we do it together. Together we will manage!*

Ownership

PHNs experienced that they owned the results of each stage in the AI process because of their participatory role during the entire research process. This experience of ownership of the content and process of the future of solution-focused parenting support in their daily practice motivated PHNs to initiate actual changes.

> ***R4:*** *AI is more than a training. It feels like we own the process and the outcomes.*
> ***R5:*** *I appreciate us creating our future together. It is our dream come true. It truly feels like something of our own!*

Discussion

This study investigated whether and how AI could facilitate transformative learning and the related changes toward solution-focused parenting support among PHNs. Throughout the AI, PHNs reported both cognitive and behavioral changes toward solution-focused parenting support. Cognitive changes included increased positive attitudes, knowledge, insights into possibilities for change, increased motivation, and self-confidence to start experimenting with this new approach. Behavioral changes included the application of solution-focused support competencies in daily practice. In addition, PHNs made more positive assumptions about solution-focused parenting support. These results are in line with previous AI studies in which both cognitive and behavioral changes in nurses were reported as a result of AI (Dewar & MacBride, 2017; Trajkovski et al., 2015).

According to PHNs, AI facilitated these changes through six mechanisms: organizational preconditions, theory solution-focused parenting support as the backbone of the entire process, preconditions of group meetings, characteristics of AI, collaborative analysis, and ownership. Although these mechanisms can be interpreted as six distinct results, some mechanisms interact with one another. In concrete terms, the categories "preconditions of the group meetings," "characteristics of AI," and "collaborative analysis" facilitated change toward solution-focused parenting support, but they also contributed to change through increasing the experienced "ownership" of the content and process. Overall, the mechanisms of AI that facilitate change can be divided into process mechanisms and content mechanisms.

Process mechanisms of AI that facilitated change were "organizational preconditions," "preconditions of group meetings," some "characteristics of AI" (process-approach, action-focused approach), "collaborative analysis," and

"ownership." These mechanisms are broadly in line with known determinants of the effective implementation of innovations associated with the organization in which the innovation takes place (Fleuren et al., 2014). The facilitation of a safe learning environment and critical reflection as components of the "preconditions of group meetings" were valuable additions to these determinants. Facilitating a safe learning environment proved to be essential for all PHNs to open up to and stay active in both collective and individual activities in the AI, even when experiencing personal difficulties. The facilitation of critical reflection contributed to the program integrity of solution-focused parenting support. Furthermore, it stimulated attainable action planning and more faithful reflection by participants at the Destiny stage. In transformative learning theories, critical reflection is emphasized as an essential factor for transformative learning in individuals and groups (Henderson, 2002).

Content-mechanisms of AI that facilitated change were "theory as the backbone of the entire process" and two "characteristics of AI" (i.e., topic is about the core of the profession, and positive and future oriented discourse). In existing theories on the implementation of innovations and transformative learning, theory is used to increase the insights of the target group as the preceding phase of change activities (Grol & Wensing, 2013). Our study adds to this by indicating that an iterative process of co-creation and use of the underlying theory of innovation at all stages facilitates gradual and in-depth insights into innovation theory and its application. Furthermore, the fact that PHNs mentioned that the topic being about the core of their profession facilitated change indicates the relevance of this topic for PHNs. This corresponds to what Fleuren et al. (2014) described as the professional obligation of innovation as a determinant of effective implementation. Finally, in contrast to other deficit-oriented implementation strategies, AI is positive and future-oriented in nature (Cooperrider et al., 2008). The focus of AI is on identifying and affirming what is, what can be, and what will be in an iterative and cyclic process connecting to the individual characteristics of each participant (e.g., level of motivation, self-efficacy, competence, and learning style). These individual characteristics are known determinants of the effective implementation of innovation (Fleuren et al., 2014). AI ensures a continuous alignment of content and the process of change according to the individual characteristics of the participants.

Most mechanisms that facilitated change can be attributed to the design of the different roles of facilitator, expert, and critical friend in our AI. The facilitator organized organizational preconditions, ensured a safe learning environment, used positive and future-oriented language, stimulated a process- and action-focused approach, structured group meetings, and guided the process of collaborative analysis. Moreover, the facilitator provided the visual representations of results

and theoretical tools. The expert added knowledge about the solution-focused parenting support theory, and ensured the integrity of this support approach, and the critical friend facilitated critical reflection during the AI. In their review, Watkins et al. (2016) confirmed that facilitation is key for AI to succeed in obtaining and maintaining change. Moreover, Henderson (2002) stated that critical reflection is essential for transformative learning. Our study indicates that, apart from a facilitator and critical friend, participation of an expert in the topic of interest also contributes to the positive outcomes of AI.

In the current study, we combined the roles of facilitator, critical friend, and expert in one person. This enabled the facilitator to shift to an expert role and act as a critical friend when needed. The combination of different roles in one person, the principal researcher, was possible in this study because she was both an experienced lecturer in nursing and a subject-matter expert. This combination of roles is common in participatory action research; however, although we had positive experiences with the combination of roles, no claims can be made that this is a necessity.

Limitations

First, this study was carried out with one team of eight PHNs. The nature of participative AI requires an intensive process to reveal details about the change mechanisms underlying transformative learning. Therefore, small-group studies involving professionals in daily practice are essential for providing rich data and deeper insights. A general limitation of case studies is that the outcomes cannot be extrapolated to other teams (Yin, 2014). Second, although PHNs experienced both cognitive and behavioral changes, no firm claim can be made about whether these changes can be referred to as transformative learning outcomes, in part because the results regarding significant changes were self-reported. Furthermore, although cognition and behavior changed over the course of the AI, these changes were not measured over time to confirm sustainable and irreversible changes.

Implications

This study has important implications for future implementations of complex innovations in the daily practice of PHNs, and presumably in other nursing contexts. First, AI explicitly facilitates both cognitive and behavioral changes in an iterative process. In the context of transformative learning, more cognitive changes in the first stages of AI should be viewed as the driving force for actual behavior change in the final stage (Henderson, 2002). Moreover, positive experiences while experimenting with solution-focused parenting support in the final stage reinforce positive cognitions as driving force for behavioral change. Thus, AI can be viewed as a supporting tool for a gradual but ongoing process of cognitive and behavioral change. Second, the implementation of complex innovations among PHNs and

possibly other nurses should be viewed as an individual cyclic learning process in a group of peers in which the personal levels of knowledge, motivation, self-confidence, and behavior are appreciated. Furthermore, creating a safe learning environment in which every individual is appreciated for his/her status, goals, and actions can enable continued involvement in a team development process, especially for less motivated, less confident, and/or less competent PHNs. Future research should focus on guiding such implementation activities with evaluation research, thus contributing to building an evidence base for the implementation of complex innovations in YH and public health nursing.

Conclusion

AI can be a promising way to facilitate transformative learning and related changes among PHNs through six mechanisms. The co-creative process contributed to the integrity and applicability of solution-focused parenting support in the daily practice of PHNs, the motivation and self-confidence to change, the incentive to experiment with challenging new support behaviors, and the ability to make actual changes in behavior. These findings warrant further research into the effectiveness of AI in facilitating professional transformative learning, including a broader set of measures of change and measurements of change over time to assess sustainability.

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Chapter 6

General discussion

Introduction

Since 2013, solution-focused parenting support has been expected to be one of the basic skills of public health nurses (PHNs) working within the Dutch youth healthcare (YH) system, and it has been designated as the preferred approach to mild parenting problems. Historically, the parenting support provided by PHNs has been problem-focused. The shift from problem-focused to solution-focused parenting support among PHNs in the Netherlands is assumed to be complex, given the differences between the two approaches. Although YH organizations have initiated a variety of implementation activities to facilitate this shift, little is known about the state of solution-focused parenting support among PHNs and effective strategies for facilitating its implementation. The general aim of this thesis is to explore the current state of solution-focused parenting support among PHNs and ways of further facilitating the shift toward this kind of parenting support by PHNs.

This thesis pursues the following research aims:

1. To explore the problem-focused and solution-focused characteristics of parenting support provided by PHNs in the YH, three years after solution-focused parenting support was implemented.
2. To explore the behavioral, normative, and control beliefs of PHNs about solution-focused parenting support.
3. To explore and explain the intention of PHNs to provide solution-focused parenting support by the concepts of attitude, subjective norm, and perceived behavioral control.
4. To investigate whether and how appreciative inquiry could facilitate transformative learning and related changes toward solution-focused parenting support among PHNs.

Main research findings

This thesis proceeds from the assumption that the implementation interventions organized within the YH system (Hensen et al., 2016) are not sufficient to facilitate the desired shift from problem-focused to solution-focused parenting support. With regard to the first research aim, factual, expressive, relational, and appealing aspects of professional messages (Schulz von Thun, 2010) were identified to determine the problem-focused and solution-focused characteristics of parenting support provided by PHNs three years after implementation of solution-focused support. The factual aspect refers to the content of a message; the expressive aspect indicates the ways in which professionals present themselves in their

messages; the relational aspect implies the professional view on the role of the parents; and the appealing aspect expresses the implicit or explicit expectations of the professional (*Chapter 2*). The results suggest that, despite the identification of solution-focused features in some aspects of a few professional messages, the various aspects of parenting support were predominantly characterized as problem-focused.

With regard to the beliefs of PHNs about solution-focused parenting support according to the theory of planned behavior (TPB), as explored in the second research aim, PHNs appeared to have moderately positive to positive beliefs about the provision of solution-focused parenting support. The TPB is used to predict and explain the intention to effect a given behavior or behavior change, and it distinguishes three types of beliefs: behavioral, normative, and control. Behavioral beliefs are positive and negative beliefs about the characteristics and consequences of a given behavior. Normative beliefs concern the expected norms of significant others. Control beliefs have to do with the existence of internal and external factors that may foster or impede the execution of the behavior of interest. (*Chapter 3*). Of these three types, the behavioral beliefs of the PHNs were the most positive, especially among older and more experienced PHNs. Control beliefs were least positive, although they were more positive in older, more experienced PHNs and those with training.

According to the TPB, an individual's attitude, subjective norm, and perceived behavioral control are influenced by behavioral, normative, and control beliefs, respectively, resulting in an intention to perform a given behavior. Attitude refers to the evaluation of a behavior as either favorable or unfavorable. Subjective norm concerns the pressure that the individual experiences from significant others to perform (or not to perform) a given behavior. Perceived behavioral control refers to the perceived simplicity of performing a behavior. It includes an individual's capability of performing and controlling a behavior. Intention comprises the willingness of people to perform a behavior and the effort that they plan to put into it (*Chapter 4*).

With regard to the exploration of the attitude, subjective norm, perceived behavioral control, and intention of PHNs within the Dutch YH system (the third aim of this thesis), results indicate that PHNs have a positive attitude, subjective norm, and perceived behavioral control with regard to the provision of solution-focused parenting support. Moreover, they have a strong intention to provide such support. Taken together, the variables of the TPB were able to explain 53% of the intention of PHNs to provide solution-focused parenting support.

Chapter 5 presents the results of appreciative inquiry (AI). AI is a participatory action research (PAR) method using a 5-D stage model (definition, discovery, dream, design, and destiny stage). Results from the exploration of whether AI could facilitate transformative learning (as part of the fourth research aim) reveal both positive cognitive and behavioral changes in PHNs toward solution-focused parenting support. The positive cognitive changes that occurred were primarily related to attitude, knowledge, insights into possibilities for change, motivation, and self-confidence. Behavioral changes included more experimentation with solution-focused techniques and the more sustainable use of some solution-focused techniques. Cognitive changes were observed at all stages of the AI, with behavioral changes (e.g., asking the "miracle question;" replacing a problem-assessment for an assessment of the preferred future) observed in the final stage (i.e., the destiny stage).

As the second part of the fourth research aim, the exploration of how AI could facilitate transformative learning revealed a number of important mechanisms: *organizational preconditions* (i.e., time, location, and preplanning); *theory on solution-focused parenting support as the backbone of the entire process* (i.e., participation of a solution-focused expert, continuous repetition of theory); *preconditions of group meetings* (i.e., safe learning environment, structured meetings, visual presentation of results, and facilitation of critical reflection), *characteristics of appreciative inquiry* (i.e., topic concerns the core of the profession; a process approach; positive, future-oriented dialogue; focus on action); *collaborative analysis* (i.e., collaboration with peers, peer support); and *ownership*.

Reflection on the main findings

The state of implementation of solution-focused parenting support

In a reflection on the implementation status of an innovation, Grol et al. (2013) distinguish five stages: orientation, insight, acceptance, change, and maintenance (Grol & Buchan, 2006; Grol & Wensing, 2004). In the orientation phase, the goal is for the target group of the change to become aware of, interested in, and involved in the subject of change. The insight phase aims to promote the urgency of change by providing information about the innovation and its actual performance. In this phase, it is important for individuals to have insight into their own current performance and the new behavior that is expected of them. In the acceptance phase, the aim is to develop a positive attitude and positive intention toward the anticipated change. The change phase entails the actual adoption of the innovation, which involves trying out and experiencing the new method,

learning the skills involved, and making any necessary practical alterations. This phase further focusses on evaluating the benefits and value of the change in terms of effectiveness, satisfaction, and possibilities for further implementation. In the maintenance phase, the goal is to integrate the innovation into new routines (Grol & Buchan, 2006; Grol & Wensing, 2004; Grol et al., 2013).
Transformative learning (i.e., change of perspectives) can take place during the change and maintenance stages as PHNs question their assumptions and perspectives about solution-focused parenting support and start to experiment with this new behavior (Henderson, 2002).

Findings from the first three studies (which explore the characteristics of parenting support among PHNs, as well as their beliefs about providing solution-focused parenting support and their intention to provide it) largely reflect the acceptance stage of implementation. Results from the study exploring the problem-focused and solution-focused characteristics of parenting support in YH reveal a very limited application of solution-focused parenting support among PHNs working in a regional YH organization in the south of the Netherlands. This suggests that the efforts that have been made thus far have not yet led to solution-focused parenting support in the daily practice of these PHNs. In other words, the change and maintenance stages of implementation was still preliminary.

The national survey results suggest that Dutch PHNs have a generally positive attitude toward solution-focused parenting support and a strong intention to provide it. As elements of the TPB, attitude and intention are important features of the acceptance stage of implementation. The results of the survey thus suggest that Dutch PHNs are likely to accept solution-focused parenting support as a new approach and that they are probably ready to enter the change stage of implementation (Ajzen, 1991; Grol et al., 2013).

Further facilitation of the shift toward solution-focused parenting support

AI was chosen as a form of PAR, as it includes all stages of implementation. It also directs special attention to the collaborative construction and alignment of the definition, the future dream, and the first draft of the design for solution-focused parenting support in youth healthcare, before focusing on practical change in the planning, action, and reflection phases of action research. These aspects made it possible to generate broad insight into ways of bridging the gap between intention and behavior, as well as to act upon such insight. In addition, the positive, strength-based focus of AI apparently provides motivation for long-term engagement (Cooperrider et al., 2008).

Given that positive intention was a prerequisite for participation in the AI, the intention to provide solution-focused parenting support was assessed once more among the small group of PHNs who were invited to collaborate in the AI. In other words, the intention of all PHNs in this group was positive. At the start of the AI, it was interesting to note that the knowledge base of these PHNs was generally restricted to the main principles of solution-focused parenting support (e.g., positive and future-oriented; parents as experts). Despite the training in solution-focused parenting support and additional peer-supervision sessions, the translation of these main principles into knowledge concerning the more detailed factual, expressive, relational, and appealing aspects of solution-focused parenting support appeared limited. This lack of detailed knowledge among the PHNs could potentially pose an obstacle to bridging the gap between intention and behavior.

The use of AI as a method of action research revealed four aspects within the process of AI that are supportive in facilitating transformative learning aimed at solution-focused parenting support in PHNs: 1) the role of the facilitator; 2) AI as part of daily practice; 3) theory on solution-focused parenting support as the backbone of the entire process; and 4) a sense of ownership on the part of PHNs.

The *facilitator role* in the process of AI appeared crucial to ensuring the continuing engagement of PHNs in the transformative learning process. More specifically, the PHNs participating in this research emphasized the facilitation of a structured and safe learning environment as supportive to their development toward solution-focused parenting support. This is also reflected in the results of previous studies, which emphasize the value of a facilitator in enabling transformative learning (Dewar & Nolan, 2013; Watkins et al., 2016). The facilitator role entails a rigorous application of the methodology (i.e., the 5-D cycle of AI) and the structural use of positive, future-oriented communication (Cooperrider et al., 2008; Dewar & Nolan, 2013; Watkins et al., 2016).
In our AI, the facilitator created a rigorous protocol to structure the application of the methodology (Cooperrider et al., 2008). Each meeting was designed around a specific stage of AI. Questions to be answered at that stage were formulated in a clear, future-oriented, and positive manner. Meetings were structured to ensure the input of all individual perspectives and the co-construction of a collaborative perspective. In addition to the importance of a structured learning environment, the PHNs also identified the facilitation of a safe learning environment as supportive of their transformative learning process. According to Gill et al. (2015), a safe learning environment is the foundation of individual transformative learning within a team. It is intended to prevent negative consequences of certain learning activities (e.g., embarrassment, fear, loss of face). A facilitator can ensure a safe learning environment by creating trust and enabling autonomous decision-making

on the part of learners, in addition to being humble, empathetic, honest, and trustworthy, while showing individualized consideration, being optimistic, using strength-based strategies, creating hope and openness, and tapping into the motivation of learners (Gill et al., 2015).
These principles were explicated in the AI research protocol and discussed with all participants at the start of this research. If necessary, the facilitator actively drew upon these principles throughout the study. For example, regardless of the state of transformative learning in which individual PHNs were situated, the facilitator first expressed appreciation for each experience as a valuable new insight into what had or had not worked for that PHN. The facilitator then re-connected to the motivation of the individual PHNs to provide solution-focused parenting support and invited them to define a new, attainable next step toward their preferred future. This approach created a safe environment in which the participants could proceed in their personal transformative learning processes, especially when they were having trouble providing solution-focused parenting support or feeling insecure toward their colleagues.

The fact that the *AI was integrated into the daily practice* of PHNs over the course of a significant period (i.e., one year) was an important factor that enabled transformative learning. It is known that the "time available for the implementation of an innovation" contributes to both a positive climate for innovation and the success of its implementation (Fleuren et al., 2014; Grol et al., 2013; van den Hoed et al., 2022). The integration of the entire AI process into their regular workload motivated PHNs to become engaged and to remain as committed to this intense learning process as they were to their other work-related activities. Furthermore, the shift toward solution-focused parenting support was no longer viewed as a straightforward intervention to be implemented. Rather, it was experienced as a long-term commitment of both the YH organization and the PHNs to the transformative learning process.
In current YH practice, the time provided to implement solution-focused parenting support is invested primarily in activities in the insight and acceptance stages of implementation, and only in the preliminary phase of the change stage (Hensen et al., 2016). The integration of AI into the daily practice of PHNs ensured that time was invested in all stages of implementation. Since it appeared that PHNs were most likely to drop out during the change and maintenance stages suggests that investing time in these stages is of the utmost importance.

Another factor that facilitated the transformative learning process of PHNs was *theory on solution-focused parenting support as the backbone of the entire process*. As demonstrated by the results of this study, the expert role can add to the knowledge base of PHNs on solution-focused parenting support through the

sharing of theoretical knowledge and repeating this knowledge throughout the various stages of the AI. This is in line with the finding of Gagnon (2011) that the active dissemination of knowledge by a credible and influential messenger in a collaborative process improves the knowledge base of its users. Moreover, it is known that learning a new complex theory and putting it into practice as intended is a long-term process that requires repetition — and spacing between repetitions — in order to stimulate effective storage in the long-term memory (Toppino & Gerbier, 2014).
In the destiny stage of AI, the "critical friend" role added to the knowledge base of PHNs. The critical friend — an expert in solution-focused parenting support — used this knowledge to question perspectives and assumptions of the PHNs. The critical friend also reflected on the program fidelity of the PHNs in terms of solution-focused action planning, as well as on their personal evaluations of their experiments in the destiny stage (Foulger, 2010).

Finally, the participants identified *ownership* as an important mechanism that facilitated transformative learning. Such feelings of ownership were associated with active participation of PHNs in the AI comprised two dimensions: 1) being in control of their own transformative learning process; and 2) being co-owners of the end products of each stage of the AI (i.e., what solution-focused parenting support is, what it should be in YH, and how they can improve it in their daily practice). As described in the literature on PAR, ownership is a major component of this design, as it implies conducting research with people, thereby allowing them greater control of the process and outcomes than is the case in non-participatory forms of research (Andersson, 2018; Bergold & Thomas, 2012). Such feelings of ownership could be explained by the concept of autonomy from the self-determination theory (SDT) (Deci & Ryan, 1985; Ryan & Deci, 2017). Autonomy refers to voluntary behavior, allowing individuals an element of choice, and acknowledging their perspectives (Ryan et al., 2019). An autonomy-supportive learning environment provides an opportunity for individuals to process and endorse all aspects of a given behavior without restraint, as well as to make adjustments when necessary (Deci & Ryan, 2000). The AI component of this research was developed according to these autonomy-supportive principles, which enabled the participating PHNs to remain in control, to make the intervention applicable to the context of YH, to become co-owners, and to contribute to feelings of ownership.

Methodological considerations

Strengths

The studies in this thesis have several strengths. Overall, the exploratory studies in the first part provide a rich picture of various stages in the implementation of solution-focused parenting support within the context of YH. Moreover, these three studies were the first to investigate the state of solution-focused parenting support in YH in the Netherlands.

In the first study, which explores the current state of solution-focused parenting support by PHNs, parenting support sessions were recorded without PHNs knowing the details of the research aim. This proved especially valuable during the member-check procedure, as the PHNs were surprised by the results. Although they believed that they were already providing solution-focused parenting support, discussion of the results led them to acknowledge that this was not the case. These results provided motivation for the PHNs to collaborate in the AI, with the goal of actually transforming their parenting support practice.

Another strength of this research is related to the selection of specific theories to contribute to the aims of the research (e.g., the theory of planned behavior (Ajzen, 1991) and the factual, expressive, relational and appealing aspects of human communication (Schulz von Thun, 2010)). Together, these theories enriched the context for an in-depth exploration of the object of study. Furthermore, the application of AI as a research method and the level of participation helped the participating PHNs to feel appreciated and in control throughout all stages of implementation. This motivated them to proceed, even when experiencing difficulties.

Further strengths of the research have to do with the outcomes of the destiny stage, which contributed to new knowledge about mechanisms that facilitate transformative learning, as well as to positive change in cognitions and practice of PHNs with regard to solution-focused parenting support. In addition, throughout the AI, the researcher was able to integrate the roles of researcher, facilitator, expert, and critical friend. As observed in studies by Wittmayer and Schäpke (2014) and by Peltola et al. (2023), these roles are important to the creation of collaborative spaces for knowledge building, learning, and practical transformation, while also allowing for self-reflection on the researcher's influence on the process and results of AI. More specifically, the AI research protocol applied in this study devotes special attention to the execution of each of these roles, as well as to their added value for facilitating the transformative learning process of PHNs. Despite the flexibility and reflexivity that the combination of roles demands from one person (the researcher), it made it easier to shift between them as needed. Finally,

each of the studies in this thesis directed considerable effort toward designing and testing measurement tools in a structured manner with relevant stakeholders.

Limitations

Several considerations should be taken into account when reviewing the results of these studies. First, although the sample of PHNs in the survey was large and distributed across the various regions of the Netherlands, and although it is assumed that the results can be generalized to all Dutch PHNs, this assumption cannot be substantiated, as the background characteristics of the entire population are unknown. Second, the sample of respondents to the questionnaire on beliefs and intention with regard to solution-focused parenting support was different from the sample addressed in the first study investigating the characteristics of parenting support. For this reason, it is not possible to draw any conclusions about the association between the intention of PHNs and their actual solution-focused behavior. Third, in the AI the behavioral-change outcomes were based on self-reports. Although these changes were investigated through critical questioning by the expert, no firm conclusions can be drawn. A fourth limitation of the research in this thesis is that outcomes are explored solely from the perspective of PHNs. Finally, transformative learning is defined as "processes that result in significant and irreversible changes in the way a person experiences, conceptualizes, and interacts with the world" (Hoggan, 2016, p. 71). Whether the cognitive and behavioral changes aimed at solution-focused parenting support were truly irreversible, and thus transformational, cannot be concluded based on the results of the fourth study. Hoggan (2016) describes a combination of typology and criteria that could be used to analyze the extent of transformative learning as an outcome. It involves the depth (evidence of deep impact), breadth (evidence of impact on multiple life contexts), and relative stability (evidence that change is not temporary) of change (e.g., in an individual's worldview and behavior) (Hoggan, 2016). In the AI, these criteria were not used as part of the outcome measure. Although PHNs made statements that could be interpreted as indications of transformative change (e.g., "I've changed my habit to think about problems and barriers. I am a changed person;" and "Questioning exception times is a panacea"), no claims can be made about the depth, breadth, and relative stability of these changes.

Recommendations for future research

The findings of the studies in this thesis point to several recommendations for future research. First, research into the characteristics of the entire population of PHNs in the Netherlands would enhance the generalizability of the results of

national studies concerning solution-focused parenting support among PHNs.
Second, determining the longer-term effect of AI on transformative learning aimed at solution-focused parenting support in YH calls for a longitudinal study design based on AI with a local YH organization. In this process, transformative learning (e.g., as described by Hoggan, 2016) should be measured at several different time points to determine the depth, breadth, and relative stability of the changes.
Given that different types of outcomes require different types of measures, future research should pay special attention to the use and/or development of valid and reliable measures to determine change (e.g., in the worldview and behavior of PHNs regarding solution-focused parenting support) resulting from AI.
Third, future research should also entail the in-depth exploration of the effectiveness of solution-focused parenting support, including positive outcomes for parents and children, as well as benefits for professionals. One condition for such research, however, is that the intervention provided must meet the requirements of program integrity. This currently does not seem to be the case. For this reason, the short-term focus of research into solution-focused parenting support in YH should be on further professional development.

Recommendations for policy and practice

Based on the results of the first study, the time and resources that have been invested in previous implementation activities do not appear to have produced the desired results. Several recommendations could be formulated to reinforce the transformative learning processes in cases of radical change, as in the shift from problem-focused to solution-focused parenting support among PHNs.
First, the AI was an intensive process, and it was still in progress at the end of the final study. The results of this thesis could nevertheless be used to intensify the participation of PHNs and to facilitate transformative learning processes from the very start of implementation into the maintenance stage. Compared to current implementation activities, more focus is needed on firm facilitation of the change and maintenance stages of implementation, given that they are the stages in which transformative learning truly occurs.
Second, the participation of an expert in solution-focused parenting support throughout the entire transformative learning process is recommended in order to warrant program integrity. In addition to contributing knowledge in the co-constructive process, this expert can affirm the moments of deep insight into solution-focused parenting support that PHNs experience (“aha! moments”).
Finally, AI could also be applied as a more practical form of action learning in the daily practice of YH. The participation of a facilitator and an expert in solution-

focused parenting support nevertheless seems essential to facilitating this process, adding knowledge, and maintaining program integrity. The role of critical friend is also essential, and it could be integrated into the expert role.

Concluding remark

As demonstrated by the results of this thesis, three years after the implementation of solution-focused parenting support in YH, the parenting support that PHNs were providing to parents experiencing mild parenting problems was of a predominantly problem-focused character. The beliefs of PHNs about solution-focused parenting support at that stage were moderately positive to positive, and their intention to provide such support was high. These results highlight the need for additional efforts to facilitate the shift towards solution-focused parenting support.

The results of this thesis further demonstrate the ability of AI to facilitate the process of change from problem-focused to solution-focused parenting support among PHNs. Strong facilitation of the entire process as part of their daily practice and the participation of an expert and critical friend is necessary in order for PHNs to learn, remain engaged and, ultimately, to grow and flourish towards providing solution-focused parenting support that complies with the integrity of the intervention.

Organizations that provide YH should be aware that, if they aspire to achieve a radical change, they will need to make firm investments in the long-term facilitation and participation of PHNs in order to ensure their ongoing motivation and effort, which is required for the implementation of change.

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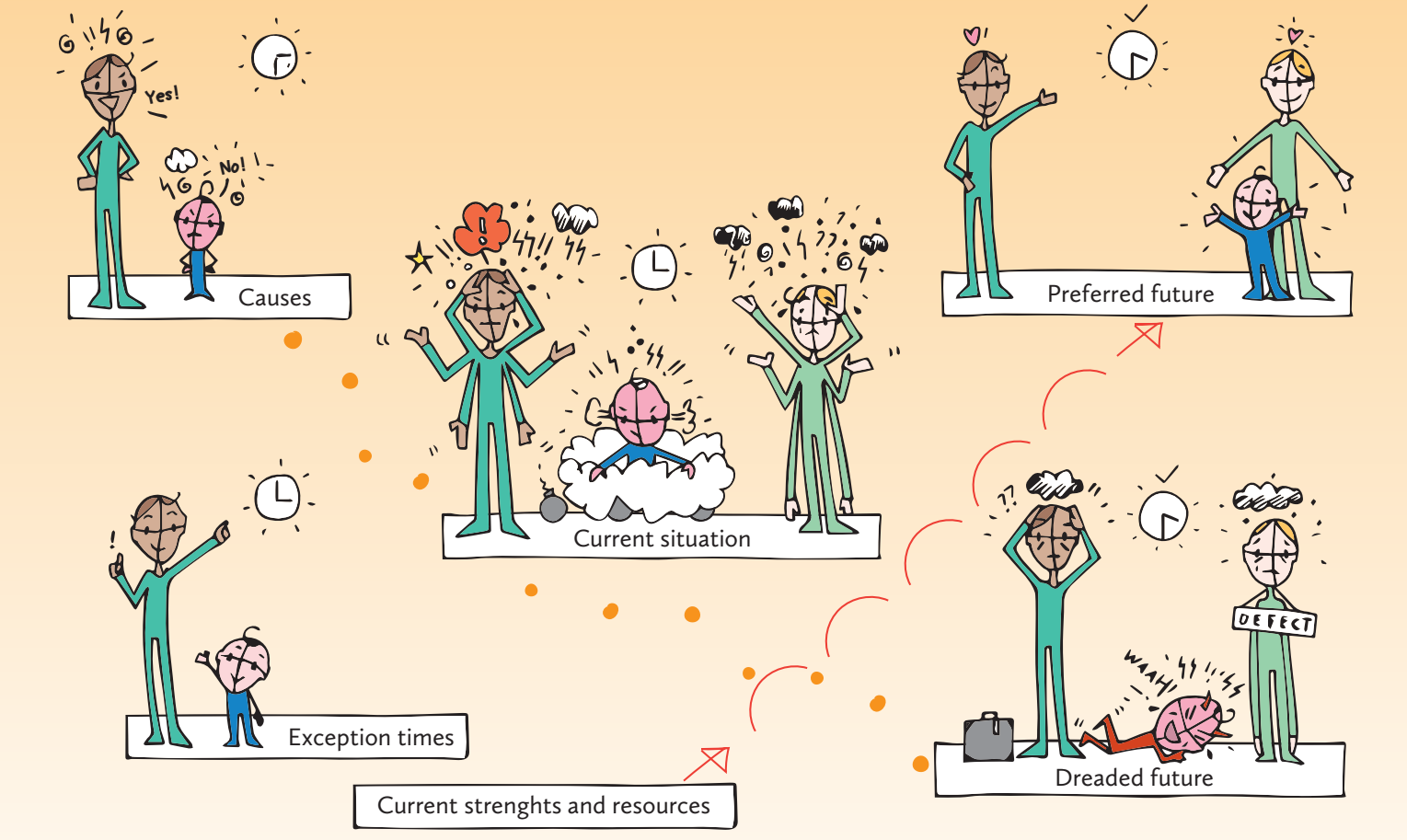
Appendix A

Illustration of difference between problem-focused and solution-focused parenting support


Yes!
No!
Causes
Current situation
Preferred future
Exception times
DEFECT
WAAH!
Dreaded future
Current strenghts and resources
PAST
PRESENT
FUTURE

Appendix B

Intention to provide solution-focused parenting support questionnaire

Demographic questions		
A1	What is your gender?	o Female o Male
A2	What is your age?	o 20–30 o 31–40 o 41–50 o 51–60 o 61–67
A3	At which organization are you employed?	▼
A4	Have you been trained in solution-focused parenting support?	o Yes o No
A5	How many years have you been working as a public health nurse?	o 0–5 o 6–10 o 11–15 o 16–20 o 21–25 o 26–30 o 31–35 o 36–40 o >40
Behavioral beliefs questions		
If I provide or would provide solution-focused parenting support to parents with mild parenting problems ...		
B1	... the same result is achieved in less time.	Totally disagree 1-2-3-4-5-6-7 Totally agree
B2	... the motivation of parents is stimulated.	Totally disagree 1-2-3-4-5-6-7 Totally agree
B3	... it stimulates a good contact with parents.	Totally disagree 1-2-3-4-5-6-7 Totally agree
B4	... the parents' perspective is central in the support process.	Totally disagree 1-2-3-4-5-6-7 Totally agree
B5	... I adopt a positive approach.	Totally disagree 1-2-3-4-5-6-7 Totally agree
B6	... the support process is less time-efficient than other support approaches.	Totally disagree 1-2-3-4-5-6-7 Totally agree
B7	... parents become more active in finding a suitable solution.	Totally disagree 1-2-3-4-5-6-7 Totally agree
B8	... I cannot deploy my professional knowledge.	Totally disagree 1-2-3-4-5-6-7 Totally agree
B9	... the strengths of parents are being confirmed.	Totally disagree 1-2-3-4-5-6-7 Totally agree
B10	Solution-focused parenting support is suitable in all cases of parenting support.	Totally disagree 1-2-3-4-5-6-7 Totally agree
Normative beliefs questions		
B11	Stakeholders think I should provide solution-focused parenting support to parents with mild parenting problems.	Totally disagree 1-2-3-4-5-6-7 Totally agree
B12	The management of my organization wants me to provide solution-focused parenting support to parents with mild parenting problems.	Totally disagree 1-2-3-4-5-6-7 Totally agree
B13	I assume my colleagues think I should provide solution-focused parenting support to parents with mild parenting problems.	Totally disagree 1-2-3-4-5-6-7 Totally agree
B14	Nurseries, preschools, and schools expect me to provide solution-focused parenting support to parents with mild parenting problems.	Totally disagree 1-2-3-4-5-6-7 Totally agree

Control beliefs questions		
B15	If I provide or would provide solution-focused parenting support to parents with mild parenting problems, I work according to a concrete methodology.	Totally disagree 1-2-3-4-5-6-7 Totally agree
B16	If I provide or would provide solution-focused parenting support to parents with mild parenting problems, I find it difficult to ask correct solution-focused questions.	Totally disagree 1-2-3-4-5-6-7 Totally agree
B17	The time available in youth healthcare to provide solution-focused parenting support to parents with mild parenting problems is insufficient.	Totally disagree 1-2-3-4-5-6-7 Totally agree
B18	The training "solution-focused parenting support" as offered by the youth healthcare is sufficient.	Totally disagree 1-2-3-4-5-6-7 Totally agree
B19	For me, carrying out peer supervision sessions into solution-focused parenting support is ...	Difficult 1-2-3-4-5-6-7 Easy
B20	For me, providing solution-focused parenting support to unmotivated parents is ...	Difficult 1-2-3-4-5-6-7 Easy
B21	For me, gaining experience in solution-focused parenting support in daily practice is ...	Difficult 1-2-3-4-5-6-7 Easy
B22	I have insufficient knowledge about solution-focused parenting support to parents with mild parenting problems.	Totally disagree 1-2-3-4-5-6-7 Totally agree
Intention questions		
C1	Generally, I expect to provide solution-focused parenting support to parents with mild parenting problems	Totally disagree 1-2-3-4-5-6-7 Totally agree
C2	Generally, I intend to provide solution-focused parenting support to parents with mild parenting problems	Totally disagree 1-2-3-4-5-6-7 Totally agree
C3	Generally, I want to provide solution-focused parenting support to parents with mild parenting problems	Totally disagree 1-2-3-4-5-6-7 Totally agree
Attitude questions		
C4	Generally, I think providing solution-focused parenting support to parents with mild parenting problems is	Bad 1-2-3-4-5-6-7 Good
C5	Generally, I think providing solution-focused parenting support to parents with mild parenting problems is	Not helping 1-2-3-4-5-6-7 Helping
C6	Generally, I think providing solution-focused parenting support to parents with mild parenting problems is	Unpleasant 1-2-3-4-5-6-7 Pleasant for me
C7	Generally, I think providing solution-focused parenting support to parents with mild parenting problems is	Unimportant 1-2-3-4-5-6-7 Important

Subjective norm questions		
C8	Generally, it is expected of me that I provide solution-focused parenting support to parents with mild parenting problems	Totally disagree 1-2-3-4-5-6-7 Totally agree
C9	People who are important to me at work think I should provide solution-focused parenting support to parents with mild parenting problems	Totally disagree 1-2-3-4-5-6-7 Totally agree
C10	Generally, I feel under social pressure to provide solution-focused parenting support to parents with mild parenting problems	Totally disagree 1-2-3-4-5-6-7 Totally agree
C11	People who are important to me at work want me to provide solution-focused parenting support to parents with mild parenting problems	Totally disagree 1-2-3-4-5-6-7 Totally agree
Perceived behavioral control questions		
C12	Whether I provide solution-focused parenting support to parents with mild parenting problems is entirely up to me	Totally disagree 1-2-3-4-5-6-7 Totally agree
C13	For me, providing solution-focused parenting support to parents with mild parenting problems is	Difficult 1-2-3-4-5-6-7 Easy
C14	I am confident that I could provide solution-focused parenting support to parents with mild parenting problems if I wanted to	Totally disagree 1-2-3-4-5-6-7 Totally agree
C15	The decision to provide solution-focused parenting support to parents with mild parenting problems is beyond my control	Totally disagree 1-2-3-4-5-6-7 Totally agree

Summary

Introduction

Parenting support for addressing mild parenting problems is a key early intervention deployed by public health nurses as part of youth healthcare in the Netherlands. Youth healthcare is an integral element of the Dutch public healthcare system, aimed at promoting physical and mental well-being among all children aged 0–18, and ensuring equal opportunities for a healthy development.

Historically, the parenting support offered by Dutch public health nurses has been problem-focused in nature, concentrating on solving typical problems by intervening on their presumed causes. As part of a system reform (2011), the approach of parenting support in youth healthcare has shifted from problem-focused to solution-focused. Solution-focused parenting support is a strength-based and future-oriented approach that aims to empower parents, improve parenting skills, and increase the ability of parents to solve future problems more independently. It seeks to solve parenting problems by identifying the preferred future, situations in which the problem does not exist (i.e., exception times), and the strengths and resources available to parents to reach this preferred future. Moreover, it taps into and reinforces the available strengths, resources, and problem-solving competencies of parents. A fundamental assumption in the process of solution-focused parenting support is that parents are aware of their preferred future, current strengths, and resources, and that they have the abilities needed to achieve their desired goals in a systematic manner. The perspective of the parent thus plays a vital role in all stages of solution-focused parenting support.

The shift from problem-focused to solution-focused parenting support aimed at normalizing mild parenting problems and strengthening the self-direction of parents. To facilitate this shift, a new parenting support guideline was introduced in youth healthcare, and various initiatives were undertaken to promote solution-focused parenting support among public health nurses, including a training and peer supervision sessions. The shift was expected to be complex for public health nurses, given the profound differences between problem-focused and solution-focused approaches. Yet, there was limited research on the implementation of solution-focused parenting support in youth healthcare and on effective mechanisms to assist public health nurses in changing toward this approach. This thesis aims to contribute to the shift toward solution-focused parenting support by examining the current state of solution-focused parenting support among public health nurses and by exploring ways to further facilitate the shift to solution-focused parenting support by public health nurses. Specific aims, methods, and results will be elaborated on in the next paragraph.

Exploring the current state of solution-focused parenting support

Chapter 2

The problem-focused and solution-focused characteristics of parenting support as provided by public health nurses, three years after solution-focused parenting support was implemented, were explored in the first, qualitative study in this thesis. Therefore, fifteen parenting support sessions across ten public health nurses and parents were audio recorded. A content analysis was used to identify problem-focused and solution-focused characteristics of the parenting support. The analysis revealed that both problem-focused and solution-focused features were present in the parenting support provided by public health nurses. However, problem-focused characteristics dominated in professional messages at all stages of the support.

Chapter 3

Subsequently, public health nurses' beliefs about solution-focused parenting support were explored. A survey was developed and administered to Dutch public health nurses to examine their behavioral, normative and control beliefs regarding solution-focused parenting support. First, beliefs were elicited through focus group discussions with public health nurses from different youth healthcare organizations. The data were analyzed using thematic analysis. The salient behavioral, normative and control beliefs of public health nurses about solution-focused parenting support were included in the questionnaire. After conducting the questionnaire, belief scales were statistically examined for internal consistency (Cronbach's alpha) and mean scores. Furthermore, differences based on background factors were explored using independent t-tests and ANOVA. The survey was completed by 449 public health nurses (response rate: 57.5%). Survey findings indicated that public health nurses held moderately positive to positive beliefs regarding solution-focused parenting support. Compared to behavioral and normative beliefs, public health nurses scored the lowest on control beliefs.

Chapter 4

Next, the intention of public health nurses to provide solution-focused parenting support was explained by the concepts attitude, subjective norm, and perceived behavioral control from the theory of planned behavior. To achieve this objective, survey questions grounded in this theory were included in the questionnaire also measuring public health nurses' beliefs (chapter 3). After conducting the questionnaire, first internal consistency, and reliability (Cronbach's alpha) were individually determined for attitude, subjective norm, perceived behavioral control, and intention. Second, since the participants (level 1) were nested within their

organizations (level 2), the intraclass correlation coefficient was calculated to evaluate whether it was necessary to control for the organizational effect. Finally, structural equation modeling was used to explain the variance in public health nurses' intention to provide solution-focused parenting support, focusing on attitude, subjective norms, and perceived behavioral control. The results showed that public health nurses have a strong intention to provide solution-focused parenting support. Together, the theory of planned behavior concepts accounted for 53% of the variance in the intention among public health nurses to provide solution-focused parenting support.

Exploring ways to further facilitate the shift

Chapter 5

The fourth study investigated a new way of facilitating the shift to solution-focused parenting support in youth healthcare. The central aim in this part was to examine whether and how appreciative inquiry could facilitate transformative learning and related changes toward solution-focused parenting support among public health nurses. Data were collected, using appreciative inquiry in a stepwise participatory action research protocol. This protocol included ten group meetings, each lasting 3.5 hours. During these meetings, semi-structured individual and focus group interviews were conducted. The data were analyzed using nominal group technique and thematic analysis. As a result of participating in the appreciative inquiry, public health nurses reported both cognitive and behavioral changes toward to solution-focused parenting support. Six key mechanisms were identified by public health nurses as facilitating these changes: organizational preconditions, theory on solution-focused parenting support as the backbone of the entire process, preconditions of group meetings, characteristics of appreciative inquiry, collaborative analysis, and ownership. Within these mechanisms, the importance of expert guidance, structured facilitation, and long-term investment by the organization in the daily practice of public health nurses was emphasized.

Recommendations for future research

Future research should entail the in-depth exploration of the effectiveness of solution-focused parenting support, including positive outcomes for parents and children, as well as benefits for professionals. Furthermore, longitudinal research is recommended to assess the long-term effects of appreciative inquiry on transformative learning, measuring changes over time.

Recommendations for policy and practice

To further promote solution-focused parenting support in youth healthcare, more focus is needed on firm facilitation of the change and maintenance stages of implementation, given that these are the stages in which transformative learning truly occurs. Moreover, using appreciative inquiry as a practical learning tool within the daily practice of public health nurses, supported by facilitators and solution-focused experts, seems essential to facilitating this transformative learning process, and maintaining program integrity.

Concluding remark

This thesis found that three years after the introduction of solution-focused parenting support, Dutch public health nurses still predominantly employed problem-focused parenting support when addressing mild parenting problems. While public health nurses showed moderately positive to positive beliefs and strong intentions toward adopting solution-focused parenting support, greater efforts are needed to facilitate this transition fully.
Organizations that provide youth healthcare should be aware that if they aspire to achieve a radical change, they will need to make firm investments in the long-term facilitation and participation of public health nurses in order to ensure their ongoing motivation and effort, which is required for the implementation of change. This research on the shift from problem-focused to solution-focused parenting support in youth healthcare highlights the ability of appreciative inquiry to facilitate such a radical change process.

Samenvatting

Introductie

Opvoedingsondersteuning bij milde opvoedingsproblemen is een belangrijke vroegtijdige interventie, die wordt ingezet door jeugdverpleegkundigen werkzaam in de jeugdgezondheidszorg. Jeugdgezondheidszorg is een integraal onderdeel van het Nederlandse publieke gezondheidszorgsysteem, gericht op het bevorderen van het fysieke en mentale welzijn van alle kinderen in de leeftijd van 0-18 jaar, waarbij gelijke kansen voor een gezonde ontwikkeling worden gewaarborgd.

Historisch gezien is de opvoedingsondersteuning door jeugdverpleegkundigen probleemgericht van aard. Hierbij staat het oplossen van problemen door in te grijpen op de veronderstelde oorzaken centraal. Als onderdeel van de Stelselherziening Jeugd (2011) is de wijze van opvoedingsondersteuning in de jeugdgezondheidszorg veranderd van probleemgericht naar oplossingsgericht. Oplossingsgerichte opvoedingsondersteuning is een kracht- en toekomstgerichte aanpak die erop gericht is om ouders te empoweren, opvoedingsvaardigheden te verbeteren en hun vermogen te vergroten om toekomstige problemen meer zelfstandig op te lossen. Oplossingsgerichte opvoedingsondersteuning probeert opvoedingsproblemen op te lossen door de gewenste toekomst van ouders, situaties waarin het probleem niet bestaat (d.w.z. uitzonderingsmomenten) en de krachten en hulpbronnen waarover ouders beschikken om de gewenste toekomst te bereiken, te identificeren. Vervolgens worden de beschikbare krachten, hulpbronnen en probleemoplossende competenties van ouders aangeboord en versterkt. Een fundamentele aanname in het proces van oplossingsgerichte opvoedingsondersteuning is dat ouders zich bewust zijn van hun gewenste toekomst, huidige krachten en hulpbronnen, en dat ze de vaardigheden hebben die nodig zijn om hun gewenste doelen op een systematische manier te bereiken. Het perspectief van de ouder speelt dus een centrale rol in alle fasen van oplossingsgerichte opvoedingsondersteuning.
De verandering van probleemgerichte naar oplossingsgerichte opvoedingsondersteuning was gericht op het normaliseren van milde opvoedingsproblemen en het versterken van de zelfregie van ouders. Om deze verandering te faciliteren, werd een nieuwe richtlijn opvoedingsondersteuning geïntroduceerd. Daarnaast werden verschillende initiatieven ondernomen om oplossingsgerichte opvoedingsondersteuning onder jeugdverpleegkundigen te bevorderen, waaronder training en intervisiebijeenkomsten. Gezien de fundamentele verschillen tussen een probleemgerichte en oplossingsgerichte benadering, werd verwacht dat deze verandering voor jeugdverpleegkundigen complex zou zijn.

Onderzoek naar de implementatie van oplossingsgerichte opvoedingsondersteuning in de jeugdgezondheidszorg en naar effectieve mechanismen om jeugdverpleegkundigen te helpen bij deze verandering was echter beperkt.
Dit proefschrift wil een bijdrage leveren aan de verandering richting oplossingsgerichte opvoedingsondersteuning door de huidige staat van oplossingsgerichte opvoedingsondersteuning onder jeugdverpleegkundigen in kaart te brengen en door manieren te onderzoeken om de verandering naar oplossingsgerichte opvoedingsondersteuning door jeugdverpleegkundigen verder te faciliteren. Specifieke doelen, methoden en resultaten zullen in de volgende paragraaf in meer detail worden beschreven.

Verkennen van de huidige staat van oplossingsgerichte opvoedingsondersteuning

Hoofdstuk 2

De probleemgerichte en oplossingsgerichte kenmerken van opvoedingsondersteuning zoals geboden door jeugdverpleegkundigen, drie jaar na de implementatie van oplossingsgerichte opvoedingsondersteuning, werden onderzocht in de eerste, kwalitatieve studie van dit proefschrift. Hiervoor werden vijftien opvoedingsondersteuningssessies van tien jeugdverpleegkundigen met ouders opgenomen. Een inhoudsanalyse werd uitgevoerd om probleemgerichte en oplossingsgerichte kenmerken van de opvoedingsondersteuning te identificeren. Uit de analyse bleek dat zowel probleemgerichte als oplossingsgerichte kenmerken aanwezig waren in de opvoedingsondersteuning door jeugdverpleegkundigen. Echter, probleemgerichte kenmerken domineerden de professionele boodschappen in alle fasen van de ondersteuning.

Hoofdstuk 3

Vervolgens werden de overtuigingen van jeugdverpleegkundigen over oplossingsgerichte opvoedingsondersteuning onderzocht. Er werd een enquête ontwikkeld en afgenomen bij Nederlandse jeugdverpleegkundigen om hun gedrags-, normatieve- en controleovertuigingen ten aanzien van oplossingsgerichte opvoedingsondersteuning te onderzoeken. Eerst werden de overtuigingen van jeugdverpleegkundigen uit verschillende jeugdgezondheidszorgorganisaties verzameld via focusgroep discussies. Deze gegevens werden geanalyseerd met behulp van thematische analyse. De meest opvallende gedrags-, normatieve- en controleovertuigingen van jeugdverpleegkundigen over oplossingsgerichte opvoedingsondersteuning werden opgenomen in de vragenlijst. Na het afnemen

van de vragenlijst werden de overtuigingsschalen statistisch onderzocht op interne consistentie (Cronbach's alpha) en gemiddelde scores. Vervolgens werden de verschillen op basis van achtergrondfactoren onderzocht met onafhankelijke t-toetsen en ANOVA. De vragenlijst is door 449 jeugdverpleegkundigen volledig ingevuld (responspercentage 57,5%). Resultaten gaven aan dat jeugdverpleegkundigen over het algemeen gematigd positieve tot positieve overtuigingen hadden over oplossingsgerichte opvoedingsondersteuning. Vergeleken met gedrags- en normatieve overtuigingen scoorden jeugdverpleegkundigen het laagst op controleovertuigingen.

Hoofdstuk 4

Vervolgens werd de intentie van jeugdverpleegkundigen om oplossingsgerichte opvoedingsondersteuning te geven, verklaard aan de hand van de concepten attitude, subjectieve norm en waargenomen gedragscontrole uit de theorie van gepland gedrag. Om dit doel te bereiken, werden enquêtevragen gebaseerd op deze theorie opgenomen in de vragenlijst waarin ook de overtuigingen van jeugdverpleegkundigen werden gemeten. Na het afnemen van de vragenlijst werden eerst de interne consistentie en betrouwbaarheid (Cronbach's alpha) individueel bepaald voor attitude, subjectieve norm, waargenomen gedragscontrole en intentie. Vervolgens werd de intraclass correlation coefficient berekend om te testen of het nodig was om te controleren voor een organisatie effect, aangezien de deelnemers (niveau 1) ingebed waren binnen hun organisaties (niveau 2). Ten slotte werd structural equation modeling toegepast om de variantie in de intentie om oplossingsgerichte opvoedingsondersteuning te geven te verklaren aan de hand van de concepten attitude, subjectieve norm en waargenomen gedragscontrole. De resultaten toonden aan dat jeugdverpleegkundigen een sterke intentie hadden om oplossingsgerichte opvoedingsondersteuning te bieden. De concepten uit de theorie van gepland gedrag verklaarden 53% van de variantie in de intentie van jeugdverpleegkundigen om oplossingsgerichte opvoedingsondersteuning te geven.

Verkennen van manieren hoe de verandering verder te faciliteren

Hoofdstuk 5

De vierde studie in dit proefschrift onderzocht een nieuwe manier van het faciliteren van de verandering richting oplossingsgerichte opvoedingsondersteuning in de jeugdgezondheidszorg. Het centrale doel van dit onderdeel was om te onderzoeken of en hoe waarderend onderzoek transformatief leren en gerelateerde veranderingen richting oplossingsgerichte opvoedingsondersteuning onder

jeugdverpleegkundigen zou kunnen faciliteren. Gegevens werden verzameld door gebruik te maken van waarderend onderzoek in een stapsgewijs participatief actieonderzoeksprotocol. Dit protocol omvatte tien groepsbijeenkomsten die elk 3,5 uur duurden. Tijdens deze bijeenkomsten werden semigestructureerde individuele en focusgroep interviews afgenomen. Deze gegevens werden geanalyseerd met behulp van nominale groepstechniek en thematische analyse. Als resultaat van hun deelname aan het waarderend onderzoek, rapporteerden jeugdverpleegkundigen zowel cognitieve- als gedragsveranderingen richting oplossingsgerichte opvoedingsondersteuning. De jeugdverpleegkundigen identificeerden zes sleutelmechanismen, die deze veranderingen faciliteerden: organisatorische randvoorwaarden, theorie over oplossingsgerichte opvoedingsondersteuning als de ruggengraat van het hele proces, randvoorwaarden van groepsbijeenkomsten, kenmerken van waarderend onderzoek, participatieve analyse en eigenaarschap. Binnen deze mechanismen werd het belang van inhoudsdeskundige begeleiding, gestructureerde facilitering en lange termijn investeringen door de organisatie in de dagelijkse praktijk van jeugdverpleegkundigen geaccentueerd.

Aanbevelingen voor toekomstig onderzoek

Toekomstig onderzoek moet de effectiviteit van oplossingsgerichte opvoedingsondersteuning, inclusief positieve uitkomsten voor ouders en kinderen en voordelen voor professionals, grondig onderzoeken. Daarnaast wordt longitudinaal onderzoek aanbevolen om de langetermijneffecten van waarderend onderzoek op transformatief leren te beoordelen, waarbij veranderingen in de loop van de tijd worden gemeten.

Aanbevelingen voor beleid en praktijk

Om oplossingsgerichte opvoedingsondersteuning in de jeugdgezondheidszorg verder te bevorderen, is meer aandacht nodig voor het stevig faciliteren van de veranderfase en behoudfase van implementatie, aangezien in deze fasen zijn het transformatief leren echt plaatsvindt. Bovendien lijkt het gebruik van waarderend onderzoek als een praktisch leermiddel binnen de dagelijkse praktijk van jeugdverpleegkundigen, ondersteund door facilitators en oplossingsgerichte experts, essentieel om dit transformatief leerproces te faciliteren en de integriteit van het programma te behouden.

Eindconclusie

Dit proefschrift laat zien dat drie jaar na de introductie van oplossingsgerichte opvoedingsondersteuning, Nederlandse jeugdverpleegkundigen nog steeds voornamelijk probleemgerichte opvoedingsondersteuning toepasten bij de aanpak van milde opvoedingsproblemen. Hoewel jeugdverpleegkundigen gematigd positieve tot positieve overtuigingen en sterke intenties hadden om oplossingsgerichte opvoedingsondersteuning te gaan gebruiken, zijn er meer inspanningen nodig om de verandering richting oplossingsgerichte opvoedingsondersteuning volledig te faciliteren.
Jeugdgezondheidsorganisaties moeten zich ervan bewust zijn dat, wanneer zij een radicale verandering willen, zij stevig zullen moeten investeren in langdurige facilitering en participatie van jeugdverpleegkundigen. Dit zorgt voor hun voortgaande motivatie en inzet, wat noodzakelijk is voor de implementatie van een verandering. Dit onderzoek over de verandering van probleemgerichte naar oplossingsgerichte opvoedingsondersteuning benadrukt het vermogen van waarderend onderzoek om zo'n complex veranderproces te faciliteren.

Dankwoord

Voorafgaand aan het bedanken van mensen die een belangrijke bijdrage hebben geleverd in het proces dat heeft geleid tot dit proefschrift, wil ik beginnen met de leden van de beoordelingscommissie: Em. prof. dr. Raat, prof. dr. van Regenmortel, prof. dr. Reijneveld, dr. Bastiaanssen en dr. Vanneste. Ik dank jullie hartelijk voor jullie inspanningen om het manuscript te lezen, te beoordelen en te voorzien van mooie complimenten en kritische vragen/opmerkingen. Ik vond het, naast alle inhoudelijke punten, fijn te lezen dat mijn nauwgezetheid in het beschrijven van procedures positief is opgevallen; daar heb ik in het bijzonder mijn best voor gedaan. Daarnaast alvast mijn dank dat jullie me op 14 februari 2025 op Tilburg University hier nog verder op gaan bevragen. Ik denk dat ik daar naar uitkijk...

'Over resources gesproken'

In 2013 stond ik bij het koffieapparaat op de Academie voor Gezondheidszorg van Avans Hogeschool. Nicole van Son (directeur) stond naast me en ik zei: "Beste Nicole, er is een grote transformatie gaande binnen het hele jeugdstelsel richting het normaliseren van lichte problemen en het benutten en versterken van de eigen kracht van ouders, kinderen en hun netwerk. Dit heeft ook grote implicaties voor de jeugdverpleegkundige in de jeugdgezondheidszorg en ik zou graag een docentstage willen combineren met een onderzoek naar hoe deze verandering daar vorm krijgt. Daarvoor is de standaard 80 uur voor een docentstage echter wel wat mager. Ik zou hiervoor graag meer uur gefaciliteerd krijgen."

De reactie van Nicole was kort maar krachtig: "Beste Liesbeth, schrijf maar een plan en wat je daarvoor nodig denkt te hebben. Als je me daarmee kunt overtuigen, onderteken ik het!"

En zo geschiedde. Wat begon met een docent-onderzoeksstage van een jaar bij GGD West-Brabant in samenwerking Avans en het lectoraat Jeugd, Gezin en Samenleving (JGS), eindigt nu in dit proefschrift waarvoor ik graag iedereen die hierbij op enige manier betrokken is geweest wil bedanken voor de samenwerking, hulp, ondersteuning en ontspanning die hiertoe hebben bijgedragen. Zonder iemand tekort te willen doen, wil ik een aantal mensen hierbij uitlichten.

Yonna Theunis, bij jou begon het allemaal tijdens de docentstage. Jij was de jeugdverpleegkundige bij wie ik een jaar lang heel veel heb geleerd over de veranderingen in de jeugdgezondheidszorg en heb ik mogen experimenteren met het doen van actieonderzoek. Je liet me toe bij je consulten, je liet je (met toestemming van de ouders) door mij observeren en opnemen op video. Je was net zo betrokken bij de analyse als ik. We hebben echt heel intens een jaar lang samen

geleerd en ontwikkeld, maar oh oh oh, wat hebben we daarnaast ook heel veel lol gehad. Bedankt voor het vertrouwen dat je me gaf om hier mee verder te gaan in een promotieonderzoek!

Nicole van Son, jouw overtuiging dat investeren in de drijfveren van medewerkers loont voor zowel de werkgever als de werknemer, heeft mij de mogelijkheden gegeven om onderzoek te doen ten behoeve van de *praktijk* van jeugdverpleegkundigen, het onderwijs in het verpleegkunde onderwijs bij Avans Hogeschool én de wetenschap rondom de zorg voor jeugd. Heel veel dank daarvoor!

Het plan dat Nicole vroeg had ik natuurlijk nooit in mijn eentje kunnen schrijven. Ik zocht hiervoor contact met ***Lisbeth Verharen****, één van de lectoren verbonden aan het toenmalige lectoraat jeugd, gezin en samenleving (JGS). Lisbeth bleek een heel fijn en toegankelijk mens én een grote inspiratiebron bij het ontwerpen van een haalbaar actiegericht onderzoek voor mijn plan. Lisbeth, ik wil je danken voor onze fijne samenwerking in de onderzoeksstage, en je begeleiding richting de start van het promotie onderzoek. Je hebt bij mij het participatief actieonderzoek-zaadje geplant en groei is sindsdien continu, stap-voor-stap aanwezig!*

Erna Hooghiemstra, tevens lector van het lectoraat JGS, ook jou ben ik dankbaar. In het bijzonder wil ik je danken dat je bij de start van het promotie onderzoek de rol van co-promotor op je nam, toen Lisbeth Avans verliet voor een prachtige baan bij de HAN. Jouw inzet om je te verdiepen in en aan te sluiten bij reeds genomen besluiten heeft ertoe bijgedragen dat het opstartproces van het promotieonderzoek op Tilburg University zonder veel vertraging door kon gaan.

Dat brengt me bij mijn begeleiders op Tranzo. Daarvoor wil ik ***Marjan de Kluijver*** *alvast noemen. Zij wist mij namelijk richting Tranzo en één van mij uiteindelijke promotoren te adviseren. Een hele goede zet, Marjan!! Nu, zoveel jaren later sta je me als paranimf bij. De cirkel is rond! Over jou later nog meer.....*

Ien van de Goor, een van mijn promotoren. Ik weet nog onze eerste kennismakingsafspraak bij GGD-West Brabant. Ik zag je en voelde binnen enkele minuten een 'klik'. Dat besluit was snel genomen en daar heb ik nooit spijt van gehad. In de eerste periode werd het even wat lastig voor me. Waar ik van nature hecht aan duidelijke criteria aan de voorkant van een proces, werd me dit in het begin van het proces helemaal niet zo duidelijk. Dat maakte me wat onrustig. Je gaf me echter het vertrouwen dat ik in het proces daar met jou aan mijn zijde wel achter ging komen. Stap voor stap. En dat is ook zo gebleken. Je bent kritisch en eerlijk, wist me altijd te prikkelen tot het opdoen van meer kennis. Soms moest

ik na een overleg zelfs eerst op zoek naar de betekenis van je vraag, voordat ik op zoek kon gaan naar de antwoorden. Daar heb ik van genoten en heel veel van geleerd. Dank daarvoor!!

Het onderwerp van dit proefschrift ligt op het snijvlak van publieke gezondheid en jeugd. Een logische begeleidingscombinatie vanuit Tranzo leek dan ook snel Ien van de Goor (academische werkplaats publieke gezondheid) en Jolanda Mathijssen (academische werkplaats jeugd).

Jolanda Mathijssen, mijn grote steun en toeverlaat als 'dagelijks begeleider' in dit hele proces. Je zei dat je deur altijd zou open staan. Dat was ook zo en daar heb ik dankbaar gebruik van gemaakt. Ik heb je ervaren als betrokken, kritisch, waarderend en als een kei in 'begeleiden/ondersteunen zonder over te nemen'. In al die jaren in ons frequente contact heb jij, naast het intensief volgen van mijn stappen in het onderzoeksproces, al mijn mogelijke emoties wel voorbij zien komen. Het fijne was dat het er bij jou allemaal mocht zijn. Dat heeft me steeds lucht gegeven om weer verder te gaan binnen mijn mogelijkheden op dat moment.

Heel belangrijk in alle fasen van dit proces is mijn co-promotor *Carin Rots*. Carin, jij begon als grote verbinder tussen mij, Tranzo en GGD West-Brabant (de praktijkpartner van dit promotieonderzoek). De inspanningen die jij hebt geleverd om dit promotieonderzoek mogelijk te maken waren enorm. Hoe zuur was het dan ook dat er aanvankelijk geen plaats voor jou was in mijn begeleidingsteam. Er waren drie plaatsen te vergeven en die plaatsen waren ingevuld door Ien, Jolanda en Lisbeth/Erna. Jij bleef je echter voor me inspannen waar je dat zinvol achtte. Dat heeft zeker in de beginfase sterk bijgedragen aan mijn introductie in de GGD organisatie en de belangrijke stakeholders binnen die organisatie. Op het moment dat er een plaats vrij kwam in het begeleidingsteam was het dan ook een heel logische keuze om jou hieraan toe te voegen. Ik dank je voor al je feedback, je praktische hulp bij het uitvoeren van onderzoeksactiviteiten en het delen van je passie voor participerend onderzoek.

GGD West-Brabant was de praktijkpartner van dit promotie onderzoek, en voor mij is *Bernadette van Oers*, toenmalig manager van de jeugdgezondheidszorg, heel belangrijk geweest in het mogelijk maken van alle onderzoeksactiviteiten binnen deze organisatie. Je gaf me de ruimte om te doen wat nodig was en ik kreeg de benodigde faciliteiten binnen de organisatie. Je had een heel sterke overtuiging dat oplossingsgericht werken de sleutel was tot het benutten en versterken van eigen krachten. In mijn gesprekken met jou was dit in alles voelbaar. Mijn onderzoek ging natuurlijk over de weg van de jeugdverpleegkundigen hier naartoe en bij het voorstel tot waarderend actieonderzoek werd je wel heel enthousiast. Deze

vorm van onderzoek was op zichzelf namelijk heel oplossingsgericht van karakter. Praktisch zou dit onderzoek echter wel betekenen dat de wensen en mogelijkheden tot groei van de jeugdverpleegkundigen leidend zouden zijn, en dat zij dus ook de mogelijkheid moesten hebben om bepaalde (organisatorische) veranderingen door te voeren. Dat betekende dat jij daar een bepaalde controle ging loslaten en vertrouwen moest hebben in de expertise van de jeugdverpleegkundigen. Dit leek voor jou haast vanzelfsprekend. Je begreep dit en ging daar in mee. Dat vond ik een heel bijzonder moment!

Na een pauzeperiode van het lectoraat jeugd, gezin en samenleving bij Avans Hogeschool kwam er een doorstart met een nieuwe lector: *Christa Nieuwboer*. De focus van het lectoraat sloot niet helemaal aan bij het onderwerp van dit promotieonderzoek. Bovendien was er in mijn begeleidingsteam inmiddels ook geen plaats meer voor een lector als co-promotor. Dat leverde een situatie op waarin belangen niet altijd overeenkwamen, maar we ons wel tot elkaar moesten verhouden. Dat was soms geen eenvoudige klus. Ik ben jou, Christa, echter wel dankbaar voor de investering die je hebt gedaan in mijn promotieonderzoek. Je bent de afspraken die ik in de beginfase met het lectoraat ben overeengekomen nagekomen, wat mij ruimte heeft gegeven om de onderzoeken goed voort te kunnen zetten. Daarnaast heb je steeds inspanning geleverd om mij te verstaan in mijn behoeften, wat soms niet eenvoudig is als ik gedreven ben (al zeg ik het zelf...).

Na 4 jaar was mijn beschikbare tijd voor promotie vanuit het lectoraat op. Ik was echter nog niet klaar. In die periode waren alle betrokkenen van Avans bij de start van mijn promotie onderzoek inmiddels niet meer bij Avans werkzaam. Bij wie moest ik nu aankloppen? Gelukkig kwam daar *Tina Hoogstraaten*, de kersverse directeur van onze academie. Tina, je kende me niet, je kende mijn historie niet en toch wist je mijn verhaal en behoefte snel op waarde te schatten. Jouw basishouding van vertrouwen maakte dat we samen op zoek gingen naar resterende mogelijkheden om dit traject mooi af te ronden. Dat was precies wat ik op dat moment nodig had. Heel veel dank!

Voor de kwaliteit van de uitvoering van de verschillende onderzoeken zijn voor mij heel veel mensen elk op hun eigen wijze heel belangrijk geweest.

Allereerst, alle ***jeugdverpleegkundigen*** die hebben deelgenomen aan de verschillende onderzoeken. De belofte van anonimiteit weerhoudt me hier bij het noemen van namen, dat zou ik natuurlijk het liefste doen. In totaal hebben ruim 450 jeugdverpleegkundigen aan dit proefschrift meegewerkt. In de eerste studie waren dit 10 jeugdverpleegkundigen van GGD West-Brabant. Ik ben deze verpleegkundigen heel dankbaar dat zij de moed hadden om hun

opvoedondersteuningsgesprekken aan ouders op te nemen en door een relatief onbekende zo kritisch te laten analyseren. Voor het vragenlijstonderzoek hebben 449 jeugdverpleegkundigen van 12 verschillende organisaties door het hele land de vragenlijst volledig ingevuld. Dat was een enorme respons. Als voormalig jeugdverpleegkundige weet ik als geen ander dat jeugdverpleegkundigen heel drukke agenda's hebben en dat er altijd nieuwe ontwikkelingen zijn die aandacht vragen. Wat fijn was het daarom om zoveel ingevulde vragenlijsten terug te ontvangen. Als laatste, het team van jeugdverpleegkundigen die samen met mij het waarderend actieonderzoek hebben vormgegeven. Ieder had zijn eigen rol en expertise, maar gelijkwaardigheid en samenwerking was de basis. De openheid, eerlijkheid, gedrevenheid, kwetsbaarheid en het respect voor onderlinge diversiteit in de bijeenkomsten waren goud waard. We hebben samen geleerd, ontworpen, geëxperimenteerd, gereflecteerd en daarnaast ook heel veel plezier gehad met elkaar. Ik ben dit promotieonderzoek gestart met onder andere een ambitie tot het leren van het doen van actieonderzoek en ik ben jullie dankbaar voor de mogelijkheden die jullie hiervoor gecreëerd hebben. Het is echt een win-win situatie gebleken!
P.S.: De kip en 'kuiken Liesbeth' staan nog steeds in mijn tuin te pronken.

Verder is mijn dank groot aan *Petra Veninga* en *Judith van Groos*. Jullie hebben samen met mij verschillende onderdelen van het onderzoek uitgevoerd en mij kritisch geëvalueerd als onderzoeker. Ik heb ervan genoten om met jullie samen te werken in de intensiteit van onderzoek uitvoeren. Dat maakte het vele malen leuker, lichter en beter.

Daarnaast veel dank aan de *peergroep met andere onderzoekers* bij Tranzo. In de loop van de tijd is de samenstelling steeds veranderd. Mensen gingen weg en mensen kwamen erbij. Ik ben in dat groepje gedurende de jaren gegroeid van 'een junior die met open mond naar andere onderzoekers en hun reeds geleverde prestaties luisterde' naar 'een senior die steeds meer kritische vragen kon stellen, suggesties kon doen voor ander onderzoek en kon vertellen over eigen onderzoek'. Daarnaast was dit groepje ook fijn voor het ervaren van steun als het even minder ging. Ondanks dat omstandigheden voor iedereen anders zijn, heb ik toch ervaren dat we op één of andere manier in hetzelfde schuitje zaten en elkaar daardoor wat makkelijker begrepen. In de laatste jaren ben ik niet meer zo actief aangehaakt. Dat heb ik jammer gevonden, zeker omdat ik jullie daarmee niet zo goed heb kunnen volgen en ondersteunen. Ik wens de groep van nu veel succes bij het vervolg van het onderzoek!

Er is nog een hele grote groep die vanuit verschillende functies op verschillende wijze ervoor gezorgd hebben dat de praktische zaken rondom het organiseren en uitvoeren van de onderzoeken tot in de puntjes geregeld waren. Ik licht er weer een aantal uit.

Dit zijn ***de mensen van het secretariaat*** op Avans en op Tranzo die ervoor zorgden dat benodigde faciliteiten in orde waren. Dat is ***Dave van de Canon shop*** op Avans, die voor mij de trage weg van het aanvragen van een ordernummer om te kunnen printen omzeilde, zodat ik op het laatste moment (meestal donderdag 16.00u) de posters voor de actieonderzoek-bijeenkomst van de volgende dag kon printen. Dat zijn ook de ***medewerkers van de schoonmaak*** op Avans, die elke maand op de dag van de bijeenkomst van het actieonderzoek, om 7.30u het betreffende lokaal voor mij als eerste gingen poetsen, zodat ik daarna voorbereidingen kon treffen. Dat zijn de ***medewerkers van de catering*** bij Avans. De wijze waarop zij haast geruisloos steeds koffie/thee/lekkers/fruit brachten tijdens de intensieve sessies, heeft bijgedragen aan onze volgehouden aandacht in die 3,5 uur.

In het bijzonder wil ik *Yvonne Gebbe, also known as 'Tante Beun',* bedanken voor haar creatieve bijdragen aan het onderzoek in de vorm van illustraties. Uren hebben we met elkaar gezeten om jou eerst de essentie van het verschil tussen probleemgerichte en oplossingsgerichte opvoedingsondersteuning uit te leggen, waarna jij deze woorden in beelden bent gaan vertalen. Deze beelden verduidelijkten mijn woorden en waren bruikbaar voor het onderzoek en voor de praktijk van jeugdverpleegkundigen. Dat is een grote meerwaarde gebleken! Ook in de laatste fase van 'het proefschrift boekje', heb je wederom een prachtige omslag getekend in dezelfde stijl. Als iemand aan me vraagt wat ik wel een beetje meer zou willen hebben, dan is dan toch wel een heel klein beetje van jouw talent!

Als laatste, wil ik ***Rian van de Pas*** van Rian Ontwerp (grafische vormgeving) bedanken voor het samen vormgeven van het uiteindelijke proefschrift. Dit was al heel lang het plan en ik riep dus al jaren: "Het komt hoor, Rian!!" Nu was het dan eindelijk zover. Ik wil je bedanken voor de structuur tijdens ons eerste gesprek. Je stelde me een aantal vragen ter verduidelijking voor jezelf en vertelde me vervolgens wat je van me nodig had om de klus te kunnen klaren. Super om dat laatste stukje, waarbij ik al mijn kostbare werk aan de buitenwereld tentoon ga spreiden, met vertrouwen in jouw handen achter te kunnen laten. Ieder zijn vak! Hoe fijn om lieve, hartelijke en geduldige mensen als jij in mijn buurt te hebben. Dat is voor mij een hele zorg minder.

Alle eerder genoemden waren heel belangrijk voor de totstandkoming van dit proefschrift. Er zijn ook nog mensen die heel belangrijk waren voor mij als persoon en daarmee dus ook voor de totstandkoming van dit proefschrift.

Allereerst, *mijn ouders Jan en Riki*. Zij hebben mij in 1974 op de wereld gezet met als belangrijke boodschap: "Zeg maar dat je van Boumans bent!" Deze uitspraak heeft mij al van jongs af aan het gevoel gegeven dat alles goed komt, want ik ben van Boumans. Ik heb daardoor durven vragen, experimenteren en veel zelfvertrouwen ontwikkeld. Zelfs in situaties waarin ik óp ben van de zenuwen, zoals bijvoorbeeld op het podium tijdens de verdediging van dit proefschrift, durf ik te geloven dat het goed komt. Dat is een waardevol cadeau, waar ik ze eeuwig dankbaar voor zal zijn. Helaas zijn mijn beide ouders in de afgelopen jaren overleden. Hun trots op mij en op dit promotieproces voel ik echter nog goed. Mijn ouders hebben bij het laatste afscheid beiden aangegeven dat ze het zo erg vinden hier niet bij aanwezig te kunnen zijn. Ik had natuurlijk niets liever gewild. Om mijn arm draag ik mooie armbanden. Een laatste cadeau van mijn ouders als dank voor ons leven samen en voor het moment dat de promotie een feit is. Op deze plek in mijn dankwoord wil ik mijn ouders herinneren in dit kader, waardoor ik op 14 februari mijn proefschrift kan verdedigen en op en top feest kan vieren. Daar kijk ik naar uit!

Patrick, natuurlijk veel dank aan jou, mijn lieve partner. Ondanks dat mijn vraag de afgelopen jaren vaak veel te groot was voor jou om eraan te kunnen voldoen, heb je er werkelijk alles wat in je macht lag aan gedaan om mijn promotieproces te faciliteren. In een periode met ouders die ziek zijn en overlijden, een coronapandemie en puberende dochters hebben we, zonder dit promotietraject, al de nodige uitdagingen doorstaan de afgelopen jaren. Ik ben heel blij dat ons dat gelukt is en dat we onze liefde, die al 32 jaar voortduurt, ook in tijden van 'veel' steeds kunnen blijven vasthouden en aanpassen aan de situatie.

Eline en Margot, onze dochters van inmiddels 19 en 17 jaar oud. Jullie waren dus 11 en 9 toen ik mijn eerste gesprek met Ien van de Goor had..... Lieve meiden, ik ben onnoemlijk trots dat ik jullie moeder ben. Ik dank jullie voor al je **geduld** als ik de afgelopen jaren weer eens afspraken vergat, me dingen niet kon herinneren of weinig tijd voor jullie kon vrijmaken. Ik dank jullie ook voor al je **ongeduld** als ik de afgelopen jaren weer eens afspraken vergat, me dingen niet kon herinneren of weinig tijd voor jullie kon vrijmaken. Ik vind het namelijk fijn dat jullie zo eerlijk en open zijn en je mening durven delen. Blijf dat vooral doen!

Tsja, en dan is er één groepje vriendinnen die meteen hierna genoemd dient te worden: mijn whiskyclub! *Jacqueline Breedveld*, *Jacqueline Roelandt* (oftewel Sjaak) en *Marjan de Kluijver*. Wat jullie voor mij betekenen is haast niet in woorden te vatten. Vriendinnen waarbij ik mijn diepste geheimen deel en weet dat die veilig zijn. Bovendien vriendinnen die eerlijk tegen mij zijn en mij ook kritische feedback kunnen en durven geven. En dat allemaal onder het genot van heerlijke whisky's bij een van ons thuis, op een festival in Nederland, of ergens in Schotland. Tijdens mijn

diepste dalen in dit promotietraject, hebben jullie mij weer laten opveren. Dank daarvoor! We vieren elke 5 jaar ons lustrum als whiskyclub met een leuke whisky trip. Ik kijk nu al uit naar de volgende op Skye!

Datzelfde geldt voor een tweede groepje dat ik graag wil bedanken: C-perta! *Hanneke Oomen* en *Marie-Thérèse van Driel* zijn twee vriendinnen van vroeger. Hanneke, door jou ben ik in de brugklas met een naar aardbei riekende geurpen gemanipuleerd tot vriendschap en daar ben ik je tot op de dag van vandaag heel dankbaar voor. Onze vriendschap omvat alle major life events van ons leven tot nu toe. Ik kijk er altijd naar uit jou (en je mannen) te zien en zoek je op wanneer ik je nodig heb. Je hebt de gave om steeds op zoek te gaan naar de mooie en positieve kant van ingewikkelde zaken. Dat heeft mij geholpen op momenten waarop ik daar moeite mee had. Dank daarvoor! Marie, wij kennen elkaar van de HBO-verpleegkunde opleiding en zijn inmiddels van de planning en de actie. Afspreken met C-perta, dagje weg, weekendje weg, samen fietsen (oh nee, dat is er nog niet van gekomen), wij hebben er altijd wel zin in. De afgelopen jaren waren druk, maar toch lukte het ons om dit te onderhouden. Ik hoop dat onze ambitie om elk jaar een C-perta weekend te organiseren van de grond komt. De positieve energie die ik van je krijg als ik bij je ben is enorm en heb ik de afgelopen jaren gebruikt bij het verder werken aan dit proefschrift. Op naar de toekomst!

Na de publicatie van het eerste artikel ontstond er spontaan een nieuwe traditie met *Marjan de Kluijver* (alwéér) en *Mariëlle Cloïn*. Mariëlle, jou heb ik leren kennen op Tranzo en er was meteen een klik. Toen het eerste artikel geaccepteerd werd voor publicatie was jij een echte aanjager om dit te vieren. Je bleef maar zeggen hoe goed je het vond, dat ik er zelf ook in ging geloven. Als reactie heb ik toen een app-groepje aangemaakt, genaamd 'Eerste publicatieborrel', om met jou en Marjan (jullie hadden al een leuke connectie..) tot een date te komen voor dit moment en voor latere publicatie-feestjes. Sindsdien hebben we elkaar meer en meer ontmoet, veel gezellige dingen in het Bredase ondernomen, is een leuke vriendschap geboren en is de groepsnaam van de app inmiddels gewijzigd in 'Wij weten het' (hierover kan ik helaas niet verder in detail treden). Op de dag dat het manuscript werd goedgekeurd door de beoordelingscommissie en ik dit meldde in de app zat ik 's ochtends op initiatief van jou, Mariëlle, in een heerlijk tentje aan de koffie met brownie en kwam jij, Marjan, 's avonds met een fles Champagne bij mij thuis om het te vieren. Dat was zo fijn. Dank dus voor alle leuke momenten tot nu toe en hopelijk volgen er velen!

Ook wil ik een aantal van mijn vrienden noemen, waarmee ik gericht activiteiten ben gaan oppakken, omdat het gewoon leuk is, ik er blij van word en omdat het soms ernstig noodzakelijk was om te ontspannen.

Sujatha Hoedeman, met jou heb ik menig avond door Breda gewandeld. Effe bijkletsen en lekker bewegen. Dat bewegen was overigens vaak beperkt tot de snelste route richting een café, waar we vervolgens vaak gevraagd werden om te vertrekken in verband met sluitingstijd. Toen het manuscript was goedgekeurd nam je me twee dagen later spontaan mee naar Yerseke voor een oesters & bubbel lunch. Dat was echt een feestje! Bedankt dat je me als paranimf wilt bijstaan bij mijn promotieplechtigheid. Ik kan jouw stabiliteit daar goed gebruiken.
Karin Barendregt, wij zijn onze hobby 'dansen' gaan oppakken. Met grote regelmaat waren wij in de Mezz te vinden voor een avondje Clubbing, 40's up, 80's verantwoord of 90's now. De structuur op zo'n avond is heel duidelijk: een paar biertjes, daarna over op fris, non-stop dansen en weinig interactie (met uitzondering van de lippenstift momentjes dan..). Heerlijk!
Iris van den Brink, toen wij elkaar ontmoetten was er direct een sauna-klik. Daar hebben wij de afgelopen jaren dan ook vaak samen vertoefd. Waar ik in het algemeen altijd van de planning ben, ben ik dat in de sauna dus helemaal niet. Dat inzicht kreeg ik toen ik de eerste keer met jou, Iris, na 3 uur op een ligbedje in de tuin te hebben gelegen, de vraag kreeg of we niet weer eens een sauna in moesten.... Het is fijn om zo lang met iemand tijd te kunnen doorbrengen, zonder dat daarbij gesproken hoeft te worden.

Als laatste, wil ik *mijn collega's van de Academie voor Welzijn, Educatie en Gezondheid bij Avans* bedanken, en in het bijzonder mijn collega's van *onderwijsteam jaar 3-4*. Ik ben er meer niet dan wel geweest in de afgelopen 8 jaar en toch heb ik me altijd onderdeel van het team VP (verpleegkunde) en de rest van de academie gevoeld. Als ik er was, waren jullie enthousiast en geïnteresseerd. Dat vond ik heel bijzonder, zeker omdat er voor jullie veel gebeurde op de academie. Er waren veel ontwikkelingen op het gebied van onderwijsontwikkeling, instroom, uitstroom, nieuwe organisatiestructuur, inwerken nieuwe collega's, afscheid nemen van collega's met een tijdelijk contract, etc. Er waren daarnaast ook vrijdagmiddagborrels, etentjes, teamdagen en nieuw management-vocabulaire in de afgelopen jaren ('regiecirkel', 'gremia', 'portefeuillehouder', ...). Ik kijk er naar uit om terug in die wereld weer intensiever aan te sluiten en vanuit daar de driehoek onderwijs-praktijk-onderzoek verder te versterken en te zien wat er in de toekomst nog op mijn pad komt.

About the author

Liesbeth Theuns-Boumans studied nursing at Avans University of Applied Sciences in Breda. She graduated in 1998 after writing a bachelor's thesis on parenting support on parents and children in poverty. After this, she worked for fourteen years as a registered nurse in the obstetrics department of a hospital and at a regional youth health care organization. During this period, she pursued the master's program Health Education and Promotion at the Faculty of Health, Medicine and Life Sciences of Maastricht University. Liesbeth graduated in 2010. Her master's thesis explored the impact of the physical and social environment of children at a nursery on their exercise behavior. Since then, Liesbeth works as a lecturer bachelor of nursing at Avans University of Applied Sciences, and since 2016 also as a science practitioner at Tranzo, Scientific Center for Care and Wellbeing at Tilburg University. Her PhD research focuses on the shift from problem-focused to solution-focused parenting support among public health nurses. Liesbeth has published several articles and has presented several times at (inter)national conferences on this topic.

This dissertation focuses on the shift from problem-focused to solution-focused parenting support by public health nurses working in the Dutch youth healthcare.
Given the fundamental differences between these two approaches, the assumption was that the implementation activities, provided in youth healthcare to facilitate this shift, would be insufficient for such a radical change. This dissertation describes the current state of solution-oriented parenting support among public health nurses, and whether and how appreciative inquiry could facilitate the shift from problem-focused to solution-focused parenting support. Recommendations for further research, policy, and practice are provided to support this change.

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